Religion and Well-being:
Assessing the evidence

Nick Spencer
Gillian Madden
Clare Purtill
Joseph Ewing

Executive summary

Theos

Join the discussion by becoming a Friend of Theos

Impact how society views Christianity and shape the cultural debate

The Friends' Programme is designed specifically for people who wish to enter the heart of the current debate. When you join, our commitment is to keep you informed, equipped, encouraged and inspired so that you can be a voice in the public square with us.

As a member of the Friends' Programme, you are provided with:

- ***Hard copies of all our latest reports*** on the most pressing issues – social justice, welfare, politics, spirituality, education, money, atheism, humanism…
- ***Free access to our events.*** Theos hosts a number of high calibre speakers (e.g. Rowan Williams, Larry Siedentop, Grace Davie) and debates ('Magna Carta and the future of liberty', 'Does humanism need Christianity?'). As a friend, you will receive invitations to all these without charge.
- ***A network of like-minded people*** who wish to share ideas and collaborate with one another. We host networking events which help you meet fellow Friends and build your own network, allowing ideas to flow and connections to form.
- ***Our monthly e-newsletter*** which is your one-stop digest for the latest news regarding religion and society.
- **If you join as an Associate**, you are ***invited to private functions with the team***, allowing you to discuss upcoming projects, review the latest issues and trends in society, and have your say in where you see the public debate is going.

You can become a Friend or Associate today by visiting our website
www.theosthinktank.co.uk

If you'd prefer additional information, you can write to us directly:
Friends Programme, Theos, 77 Great Peter Street, London, SW1P 2EZ

If you have any inquiries regarding the Programme, you can email us at:
friends@theosthinktank.co.uk

Religion and Well-being: Assessing the evidence

Nick Spencer
Gillian Madden
Clare Purtill
Joseph Ewing

Executive summary

executive summary

This study evaluates the evidence from 139 academic studies conducted over the last 30+ years examining the relationship between religion and well-being. Across the majority of these studies, the data show a positive correlation between religion and well-being. This study not only collates these data but aims to clarify the nature of the relationship between religion and well-being.

It does this by teasing apart the different ways 'religion' and 'well-being' have been understood in the academic literature and surveys. Although the precise categorisations are contestable and different studies sometimes spread over different categories, we identified five conceptions of religion and four of well-being. These are:

- Religion: religious affiliation, subjective religiosity, religious belief, religious group participation, and religious personal participation
- Well-being: subjective well-being, mental health, physical health, and health supporting behaviours
- The definitions of these categories are given in the report, and also in the footnotes to this executive summary.

Having been identified from within the academic studies, these various conceptions of religion and well-being were then used as a framework for analysing the findings.

The data show that the picture is not simply that 'religion' is good for 'well-being' but rather one in which certain aspects of religion are better correlated with certain aspects of well-being.

Social religious participation[1] evidenced the strongest positive correlation across all measures of well-being.

Many of the studies evidenced a straightforward, strong positive correlation between personal religious participation[2] and well-being, most notably mental health.[3]

Religious belief[4] was found to have a largely positive, but more varied, impact on the different measures of well-being.

Subjective religiosity[5] had mixed effects on different indicators of well-being, particularly in the categories of physical health[6] and health supporting behaviours.[7]

The loosest category of our indicators of religion, religious affiliation,[8] was shown to have the weakest effect on well-being.

Of the measures of well-being, subjective well-being[9] seems to be the most sensitive to the effects of the different types of religiosity.

Higher levels of involvement in religion are more beneficial to mental health overall.

Within the category of physical health the phenomenon of religious coping[10] is quite evident.

At the most generalised level, it seems that the more serious, genuinely held and practically-evidenced a religious commitment is, then the greater the positive impact it is likely to have on well-being.

references – executive summary

1 'Social religious participation' pertains to the active (and regular) participation in group religious worship services, although some studies include other forms of religious social participation, such as volunteering.

2 'Religious personal participation' pertains to engaging in acts of private devotion such as prayer, scripture reading, or listening to religious music.

3 'Mental health' pertains to measures of depression, anxiety and the like, and has a more clinical focus than subjective well-being.

4 'Religious belief' pertains to personal belief in God or a higher power, and assent to tenets or doctrines of a religious group, for example, belief in an afterlife.

5 'Subjective religiosity' pertains to the degree of influence that beliefs have on a person's decisions and lifestyle and the sense of having a personally meaningful relationship with God or a higher power.

6 'Physical health' pertains to indicators including chronic pain, recovery rate from illness, and mortality rate and like mental health is a more clinical category than subjective well-being.

7 'Health supporting behaviours' pertains to those activities that tend to have a positive effect on physical health, such as by preventing substance abuse or addiction, or by encouraging exercise or healthy eating.

8 'Religious affiliation' pertains to the extent to which an individual identifies with religion. Although this can range from a cultural affinity to full community participation, this is nonetheless is a "low threshold" category, i.e. it need not demand significant commitment on behalf of the respondent.

9 'Subjective well-being' pertains to measures of self-reported happiness, including life satisfaction, personal evaluation of progress towards life goals, and having a sense of meaning in life.

10 'Religious coping' pertains to the habit of religiosity (in different guises) being used as a way of offsetting the effects of poor health, and consequently promoting a better sense of well-being.

introduction

Public discourse about religion today is as criss-crossed by stories as battlefields once were by trenches. For all you might try to venture out into narrative no-man's-land and say something genuinely new or different, the likelihood is that you will stumble back into one of the enduring, deeply-embedded lines that we encounter with almost wearying familiarity. If, as Christopher Booker once wrote in a 700-page book on the topic, there are only "seven basic plots" to which all narrative art forms eventually conform, much the same idea, give or take a plot or two, seems to applies to religion in Britain today.

We might debate what those basic religious plots are. "Fundamentalist violence and radicalisation" is one. "Issues of sexuality" is obviously another, with "the Anglican Communion" being a third (or possibly only a sub-plot of the second). "Social activism" and "Pope Francis" both also make good claims. Alongside all these, however, one of the most frequent and best established stories is surely the one about "religion and well-being".

This states, in its various permutations, that religion is good for well-being (or life-satisfaction or happiness); that the religious are happier than the non-religious; that atheists are more miserable; that religious practices are good for you; and so forth. Thus, according to *The Week* in 2016, 'Middle-aged atheists [are] the 'unhappiest people' in Britain';[1] according to *Newsweek* in 2015, 'Religion [is] Better for Mental Health Than Sport';[2] and according to the *Daily Mail* in 2014, 'Religious people [are] much happier and have more 'life satisfaction' than others'.[3]

These newspapers are not the source of these claims. *The Week* was reporting on a substantial study conducted by the Office for National Statistics,[4] *Newsweek* on another big study by the London School of Economics and the Erasmus University Medical Center in the Netherlands,[5] and *The Mail* on one from the Austin Institute for the Study of Family and Culture.[6] In other words, the findings are not only repeated but also robust and reputable.

It should not need saying, but probably does, that such research says nothing about the truth content of whichever religion is in question. Just because 'religion' (we shall return to what that means) apparently makes you 'happy' (ditto) that doesn't mean it's true.

That recognised, the repeated connection between religion and well-being has encouraged a certain shift in the broader intellectual climate – from seeing religion as an epiphenomenon, an incidental, secondary entity, essentially parasitic on political or economic injustice or intellectual backwardness and due therefore to disappear with the advent of communism, industrialisation or modernisation – to seeing it as intrinsic to and deeply-entrenched within human nature, and thereby more likely to morph than to disappear in the future.

