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# High-cost Religion, Religious Switching, and Health

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## Abstract

Previous research has devoted significant attention to understanding the link between health and personal religious beliefs and practices, typically finding that more religious people tend to have better health. However, almost no attention has been given to how switching religious groups or leaving religion altogether is related to self-reported health. Due to selection and causation mechanisms, switching from high-cost groups that are theologically and culturally exclusive could be associated with poor health more than switching from other religious groups. Using data from the 1972 through 2006 General Social Surveys, we examine the relationship between health and religious switching as moderated by the religious tradition of origin. We find that people who are raised and stay in high-cost sectarian groups, such as the Latter-day Saints and Jehovah's Witnesses, have better self-reported health than those raised and staying in other religious traditions. However, people who leave such groups are more likely to report worse health than those who leave other groups.

## Keywords

religion, reaffiliation, switching, denominations, health

Leaving one's religious group represents a significant event in the life of most individuals. It can result in dramatic changes in one's identity, social networks, and even life course. Because of strong social bonds to and identification with their religion, most people remain in the religious group in which they were raised (Hadaway and Marler 1993; Stark and Finke 2000; Loveland 2003).

Despite, or possibly because of its relative rarity, religious switching has had an important role in theories of religious dynamics (Sherkat 2001). While religious switching has received significant attention in the literature, much of this attention has focused on understanding rates and patterns of inward and outward mobility (Sherkat and Wilson 1995; Sherkat 2001). There has been research examining motivations for switching, but much of this research has centered on mechanisms such as family formation or dissolution (Sandomirsky and Wilson 1990) and economic mobility (Ellison and Sherkat 1990). Attention to the potential consequences of religious switching has been even more limited.

We look to expand this work by focusing on the role of health in religious switching. We argue that poor health could be an outcome and/or a cause of religious switching, particularly when considering switching from so-called high-cost religious groups that are theologically, socially, and culturally exclusive. Such groups may have exit costs that negatively impact the physical well-being of individuals leaving them, and poor health may also motivate some people to switch from these groups due to their disillusionment with the religious group or an inability to fully participate in it.

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## THEORY AND EVIDENCE

### *High-cost Religion*

Beginning with church-sect typologies (Johnson 1963) and going through to more recent discussions about “strict churches” (Iannaccone 1994), sociologists have long been interested in how religious groups vary in the costs and sacrifices they require from members. A significant amount of research has examined the relationship between religious costs and the commitment of individuals in religious groups (Iannaccone 1994). Groups with high levels of such costs have been found to have higher retention rates (Sherkat 2001), higher levels of participation (Stark and Finke 2000; Scheitle and Finke 2008), and, in turn, higher growth rates (Iannaccone, Olson, and Stark 1995; Finke and Stark 2005). High personal and social costs drive commitment through a number of mechanisms. High-cost religious groups often explicitly proscribe nonmember relationships and prescribe member relationships. These groups can produce stigma that both limits ties to nonmembers and heightens unity among members, regardless of any explicit rules about such relationships (Iannaccone 1992). The time and commitment demands of a high-cost group reinforce these formal and informal boundaries (Scheitle and Adamczyk 2009). When a person is required to spend a great deal of time within the group to fulfill his or her membership expectations, it is only natural that the individual’s social bonds will be concentrated within the group. Resulting from these strong ties to the group, weak ties outside of the group, and socialization into an inherently exclusive theological system, the identity of members becomes much more fused to the group. Being part of a high-cost religious group serves as a primary aspect of one’s identity as opposed to a secondary or tertiary one.<sup>1</sup>

In the United States, groups such as the Latter-day Saints (commonly called Mormons) and Jehovah’s Witnesses are typically considered to be among the most demanding, high-cost, theologically and culturally exclusive religious groups (Iannaccone et al. 1995). Both have distinctive beliefs, and members face many upfront costs, including high levels of required participation, behavioral and social restrictions, and often hostility from the outside world (Schaefer and Zellner 2008). Conservative Protestant groups (e.g., Southern Baptist Convention, Lutheran Church-Missouri Synod) are considered to be less costly and demanding than these “sectarian” groups, but

more costly than liberal or mainline Protestant groups (e.g., Presbyterian Church [U.S.A.], United Church of Christ).

### *Health and Religion*

In addition to generating higher levels of commitment, research has shown that the dynamics within high-cost groups may provide health benefits for their members. Much research has examined the overall role of religion for health generally, finding a positive effect on or association with outcomes such as hypertension (Levin and Vanderpool 1989), cancer (Troyer 1988), longevity (Idler and Kasl 1992; Strawbridge et al. 1997), and recovery from heart surgery (Oxman, Freeman, and Manheimer 1995), as well as overall self-rated physical health (Krause 2006), well-being (Ellison 1991; Maselko and Kubzansky 2005), and healthy life styles (Wallace and Forman 1998; Benjamins and Brown 2003; Hill et al. 2007; Hill and McCullough 2008). Although much of this research focuses on religious involvement and personal religiosity, several studies (Cochran, Beeghley, and Bock 1988; Troyer 1988; Gardner, Sanborn, and Slatler 1995) have also found that people who affiliate with high-cost religious sects, such as the Latter-day Saints (Mormons) or Jehovah’s Witnesses, may be more likely than others to reap the benefits of religion for their health.