Precisely what further conclusions one draws from these studies will depend on what we understand from 'religion' and what from 'well-being'. The terms are susceptible to a range of different interpretations and meanings. Religion, for example, might mean affiliation – the extent to which I identify as 'belonging' to a particular religion. It might mean religiosity – the importance that I attach to religion in my life. It might mean belief – the extent to which I hold the creeds of a particular religion to be factually true. It might mean group participation – the extent to which I join in with what other people of that religion do. Or it might be personal participation – the extent to which I perform the practices of that religion personally. There are, no doubt, other ways of skinning that particular religious cat, but these five cover a good range of the options, moving broadly speaking from the more casual form of religious involvement to the more serious.

A similar approach is necessary when dealing with well-being, with the added challenge that the terminology is even more diverse and slippery, and often used interchangeably. Thus, not only do studies talk of 'happiness', 'life-satisfaction' and 'well-being' interchangeably, but those very terms are to some degree open to the interpretation of the subject: the difference between happiness, life-satisfaction and well-being is, to some degree, in the eye of the respondent.

The ONS study cited above in fact assesses four different dimensions – anxiety, happiness, life-satisfaction, and worthwhileness – in a way that intuitively progresses from the more ephemeral to the more permanent. Thus, of the first two they ask "Overall, how anxious did you feel yesterday?" and "Overall, how happy did you feel yesterday?"; of the third, "Overall, how satisfied are you with your life nowadays?"; and of the last, "Overall, to what extent do you feel the things you do in your life are worthwhile?" This movement – from anxiety and happiness on a day by day basis, through life-satisfaction on a slightly larger timescale ("nowadays") to worthwhileness on a still larger timescale ("your life") – is clearly measuring different things.

Unfortunately other studies – the study of the correlation of religion and well-being has been on-going for decades – are not always as carefully graded, and can talk of happiness, life-satisfaction or well-being in more generic or interchangeable ways. The ONS study assesses four different factors although they are still all factors of the same dimension,

namely subjective well-being. There are various other ways of assessing 'well-being'. Other studies look at what might be called objective well-being, measures of mental and of physical health that are somewhat less dependent on what the respondent themselves thinks of their condition. To these three categories – subjective well-being, mental health, and physical health – we can also add a fourth, under the category of "health supporting behaviours", in other words those habits and practices that prevent a subject from falling or feeling ill.

Our study adopts these two different categorisations – for religion: religious affiliation, subjective religiosity, religious belief, religious group participation, and religious personal participation; and for well-being: subjective well-being, mental health, physical health, and health supporting behaviours – as a means of understanding the true nature of the inter-relationship between 'religion' and 'well-being'.

Its objective, firstly, is to provide a long-term and detailed assessment of the "religion is good for well-being" story with which we started. Is it? And if it is, as these repeated news stories and academic studies claim (and here we move on to the second objective) what does that mean? Does it mean all kinds of religion support all kinds of well-being equally? Or that all kinds of religion support all kinds of welfare but to different degrees? Or that some kinds of religion support some kinds of welfare to some extent, whereas others are neutral to or even destructive of others?

Behind these various questions there lurks an ultimate one that the data cannot answer. Why? What is it about 'religion', however that is understood, that supports (if it does) 'well-being', however that is understood. Research can equip us to engage with this, by delineating the ways in which different aspects of religion are correlated with different kinds of well-being. Correlation is not causation, however, and whatever conclusions we draw from this delineation will invariably be tentative.

this study

This project is a summary study (not technically a meta-analysis as it has not sought formally to synthesise the results into a single, coherent study) of 139 individual studies[7] that have been conducted into the relationship between religion and well-being over the last thirty or so years. Although studies of the relationship between religion and well-being have been conducted since the 1960s,[8] the field only began to take off in the 1980s, with growing numbers in the last 20 years. The studies are taken from a wide range of academic sources, that range being so wide that attempting any kind of formal synthesis would be futile. What this study does try to do is categorise and assess these studies in such a way as to understand the true nature of the relationship between religion and well-

being. In effect, rather that stopping at the line "there is a correlation between religion and well-being," it tries to disambiguate the two terms and then cross-compare the disambiguated terms. How does religious affiliation correlate with subjective well-being, for example? Or how does religious belief correlate with mental health? Or religious group participation with physical health?

Mathematically-acute readers will pick up on the fact that the breakdown of the terms along the lines mentioned above will mean that there are, in total, twenty different points of comparison, or graphically expressed, twenty different cells to fill in:

Well-being / **Religion**	Subjective Well-being	Mental Health	Physical Health	Health Supporting Behaviours
Religious Affiliation				
Subjective Religiosity				
Religious Belief				
Religious Group Participation				
Religious Personal Participation				

This makes for a large study with plenty of sub-sections, which is precisely what this volume is, comprising five chapters (pertaining to the five different categories of religion) each with four sections in it (pertaining to the different categories of well-being). Hopefully this structure, coupled with fuller (and oft-repeated) definitions of the different categories used should make a long and detailed report easier to navigate and read.

All that duly acknowledged, however, it is important to enter a critical caveat at this juncture. The academic studies that make up the meat of this survey report do not always naturally limit themselves to these categories. Some focus tightly on religious belief or on mental health, for example, but others spread their interest across multiple categories, religious affiliation and subjective religiosity, for example, or subjective well-being and mental health. That means that a number of these studies appear in more than one of the twenty sections in the report.

What we have done here is to systematise, categorise and analyse the complex, multivalent relationship between religion and well-being from thirty years of academic literature in as consistent and coherent a way as possible.

Across the majority of the 139 studies analysed as part of this project, the data show a positive correlation between religion and well-being.

Moreover, the fact that the studies do not always articulate their focus(es) in consistent or clear ways means that there are inevitably judgement calls to be made on where one slots different surveys. Readers who do make it through the meat of the study – and be warned, it is slow and not always gripping reading – may sometimes find themselves feeling that a particular study belonged in a different category, or perhaps more than one particular category. This is unavoidable in the context. What we have done here is to systematise, categorise and analyse the complex, multivalent relationship between religion and well-being from thirty years of academic literature in as consistent and coherent a way as possible. We hope that is what we have achieved but even if we have there will be rough edges, loose ends and grounds for re-consideration and revision.

The picture is not simply that 'religion' is good for 'well-being' but rather one in which certain aspects of religion are better correlated with certain aspects of well-being.

the findings

What did we find? There are various ways the findings of *Religion and Well-being* might be summarised, but the following points offer, we think, the best overview of the literature we have surveyed.

1. The widely-reported correlation between religion and well-being – the deep narrative with which we began – holds well. Across the majority of the 139 studies analysed, the data show a positive correlation between religion and well-being.

2. While there is substantial evidence to suggest that religion largely has a positive effect on well-being, there is also evidence of variation. The picture is not simply that 'religion' is good for 'well-being' but rather one in which certain aspects of religion are better correlated with certain aspects of well-being.

3. Social participation evidenced the strongest positive correlation across all measures of well-being. The overwhelming consensus among the studies in our matrix was that religious social participation was conducive to all signals of well-being. Regular, frequent religious service attendance seemed to have the biggest impact on well-being, though lower levels of attendance and other types of participation, such as volunteering, also has some effect.

4. More private forms of participation – 'religious personal participation' – also evidenced a strong positive correlation, although to a lesser degree than religious group participation. In some cases more distress was associated with more

personal participation, though in the context of the study it is clear that the private religious activity did not cause the negative impact on well-being, but was a response to it. More broadly, many of the studies evidenced a straightforward, strong positive correlation between personal participation and well-being, most notably in the area of mental health.

5. Religious belief was found to have a largely positive, but more varied, impact on the different measures of well-being. Subjective well-being evidenced a strong positive correlation with religious belief, with 18 of the 19 studies in this section supporting the notion that belief has a positive effect on subjective well-being. The effect of religious belief was less pronounced in relation to mental health, and significantly weaker correlations were found with physical health and health supporting behaviours.

Many of the studies evidenced a straightforward, strong positive correlation between personal participation and well-being, most notably in the area of mental health.

6. Subjective religiosity had mixed effects on different indicators of well-being, particularly in the categories of physical health and health supporting behaviours. A significant number of studies evidenced a strong positive relationship between subjective religiosity and subjective well-being. To a lesser degree, there was also a positive correlation for another indicator of well-being, with higher levels of subjective religiosity having a positive impact on mental health. The effect of subjective religiosity on mental health was found to be ambiguous and inconclusive and there were not enough studies focused on health supporting behaviours to draw any clear conclusions.

7. Perhaps unsurprisingly the loosest category of our indicators of well-being, religious affiliation, was shown to have the weakest effect on well-being. Both subjective well-being and health supporting behaviours were impacted by some form of religious affiliation, though the results for the other measures of well-being were mixed. Once again, the studies in this category do not suggest that there are negative effects of religious affiliation on well-being, but there is not a strong positive correlation either.

8. Of the measures of well-being, subjective well-being seems to be the most sensitive to the effects of the different types of religiosity and is shown to be most strongly affected in each chapter. Subjective well-being also seems to be the category within well-being with the highest association with the phenomenon of religious coping. In each chapter there was evidence of a positive correlation, and in most cases it was noticeably strong. The weakest positive correlation was in

The loosest category of our indicators of well-being, religious affiliation, was shown to have the weakest effect on well-being.

the chapter on religious affiliation; perhaps because this signifies the lowest level of involvement in religion and therefore reaps the least benefit in terms of well-being.

9. Mental health either showed a mixed correlation or a strong positive one. The mixed correlations were found in the chapters on religious affiliation and subjective religiosity, which are the lowest threshold categories of our indicators of well-being. Religious belief, social participation and personal participation all evidenced significantly stronger positive correlations. This indicates that higher levels of involvement in religion are more beneficial to mental health overall.

10. Within the category of physical health the phenomenon of religious coping is quite evident. Essentially this means that those with poor health often turn to religion as a source of comfort (rather than fall ill because of their religiosity). This works in the opposite way to most other categories, as the type of well-being is exerting an influence on aspects of their religion.

11. It is difficult to draw any strong conclusions on the measure of health supporting behaviours as there are significantly fewer studies in this area. This leads to varied results, with affiliation and belief evidencing a positive correlation, social participation showing a stronger positive correlation and both subjective religiosity and personal participation giving mixed results.

what does this mean?

What can we draw from this closer examination of the various relationships between the different subcategories of religion and well-being?

There is undoubtedly a correlation between the two, although it is not entirely consistent or homogenous. Religion does, as a rule, lead to well-being although in a variety of ways. In some instances, religious belief can give people's suffering meaning, and provide an interpretive framework by means of which they can cope with it.

Social participation evidenced the strongest positive correlation across all measures of well-being.

That said, belief alone is not as strongly correlated with well-being as social and personal participation activities, with one study even reporting that those with religious belief, where it was not coupled with social and personal participation activities, could lead to higher levels of

depression. Similarly, belief alone is not enough as there were signs that *types* of belief mattered. Different types of belief in God (punitive or benevolent) and different types of attachments (secure, avoidant, and anxious) could have different effects. One study, for example, reported that belief in the afterlife is inversely associated with feelings of anxiety, while strong beliefs in the pervasiveness of sin are positively linked to anxiety. Belief matters but it is not everything.

Religious belief was found to have a largely positive, but more varied, impact on the different measures of well-being.

Personal and, even more, social religious participation seem to be the most strongly correlated with well-being, although, again, this is not straightforward. Thus, there is some evidence that group participation for extrinsic rather than intrinsic reasons – seeing participation as a means to another end (recognition or advancement, for example) rather than an end in itself – can wipe out any of the positive benefits of any such participation, and even be associated with negative benefits.

Similarly, just as not all social religious participation may be good (some cults or religious sects may encourage behaviours that do not support good health), other forms of social participation that have nothing to do with religion can be associated with well-being. No one has ever claimed that *only* religious social participation is good for you, or that such participation is *always* good for you.

For all the complexities, it is reasonably clear that affiliation is a weak correlate to well-being. What you call yourself does not correspond strongly to how well you feel, although even here one has to be alert to the shifting sands: how someone religiously affiliates means different things depending on which religion is being discussed in which culture and at which time. Affiliation is, as this report calls it, a low-threshold category, but one still has to be careful not to trip up.

Subjective religiosity had mixed effects on different indicators of well-being, particularly in the categories of physical health and health supporting behaviours.

It will be clear that summarising all these different findings neatly is problematic. As soon as you go beyond the main plot line that religion and well-being are positively linked, you are faced with such a plethora of sub-plots that you are in danger of losing the plot altogether.

One way of regaining it might be in the very idea of narrative with which we started. Humans live according to narratives, consciously and sub-consciously adopted. These articulate various understandings of who they are and what they are worth, what they do and what they should do, what they value and what they reject, what is their purpose

Of the measures of well-being, subjective well-being seems to be the most sensitive to the effects of the different types of religiosity.

and what is their destiny. One way of understanding negative well-being is as the adoption of destructive or dehumanising narratives, that erode human worth, purpose and hope, sometimes as a result of and sometimes resulting in equally destructive habits. Reversing, retelling or extracting oneself from such narratives and habits is difficult, sometimes seemingly impossible.

The findings of the studies in this research might be understood to be gesturing towards the conclusion that the more that someone believes in and inhabits an overarching narrative of love and generosity, which they believe is ontological (i.e. written into the very fabric of the universe) rather than contingent (i.e. simply an admirable but essentially arbitrary personal choice with no resonance beyond the individual), the more likely they are to enjoy better well-being (with one caveat, to which we will return below).

This statement, specifically the phrase "adheres to an overarching narrative of love and generosity", requires clarification. The phrase is intended to mean two things: firstly, believing that one is placed within an overarching or 'cosmic' or spiritual story in which the divine is characterised by love, acceptance and generosity, and accordingly the human has some kind of worthwhileness and purpose; and secondly, that in response one acts out that belief and those values of love and generosity through personal affiliation, personal habits, and personal participation in a group – in effect, in spite of the vicissitudes of whatever life throws at you, you live according to the narrative in which love flows from above, through you, to others.

The caveat is no less important. This adherence needs to be authentic. As soon as the desire to achieve well-being becomes the goal of religiosity, rather than a side-effect, the whole system collapses in on itself. To join community for the sake of 'me' is to kill community. To be generous for the sake of receiving something is to obliterate the meaning of generosity. Prayer that is a shopping list directed at some cosmic cash card soon ceases to be prayer. If there is any well-being to be got from religion, it should be got on the way, almost accidentally. Instead, to adapt a phrase, the seeker after well-being should seek first the kingdom of heaven, because only then will these others things be given to him or her.

Higher levels of involvement in religion are more beneficial to mental health overall.

There is no guarantee in any of this. Adhering to a spiritual narrative of love and generosity will not protect you from ill-health (although it may cement a good many health supporting behaviours so as to make ill-health a rarer-than-average likelihood). Adhering

to such a narrative will not guard you against all times of loneliness or worthlessness (although being part of a generous and supportive community should help you deal with such times). Adhering to this narrative will not indemnify you against those feelings of pointlessness and futility that all flesh seems heir to (although it should help you revise and rewrite those feelings when they do come). The relationship between religion and well-being is only ever going to be probabilistic.

Adhering to a spiritual narrative of love and generosity will not protect you from ill-health.

To conclude with a point made earlier: none of this means that 'religion' is true. The surveys covered in this report cover a range of different religions, which do not believe or even do the same thing. What it does suggest is that religiosity is a complex phenomenon with complex but deep and inherent links with human well-being. However else we may see the religious narratives that criss-cross our public discourse change over the years to come, we can be confident that we will hear much more of this one.

note

A number of studies have come to our attention since this meta-study was completed. Most recently there have been the publication of Li Shanshan et al's study in JAMA Internal Medicine, the peer-reviewed medical journal published by the American Medical Association, entitled 'Association of Religious Service Attendance With Mortality Among Women', and Gail Ironson et al's study into the 'Relationship Between Spiritual Coping and Survival in Patients with HIV', published in the Journal of General Internal Medicine.

The former of these found that "frequent attendance at religious services was associated with significantly lower risk of all-cause, cardiovascular, and cancer mortality among women"; the latter reported that "overall positive spiritual coping significantly predicted greater survival over 17 years", and claimed that theirs was the "first study showing a prospective relationship of spiritual coping in people who are medically ill with survival over such a long period of time". In other words, both of these studies support the overall picture presented by those that are included within this analysis.

Shanshan's study concluded that "religion and spirituality may be an underappreciated resource that physicians could explore with their patients, as appropriate." This is precisely the kind of suggestion and ensuing debate that this particular meta-study is hoping to catalyse.

introduction – references

1 http://www.theweek.co.uk/69192/middle-aged-atheists-the-unhappiest-people-in-britain

2 http://europe.newsweek.com/religion-better-mental-health-sport-study-finds-331240

3 http://www.dailymail.co.uk/news/article-2886974/Study-Religious-people-happier-life-satisfaction-others.html

4 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-429189%20

5 http://www.lse.ac.uk/newsAndMedia/news/archives/2015/08/Church&MentalHealth.aspx

6 http://relationshipsinamerica.com/religion/are-religious-people-happier-people

7 Technically speaking, a small number of these individual studies are themselves summaries or meta-analyses, so the total number of individual studies surveyed is greater even than this, but for simplicity's sake we can say it comprises 139 studies.

8 A few of these earliest studies are actually included in one of the summary studies included in this report.

appendix 1

bibliography and index of studies

Author(s)	Title and Publication details	Chapters
Acklin MW, Brown EC, Mauger PA.	The role of religious values in coping with cancer. *J Relig Health*. 1983 Dec;22(4):322-33. 1983	2.1
Alexander F, Duff RW.	Influence of religiosity and alcohol use on personal well-being. *Journal of Religious Gerontology*. Volume 8, Issue 2. 1992	1.1, 1.2, 1.4, 3.4
Andersson G.	Chronic Pain and Praying to a Higher Power: Useful or Useless? *J Relig Health*. 2008 Jun;47(2):176-87. 2007	5.2, 5.3
Ayele H, Mulligan T, Gheorgiu S, Reyes-Ortiz C.	Religious Activity Improves Life Satisfaction for Some Physicians and Older Patients. *J Am Geriatr Soc*. 47(4):453-5. 1999	2.1, 5.1
Baetz M, Griffin R, Bowen R, Koenig HG, Marcoux E.	The association between spiritual and religious involvement and depressive symptoms in a Canadian population. *J Nerv Ment Dis*. 192(12):818-22. 2004	3.2, 4.2
Balbuena L, Baetz M, Bowen R.	Religious Attendance, Spirituality, and Major Depression in Canada: A 14-Year Follow-up Study. *Can J Psychiatry*. 58(4):225-32. 2013	1.2, 4.2
Ball J, Armistead L, Austin B.	The relationship between religiosity and adjustment among African-American, female, urban adolescents. *J Adolesc*. 26(4):431-46. 2003	1.1, 1.2, 3.1, 4.1, 4.2
Banerjee AT, Strachan PH, Boyle MH, Anand SS, Oremus M.	Attending Religious Services and Its Relationship with Coronary Heart Disease and Related Risk Factors in Older Adults: A Qualitative Study of Church Pastors' and Parishioners' Perspectives. *J Relig Health*. 53(6):1770-85. 2013	4.2, 4.3
Barber BK.	Political violence, social integration, and youth functioning: Palestinian youth from the Intifada. *Journal of Community Psychology*. 29(3): 259–280. 2001	2.2, 4.2, 5.2

Baroun KA.	Relations among religiosity, health, happiness and anxiety for Kuwaiti adolescents. *Psychol Rep*. 99(3):717-22. 2006	3.1, 3.2
Ben-Meir J, & Kedem P.	Religiousness measure for the Jewish population in Israel. *Megamot*, 24, 353-362, (in Hebrew) 1979	1.1
Benjamins MR.	Does religion influence patient satisfaction? *Am J Health Behav*. 30(1):85-91. 2006	2.1, 3.4
Benjamins MR.	Predictors of preventive health care use among middle-aged and older adults in Mexico: the role of religion. *J Cross Cult Gerontol*. 22(2):221-34. 2007	3.4, 4.4
Benjamins MR, Trinitapoli J, Ellison CG.	Religious Attendance, Health Maintenance Beliefs, and Mammography Utilization: Findings from a Nationwide Survey of Presbyterian Women. *Journal for the Scientific Study of Religion*. 45(4) 597–607. 2006	4.4
Bradshaw M, Ellison CG, Fang Q, Mueller C.	Listening to Religious Music and Mental Health in Later Life. *The Gerontologist*. 2014	5.1
Branco KJ.	Religious activities, strength from faith, and social functioning among African American and white nursing home residents. *Journal of Religion, Spirituality & Aging*. 19(4). 2007	2.1, 4.1, 4.2
Brown PH, Tierney B.	Religion and subjective well-being among the elderly in China. *The Journal of Socio-Economics*. 38(2): 310-319. 2009	4.1, 5.1
Burazeri G, Goda A, Kark JD.	Religious observance and acute coronary syndrome in predominantly Muslim Albania: a population-based case-control study in Tirana. *Ann Epidemiol*. 18(12):937-45. 2008	4.3, 5.3
Burgener, SC.	Caregiver religiosity and well-being in dealing with Alzheimer's dementia. *J Relig Health*. 33(2):175-89. 1994	4.1
Büssing A, Fischer J, Ostermann T, Matthiessen PF.	Reliance on God's Help as a Measure of Intrinsic Religiosity in Healthy Elderly and Patients with Chronic Diseases. Correlations with Health-Related Quality of Life? *Applied Research in Quality of Life*. 4(1): 77-90 2009	2.2, 2.3
Carver CS, Pozo C, Harris SD, Noriega V, Scheier MF, Robinson DS, Ketcham AS, Moffat Jr FL, Clark KC.	How coping mediates the effect of optimism on distress: A study of women with early stage breast cancer. *J Pers Soc Psychol*. 65(2):375-90. 1993	3.1
Chang B, Skinner KM.	The relationship between sexual assault, religiosity, and mental health among male veterans. Int *J Psychiatry Med*. 33(3):223-39. 2003	2.2, 4.2

Cohen AB.	The Importance of Spirituality in Well-Being for Jews and Christians. *Journal of Happiness Studies* 3(3): 287-310. 2002	4.3, 5.3
Cohen AB, Pierce JD, Chambers J, Meade R, Gorvine BJ, Koenig HG.	Intrinsic and extrinsic religiosity, belief in the afterlife, death anxiety, and life satisfaction in young Catholics and Protestants. *Journal of Research in Personality*. 39(3):307–324 2005	3.1
Connor P.	Balm for the soul: immigrant religion and emotional well-being. *International Migration*. 50(2):130-157 2010	4.1
Contrada RJ, Goyal TM, Cather C, Rafalson L, Idler EL, Krause TJ	Psychosocial factors in outcomes of heart surgery: the impact of religious involvement and depressive symptoms. *Health Psychol*. 23(3):227-38. 2004	3.2, 3.3, 4.2, 4.3
Corrigan P, McCorkle B, Schell B, Kidder K.	Religion and Spirituality in the Lives of People with Serious Mental Illness. *Community Ment Health J*. 39(6):487-99. 2003	3.1
Corsentino EA, Collins N, Sachs-Ericsson N, Blazer DG.	Religious attendance reduces cognitive decline among older women with high levels of depressive symptoms. *J Gerontol A Biol Sci Med Sci*. 64A(12): 1283–1289. 2009	4.2
Croezen S, Avendano M, Burdforf A van Lenthe FJ.	Social Participation and Depression in Old Age: A Fixed-Effects Analysis in 10 European Countries. *American Journal of Epidemology, Vol.* 182 No. 2, 2015	Introduction
Dalmida SG, Holstad MM, Diiorio C, Laderman G	Spiritual well-being, depressive symptoms, and immune status among women living with HIV/AIDS. *Women Health*. 49(2-3):119-43. 2009	2.3, 5.2, 5.3
Dupre ME, Franzese AT, Parrado EA.	Religious attendance and mortality: implications for the black-white mortality crossover. *Demography*. 43(1):141-64. 2006	4.3
Ell KO, Mantell JE, Hamovitch MB, Nishimoto RH.	Social Support, Sense of Control, and Coping Among Patients with Breast, Lung, or Colorectal Cancer. *Journal of Psychosocial Oncology* 7(3): 63-89. 1989	4.2
Ellison CG, Hummer RA, Cormier S, Rogers RG.	Religious involvement and mortality risk among African American adults. *Research on Aging* 22(6): 630-667. 2000	4.3
Ellison CG, Burdette AM, Hill TD.	Blessed assurance: religion, anxiety, and tranquility among US adults. *Soc Sci Res*. 38(3):656-67. 2009a	3.2, 4.2
Ellison CG, Zhang W, Krause N, Marcum JP.	Does Negative Interaction in the Church Increase Depression? Longitudinal Findings from the Presbyterian Panel Survey. *Sociol Relig*. 1;70(4):409-431. 2009b	4.2
Ellison CG.	Religious Involvement and Subjective Well-Being. *J Health Soc Behav*. 32(1):80-99. 1991	2.1, 4.1, 5.1

Fehring RJ, Miller JF, Shaw C.	Spiritual well-being, religiosity, hope, depression, and other mood states in elderly people coping with cancer. *Oncol Nurs Forum*. 24(4):663-71. 1997	2.1, 2.2, 3.1, 3.2
Ferriss AL.	Religion and the Quality of Life. *Journal of Happiness Studies*. 3: 199-215. 2002	3.1, 4.1
Flannelly KJ, Ellison CG, Galek K, Silton NR	Belief in life-after-death, beliefs about the world, and psychiatric symptoms. *J Relig Health*. 51(3):651-62. 2012	3.2
Flannelly KJ, Koenig HG, Ellison CG, Galek K, Krause N.	Belief in life after death and mental health: findings from a national survey. *J Nerv Ment Dis*. 194(7):524-9. 2006	3.2
Friedlander Y, Kark JD, Stein Y.	Religious orthodoxy and myocardial infarction in Jerusalem – a case control study. *Int J Cardiol*. 10(1):33-41.1986	1.3
Gillum RF, Holt CL.	Associations Between Religious Involvement and Behavioral Risk Factors for HIV/AIDS in American Women and Men in a National Health Survey, *Ann Behav Med*. 40(3):284-93 2010	4.4
Goldstein ED	Sacred moments: implications on well-being and stress. *J Clin Psychol*. (10):1001-19. 2007	5.1
Green M, Elliott M.	Religion, Health, and Psychological Well-Being. *Journal of Religion and Health*. 49(2): 149-163. 2010	1.1, 1.3, 3.1, 3.3
Green MR, Emery CF, Kozora E, Diaz P, Make BJ.	Religious and Spiritual Coping and Quality of Life Among Patients With Emphysema in the National Emphysema Treatment Trial. *Respir Care*. 56(10):1514-21. 2011	1.1
Greene KV, Yoon BJ.	Religiosity, economics and life satisfaction. *Review of Social Economy*. 62(2):245-261. 2004	4.1
Greenfield EA, Marks NF.	Religious Social Identity as an Explanatory Factor for Associations Between More Frequent Formal Religious Participation and Psychological Well-Being. *Int J Psychol Relig*. 17(3):245-259. 2007	4.1, 4.2
Hackney CH, Sanders GS	Religiosity and mental health: a meta-analysis of recent studies, *Journal for the Scientific Study of Religion*. Volume 42, Issue 1, 2003	5.2
Helm HM, Hays JC, Flint EP, Koenig HG, Blazer DG.	Does private religious activity prolong survival? A six-year follow-up study of 3,851 older adults. *J Gerontol A Biol Sci Med Sci*. 55(7):M400-5. 2000	5.3
Hill PC, Butter EM.	The role of religion in promoting physical health. *Journal of Psychology and Christianity*. 14:141-155. 1995	1.3, 1.4, 3.3, 3.4

Hill PC, Pargament KI.	Advances in the Conceptualisation and Measurement of Religion and Spirituality: Implications for Physical and Mental Health Research, *The American Psychologist*, Vol. 58(1), 2003	Introduction
Hill TD, Angel JL, Ellison CG, Angel RJ.	Religious attendance and mortality: an 8-year follow-up of older Mexican Americans. *J Gerontol B Psychol Sci Soc Sci*. 60(2):S102-9. 2005	4.3
Hill TD, Ellison CG, Burdette AM, Musick MA.	Religious involvement and healthy lifestyles: evidence from the survey of Texas adults. *Ann Behav Med*. 34(2):217-22. 2007	1.4, 4.4
Hill TD, Rote SM, Ellison CG, Burdette AM.	Religious Attendance and Biological Functioning: A Multiple Specification Approach. *J Aging Health*. 26(5): 766-785. 2014	4.3
Holland JC, Passik S, Kash KM, Russak SM, Gronert MK, Sison A, Lederberg M, Fox B, Baider L.	The role of religious and spiritual beliefs in coping with malignant melanoma. *Psychooncology*. 8(1):14-26. 1999	3.1
Holland JM, Neimeyer RA.	Reducing the risk of burnout in end-of-life care settings: The role of daily spiritual experiences and training. *Palliat Support Care*. 3(3):173-81. 2005	5.2
Horton KD, Ellison CG, Loukas A, Downey DL, Barrett JB.	Examining attachment to God and health risk-taking behaviors in college students. *J Relig Health*. 51(2):552-66. 2012	2.4
Hoverd WJ, Sibley CG.	Religion, deprivation and subjective wellbeing: testing a religious buffering hypothesis. *International Journal of Wellbeing*. 3(2) 2013	1.1
Hummer RA, Rogers RG, Nam CB, Ellison CG.	Religious involvement and U.S. adult mortality. *Demography*. 36(2):273-85. 1999	4.3
Idler EL, Kasl SV.	Religion among Disabled and Nondisabled Persons I: Cross-sectional Patterns in Health Practices, Social Activities, and Well-being. *J Gerontol B Psychol Sci Soc Sci*. 52(6):S294-305. 1997a	4.3
Idler EL, Kasl SV.	Religion among disabled and nondisabled persons II: attendance at religious services as a predictor of the course of disability. *J Gerontol B Psychol Sci Soc Sci*. 52(6):S306-16. 1997b	4.3
Iecovich E.	Religiousness and Subjective Well-Being Among Jewish Female Residents of Old Age Homes in Israel. *Journal of Religious Gerontology*. 13(1):31-46. 2002	1.1, 2.1, 3.1

Ironson G, Stuetzle R, Fletcher MA.	An Increase in Religiousness/Spirituality Occurs After HIV Diagnosis and Predicts Slower Disease Progression over 4 Years in People with HIV. *J Gen Intern Med*. 21(Suppl 5): S62–S68. 2006	4.3, 4.4, 5.3
Ironson G, Stuetzle R, Ironson D, Balbin E, Kremer H, George A, Schneiderman N, Fletcher MA.	View of God as benevolent and forgiving or punishing and judgmental predicts HIV disease progression. *J Behav Med*. 34(6):414-25 2011	3.3
Jarvis GK and Northcott HC.	Religion and differences in morbidity and mortality. *Social Science and Medicine*, Vol.25(7), 1987	3.4
Jeppsen B, Possel P, Winkeljohn Black S, Bjerg A, Wooldridge D.	Closeness and Control: Exploring the Relationship Between Prayer and Mental Health. *Counseling and Values*. 60(2): 164-185. 2015	2.2
Johnson SC, Spilka B.	Coping with breast cancer: The roles of clergy and faith. *J Relig Health*. 30(1):21-33. 1991	2.1, 2.2
Joshi S, Kumari S, Jain M.	Religious Belief and Its Relation to Psychological Well-being. *Journal of the Indian Academy of Applied Psychology*. 34(2): 345-354. 2008	4.2
Kallay E.	Investigation of the relationship between religious growth, positive affect, and meaning in life in a sample of female cancer patients. *Cognition, Brain, Behavior*. 12(2):161-182. 2008	2.1
Kao T, Tsai D, Wu K, Shiah C, Hsieh B, Chen W.	Impact of religious activity on depression and quality of life of chronic peritoneal dialysis patients in Taiwan. *J Formos Med Assoc*. 102(2):127-30. 2003	3.2
Kim KH.	Religion, body satisfaction and dieting. *Appetite*. 46(3):285-296. 2006	3.4, 4.1
King M, Weich S, Nazroo J, Blizard B.	Religion, mental health and ethnicity. EMPIRIC – A national survey of England. *Journal of Mental Health*. 15 (2), 153-62, 2006	4.2, 5.2
King M, Marston L, McManus S, Brugha T, Meltzer H, Bebbington P.	Religion, spirituality and mental health: results from a national study of English households. *British Journal of Psychiatry*. 202 (1), 68-73, 2013	4.2, 5.2
King DE, Mainous AG, Steyer TE, Pearson W.	The relationship between attendance at religious services and cardiovascular inflammatory markers. *Int J Psychiatry Med*.31(4):415-25. 2001	4.3
Kirby SE, Coleman PG, Daley D.	Spirituality and Well-Being in Frail and Nonfrail Older Adults. *J Gerontol B Psychol Sci Soc Sci*. 59(3):P123-9. 2004	3.1

Koenig HG.	Religion and Remission of Depression in Medical Inpatients With Heart Failure/Pulmonary Disease. *J Nerv Ment Dis*. 195(5):389-95. 2007a	4.2
Koenig HG.	Religion and Depression in Older Medical Inpatients. *Am J Geriatr Psychiatry*. 15(4):282-91. 2007b	1.2, 2.2, 4.2, 5.2
Koenig HG, Hays JC, George LK, Blazer DG, Larson DB, Landerman LR.	Modeling the Cross-Sectional Relationships Between Religion, Physical Health, Social Support, and Depressive Symptoms. *Am J Geriatr Psychiatry*. 5(2):131-44. 1997	4.2, 4.3, 5.2, 5.3
Koenig HG, Hays JC, Larson DB, George LK, Cohen HJ, McCullough ME, Meador KG, Blazer DG.	Does Religious Attendance Prolong Survival? A Six-Year Follow-Up Study of 3,968 Older Adults. *J Gerontol A Biol Sci Med Sci*. 54(7):M370-6. 1998	4.3
Koenig LB, Vaillant GE.	A prospective study of church attendance and health over the lifespan. *Health Psychol*. 28(1):117-24. 2009	4.1, 4.3, 4.4
Krause N.	Stress, Religiosity, and Psychological Well-Being among Older Blacks. *Journal of Aging and Health*. 4(3): 412-439. 1992	2.1, 4.1
Krause N.	Religious Meaning and Subjective Well-Being in Late Life. *J Gerontol B Psychol Sci Soc Sci*. 58(3):S160-70. 2002	2.1
Krause N.	Religious Involvement, Gratitude, and Change in Depressive Symptoms Over Time. *Int J Psychol Relig*. 19(3): 155–172. 2009	2.1, 4.1
Krause N.	Praying for Others, Financial Strain, and Physical Health Status in Late Life. *Journal for the Scientific Study of Religion*. 42(3): 377-391 2003a	5.3
Krause N.	Race, Religion, and Abstinence from Alcohol in Late Life. *J Aging Health*. 15(3):508-533. 2003b	1.4, 2.4, 4.4, 5.3
Krause N, Liang J, Shaw BA, Sugisawa H, Kim H, Sugihara Y.	Religion, Death of a Loved One, and Hypertension Among Older Adults in Japan. *J Gerontol B Psychol Sci Soc Sci*. 57(2):S96-S107. 2002	3.2, 3.3
Krause N, Wulff KM.	Religious Doubt and Health: Exploring the Potential Dark Side of Religion. *Sociology of Religion*. 65(1): 35-56. 2004	4.2
Krause N, Ellison CG.	Forgiveness by God, Forgiveness of Others, and Psychological Well-Being in Late Life. *J Sci Study Relig*. 1; 42(1): 77–94. 2003	2.1
Laurencelle RM, Abell SC, Schwartz DJ.	The Relation Between Intrinsic Religious Faith and Psychological Well-Being. *The International Journal for the Psychology of Religion*. 12(2): 109-123. 2002	2.2, 3.2

Lavrič M, Flere S.	The Role of Culture in the Relationship Between Religiosity and Psychological Well-being. *J Relig Health*. 47(2):164-75. 2008	2.1, 3.1, 4.1
Lawton, M.P.	The Philadelphia geriatric center morale scale: A revision, *Journal of Gerontology.* 30, 85-89 1975	1.1
Lelkes O.	Tasting freedom: happiness, religion and economic transition. *Journal of Economic Behavior and Organisation*. 59(2): 173-194. 2006	3.1, 4.1
Levin JS, Chatters LM.	Religion, Health, and Psychological Well-Being in Older Adults: Findings from Three National Surveys. *J Aging Health*. 10(4):504-31. 1998	4.1, 4.3
Maltby J, Day L.	Depressive symptoms and religious orientation: examining the relationship between religiosity and depression within the context of other correlates of depression. *Personality and Individual Differences*. 28(2): 383-393. 2000	2.2, 4.2
Maltby J, Lewis CA, Day L.	Religious orientation and psychological well-being: The role of the frequency of personal prayer. *British Journal of Health Psychology*. 4(4): 363-378. 1999	4.1, 5.1, 5.2
Maselko J, Gilman SE, Buka S.	Religious service attendance and spiritual well-being are differentially associated with risk of major depression. *Psychol Med*. 39(6):1009-17. 2009	4.2
Masters KS, Bergin AE.	Religious Orientation and Mental Health. *Psychol Med*. 39(6):1009-17. 1992	3.2
McIntosh D, Spilka B.	Religion and Physical Health: the role of personal faith and control beliefs. *Research in the Social Scientific Study of Religion*. 2: 167-194. 1990	2.3
McNulty K, Livneh J, Wilson LM.	Perceived Uncertainty, Spiritual Well-Being, and Psychosocial Adaptation in Individuals With Multiple Sclerosis. *Rehabilitation Psychology*. 49(2): 91-99. 2004	2.1
Milevsky A, Levitt MJ.	Intrinsic and extrinsic religiosity in preadolescence and adolescence: Effect on psychological adjustment. *Mental Health, Religion & Culture*. 7(4): 307-321. 2004	2.1
Musick MA, Wilson J.	Volunteering and depression: the role of psychological and social resources in different age groups. *Soc Sci Med*. 56(2):259-69. 2003	4.2
Nonnemaker JM, McNeely CA, Blum RW.	Public and private domains of religiosity and adolescent health risk behaviours: evidence from the National Longitudinal Study of Adolescent Health. *Soc Sci Med*. 57(11):2049-54. 2003	2.4, 4.4, 5.4

Noor NM.	Work and women's well-being: religion and age as moderators. *J Relig Health*. 47(4):476-90. 2008	3.1
Obisesan T, Livingston I, Trulear HD, Gillum F.	Frequency of attendance at religious services, cardiovascular disease, metabolic risk factors and dietary intake in Americans: an age-stratified exploratory analysis. *Int J Psychiatry Med*. 36(4):435-48. 2006	4.3, 4.4
O'Brien ME.	Religious faith and adjustment to long-term hemodialysis. *J Relig Health*. 21(1):68-80. 1982	2.1
Office for National Statistics	Measuring National Well-being: At what age is Personal Well-being the highest?. [Online]. *Office for National Statistics*.	
Oman D, Reed D.	Religion and mortality among the community-dwelling elderly. *Am J Public Health*. 88(10): 1469–1475. 1998	4.3
Page RL, Ellison CG, Lee J.	Does religiosity affect health risk behaviors in pregnant and postpartum women? *Matern Child Health J*. 13(5):621-32. 2009	4.4
Pargament KI, Koenig HG, Tarakeshwar N, Hahn J.	Religious Coping Methods as Predictors of Psychological, Physical and Spiritual Outcomes among Medically Ill Elderly Patients: A Two-year Longitudinal Study. *J Health Psychol*. 9(6):713-30. 2004	3.2, 4.2, 4.3
Pearce MJ, Rivinoja CM, Koenig HG.	Spirituality and health: empirically based reflections on recovery. *Recent Dev Alcohol*. 18:187-208. 2008	4.2
Powell LH, Shahabi L, Thoresen CE.	Religion and spirituality: Linkages to physical health. *Am Psychol*. 58(1):36-52. 2003	4.3, 4.4
Pressman P, Lyons JS, Larson DB, Strain JJ.	Religious belief, depression, and ambulation status in elderly women with broken hips. *Am J Psychiatry*. 147(6):758-60. 1990	3.3
Raleigh ED.	Sources of hope in chronic illness. *Oncol Nurs Forum*. 19(3):443-8. 1992	3.1
Reyes-Ortiz CA, Berges IM, Raji MA, Koenig HG, Markides KS.	Church attendance mediates the association between depressive symptoms and cognitive functioning among older Mexican Americans. *J Gerontol A Biol Sci Med Sci*. 63(5):480-6. 2008	4.2
Rippentrop AE, Altmaier EM, Chen JJ, Found EM, Keffala VJ.	The relationship between religion/spirituality and physical health, mental health, and pain in a chronic pain population. *Pain*. 116(3):311-21. 2005	2.2, 5.2, 5.3
Roberts JA, Brown D, Elkins T, Larson DB.	Factors influencing views of patients with gynecologic cancer about end-of-life decisions. *Am J Obstet Gynecol*. 176(1 Pt 1):166-72. 1997	2.1, 3.1

Rote S, Hill TD, Ellison CG.	Religious attendance and loneliness in later life. *Gerontologist*. 53(1): 39–50. 2012	4.1
Schieman S, Bierman A, Ellison CG.	Religious involvement, beliefs about God, and the sense of mattering among older adults. *J Sci Study Relig*. 49(3):517-35. 2010	3.1, 4.1, 5.1
Schnall E, Wassertheil-Smoller S, Swencionis C, Zemon V, Tinker L, O'Sullivan MJ, Van Horn L, Goodwin M.	The relationship between religion and cardiovascular outcomes and all-cause mortality in the Women's Health Initiative Observational Study. *Psychol Health*. 25(2):249-63. 2010	1.3, 2.3, 4.3
Seeman TE, Kaplan GE, Knudsen L, Cohen R, Guralink J.	Social network ties and mortality among the elderly in the Alameda County study. *Am J Epidemiol*. 126(4):714-23. 1987	4.3
Shaw B, Han JB, Kim E, Gustafson D, Hawkins R, Cleary J, McTavish F, Pingree S, Eliason P, Lumpkins C.	Effects of prayer and religious expression within computer support groups on women with breast cancer. *Psychooncology*. 16(7):676-87. 2006	2.1, 5.1
Siegel K, Anderman SJ, Schrimshaw EW.	Religion and coping with health-related stress. *Psychology & Health*. 16(6): 631-653. 2001	3.1, 4.1, 4.4
Silton NR, Flannelly KJ, Galek K, Ellison CG.	Beliefs about God and mental health among American adults. *Journal of Religion and Health*. 53(5): 1285-1296. 2014	3.2
Simoni JM, Ortiz MZ.	Mediational models of spirituality and depressive symptomatology among HIV-positive Puerto Rican women. *Cultur Divers Ethnic Minor Psychol*. 9(1):3-15. 2003	4.2
Smith FT, Harman RK, Richards PS, Fischer L.	Intrinsic religiousness and spiritual well-being as predictors of treatment outcome among women with eating disorders. *Eat Disord*. 11(1):15-26. 2003	1.2, 2.2
Snoep L.	Religiousness and happiness in three nations: a research note. *Journal of Happiness Studies*. 9(2): 207-211. 2007	1.1, 4.1, 5.1
Spilka B, Zwartjes WJ, Zwartjes GM.	The role of religion in coping with childhood cancer. *Pastoral Psychology*. 39(5): 295-304. 1991	3.1, 5.1
Strawbridge WJ, Shema SJ, Cohen RD, Kaplan GA.	Religious attendance increases survival by improving and maintaining good health behaviors, mental health, and social relationships. *Ann Behav Med*. 23(1):68-74. 2001	4.2, 4.4
Strawbridge WJ, Shema SJ, Cohen RD, Kaplan GA.	Frequent attendance at religious services and mortality over 28 years. *Am J Public Health*. 87(6): 957–961. 1997	4.3, 4.4

Suhail K, Chaudhry HR.	Predictors of subjective well-being in an eastern Muslim culture. *Journal of Social and Clinical Psychology*. 23(3): 359-376. 2004	1.1
Tarakeshwar N, Pargament KI, Mahoney A.	Initial development of a measure of religious coping among Hindus. *Journal of Community Psychology*. 31(6):607 2003	2.2
Tartaro J, Luecken LJ, Gunn HE.	Exploring heart and soul: effects of religiosity/ spirituality and gender on blood pressure and cortisol stress responses. *J Health Psychol*. 10(6):753-66. 2005	2.3, 4.3, 5.3
Tiliouine H, Cummins RA, Davern M.	Islamic religiosity, subjective well-being, and health. *Mental Health, Religion & Culture*. 12(1): 55-74. 2009	4.1, 5.1
Tix AP, Frazier PA.	The use of religious coping during stressful life events: Main effects, moderation, and mediation. *J Consult Clin Psychol*. 66(2):411-22. 1998	1.1
Trinitapoli J, Regnerus MD.	Religion and HIV risk behaviors among married men: initial results from a study in rural sub-Saharan Africa. *Journal for the Scientific Study of Religion*. 45(4): 505–528. 2006	1.4, 4.4
Webb M, Charbonneau AM, McCann RA, Gayle KR.	Struggling and enduring with God, religious support, and recovery from severe mental illness. *J Clin Psychol*. 67(12):1161-76. 2011	4.2
Wong Y, Tsai W, Lin J, Poon C, Chao S, Hsiao Y, Chan M, Cheng C, Wang C, Wang C, Liu S.	Socio-demographic factors in the prognosis of oral cancer patients. *Oral Oncology*. 42(9): 893–906. 2006	3.3
Wong YJ, Rew L, Slaikeu KD.	A systematic review of recent research on adolescent religiosity/spirituality and mental health. *Issues Ment Health Nurs*. 27(2):161-83. 2006	3.2, 4.2
Zaldivar A, Smolowitz J.	Perceptions of the Importance Placed on Religion and Folk Medicine by Non-Mexican-American Hispanic Adults with Diabetes. *Diabetes Educ*. 20(4):303-6. 1994	3.4

Previous **Theos** reports include:

"Doing God"
A Future For Faith in the Public Square
Nick Spencer | 978-0-9554453-0-9

Neither Private nor Privileged
The Role of Christianity in Britain today
Nick Spencer | 978-0-9554453-3-0

Talking God
The Legitimacy of Religious Public Reasoning
Jonathan Chaplin | 978-0-9554453-4-7

Rescuing Darwin
God and evolution in Britain today
Nick Spencer and Denis Alexander
978-0-9554453-5-4

Religion and Identity
Divided loyalties?
Sean Oliver-Dee | 978-0-9554453-7-8

Free to Believe?
Religious Freedom in a Liberal Society
Roger Trigg | 978-0-9562182-1-6

Doing God in Education
Trevor Cooling | 978-0-9562182-3-0

Turbulent Priests?
The Archbishop of Canterbury in contemporary English politics
Daniel Gover | 978-0-9562182-5-4

Multiculturalism:
a Christian Retrieval
Jonathan Chaplin | 978-0-9562182-6-1

Give us our Ball Back
Reclaiming Sport for the Common Good
Paul Bickley and Sam Tomlin

Religion and Law
Nick Spencer (ed.) | 978-0-9562182-8-5

From Goodness to God
Dr Angus Ritchie | 978-0-9562182-9-2

Post-Religious Britain?
Nick Spencer and Holly Weldin

Is there a 'Religious Right' Emerging in Britain?
Andy Walton, Andrea Hatcher and
Nick Spencer | 978-0-9574743-0-7

Making Multiculturalism Work
David Barclay | 978-0-9574743-1-4

Voting and Values in Britain:
Does religion count?
Ben Clements and Nick Spencer

The Future of Welfare
Nick Spencer (ed) | 978-0-9574743-3-8

How to Think about Religious Freedom
Nick Spencer | 978-0-9574743-4-5

More than an Educated Guess:
Assessing the evidence on faith schools
Elizabeth Oldfield, Liane Hartnett and
Emma Bailey | 978-0-9574743-2-1

The Case for Christian Humanism
Angus Ritchie and Nick Spencer
978-0957474369

Just Money:
How Catholic Social Teaching Can Redeem Capitalism
Clifford Longley | 978-0957474352

"Speaking Up" – Defending and Delivering Access to Justice
Andrew Caplen and David McIlroy
978-0-9574743-7-6

The Church and the Charter
Christianity and the forgotten roots of the Magna Carta
Thomas Andrew | 978-0-9574743-8-3

Who wants a Christian coronation?
Nick Spencer and Nicholas Dixon
978-0-9931969-0-4

A Very Modern Ministry:
Chaplaincy in the UK
Ben Ryan | 978-0-9574743-9-0

The Problem of Proselytism
Paul Bickley | 978-0-9931969-1-1

A Soul for the Union
Ben Ryan | 978-0-9931969-2-8

Catholic Social Thought and Catholic Charities in Britain Today:
Need and Opportunity
Ben Ryan | 978-0-9931969-3-5

Religion and Well-being:
Assessing the evidence

The relationship between religion and well-being is widely and frequently reported. Academic studies published in peer-reviewed journals regularly confirm the widespread belief that 'religion' is good for 'well-being'.

But what do we mean by 'religion' and what do we mean by 'well-being'? Neither term is exactly self-explanatory.

This report evaluates the evidence from nearly 140 academic studies conducted over the last three decades examining the relationship between religion and well-being in a wide range of countries and contexts.

It clarifies the key terms, showing how 'religion' has been used to cover a multitude of subtly different concepts (e.g. religious affiliation, subjective religiosity, religious belief, religious group participation, and religious personal participation), as has 'well-being' (e.g. subjective well-being, mental health, physical health, and health supporting behaviours).

By doing so the report not only clarifies the extent to which religion is good for well-being, but begins to explain what this means, adding detail to the big familiar picture.

Ultimately it confirms that big picture – religion is indeed good for well-being – but by showing the nuances of that relationship, *Religion and Well-being* hopes to inform the debate about how society should capitalise on this important resource.

Authors:

Nick Spencer is Research Director at Theos.

Gillian Madden is a former research intern at Theos. She is currently completing a MA in Christian Leadership (St Mellitus College), and read Politics and International Relations at Macquarie University (Sydney).

Clare Purtill is a former research intern at Theos. She read Theology and Religion at Durham University and has an MA in Christian Theology (Catholic Studies).

Joseph Ewing is a former research intern at Theos. He read Philosophy, Politics and Economics at Oxford University.

Theos