Several mechanisms have been pointed to as underlying the association between religion and health, both generally and specifically for high-cost religious groups. Many religious groups offer their members formal and informal support that can positively shape their health (George, Ellison, and Larson 2002). Formal forms of support may include programs where health-related services and information are disseminated (Brown and Adamczyk 2009) and opportunities for formal counseling from a pastor are available (Chalfant et al. 1990). Church members may also serve as valuable sources of informal support, providing money, goods, and services (i.e., transportation), along with information about other sources for health-related help (Maton 1987; Taylor and Chatters 1988). While secular groups may provide these kinds of benefits, as Ellison and Levin (1998) point out, support from other religious adherents may be more efficacious than assistance obtained elsewhere because people in church-based social networks share a similar worldview, and, as a result, are more tightly-knit. Sharing the same worldview could also bolster the effects of personal religious

beliefs on health by giving people an opportunity to place their health problems in a religious narrative that others also support (Krause 2006).

Beyond the support of a religious congregation, most religions prescribe and proscribe behaviors that coincide with positive health outcomes. While all religions are likely to discourage some behaviors, high-cost religious groups may be particularly likely to encourage some health-related behaviors and discourage others, such as smoking and drinking, that jeopardize health outcomes (Phillips et al. 1980; Cochran et al. 1988). Gardner et al. (1995), for example, compared rates of cervical cancer between Mormon and non-Mormon women in Utah and found lower rates of cancer among Mormon women, which was largely explained by their lower rates of smoking and less risky sex-related behaviors. Additionally, the tight-knit structure of high-cost religious groups can increase supervision and regulation, which raises the cost of participating in health-compromising behaviors that are religiously proscribed (Ellison and Levin 1998; Adamczyk and Palmer 2008). These ideas lead to our first hypothesis:

- H1: People who are raised in and stay in high-cost religious groups will report better health than people who are raised and stay in other religious groups.

### *Health and Religious Switching*

Researchers have found a diverse range of social factors to be associated with religious switching, including geographic mobility (Smith, Sikkink, and Bailey 1998), marriage (Musick and Wilson 1995), and parental divorce (Lawton and Bures 2001). The role of these factors appears to vary for different religious groups. For example, Smith and Sikkink (2003) found that switching to an Evangelical or Fundamentalist faith was associated with marriage, but marriage was not associated with switching to Catholicism or switching to no religion. Likewise, while switching to Catholicism was associated with remaining in the North or moving from the South to the North, becoming nonreligious was associated with remaining in the North and having few or no children.

The role of health as either a predictor or outcome of religious switching has not received much attention. While we hypothesize that people who are raised in and stay in high-cost religious faiths will have better self-reported health than people in

other religious groups, the relationship between health and switching from high-cost religious groups is less clear. Few researchers have compared the characteristics of people who leave high-cost religious groups to the characteristics of people who leave other religious groups, in part because few national studies have enough respondents who leave high-cost religious groups to conduct multivariate analyses. For example, Smith and Sikkink's (2003) study of religious retention and switching included only thirteen Mormons. They found a correlation between staying Mormon and being white, married, and having more children. Leaving the Mormon faith was associated with having ever been divorced.

Despite a lack of previous attention, there are reasons to believe that both causation and selection mechanisms could produce an association between religious switching and worse health for individuals who switch from such high-cost groups.

### *Causation*

Although a boon for measures of group commitment and for members' health, the social and psychological features of high-cost religious groups raise the stakes if and when an individual decides to exit the group. While the strong social ties to the group and psychological ties to the religion lead more people to stay within the high-cost religious group (Sherkat 2001), those who do leave will find those ties represent a large liability that must be paid upon exit. Strained or severed family relationships, loss of self-identity, social isolation, and the personal stress that accompanies these issues are all representative of the costs that are enacted upon exit from a high-cost religion. One ex-member discussed these costs:

Suddenly my social identity was no longer there. My family ties were no longer there. My career and job functioning were no longer there. My housing was no longer there. All the things upon which I had built a life were no longer there. (quoted in Rothbaum 1988:205)

Faced with these costs, many members of high-cost groups will simply stay in the group to avoid payment of these exit costs, regardless of what this means. For instance, Ebaugh (1977) found that some Catholic nuns who wanted to leave their order did not do so as it would have cost too much in terms of their identity. Similarly, individuals in

strained or even abusive marriages may remain within them if divorce would invoke the costs of exiting their religious group (Ammerman 1987; Sharp 2009).

If members of high-cost faiths decide to leave, they may also lose some of the health-related benefits of affiliation. Upon leaving the group, religious proscriptions may soften, there may be less supervision and regulation, informal and formal social support could decrease, and there may be the loss of a shared worldview that can contribute to positive health outcomes. In contrast to other religious groups, high-cost religious groups may be particularly likely to vilify defectors, and the social sanctions that may be imposed on defectors could undermine the health benefits that religion-based social networks can provide. Additionally, research by Myers (2004) finds that religious congruence amongst family members is associated with increased social support. Individuals who leave high-cost religious groups may also be leaving the faith of their parents and other family members, which could weaken the familial-based social support that can contribute to good health. Finally, from the perspective of Pearlin et al.'s (1981) stress paradigm, switching away from a high-cost religious group could be seen as a major life event, resulting in psychological stress that could adversely affect overall health and well-being.

Since Latter-day Saints and Jehovah's Witnesses do not have compatible groups to which adherents can easily switch to as an alternative, people who choose to leave these faiths may be at a particular health disadvantage compared to people who disaffiliate from other, more low-cost faiths. Furthermore, given the unique cultural aspects of such groups, the impact of leaving a high-cost group could have an effect that extends beyond reduced social support and regulations. It may not be easy to ever fully replace the less tangible aspects of high-cost religious groups. In short, leaving high-cost religious groups could produce negative outcomes that exceed the sum of its parts.

### **Selection**

Because of the high costs of religious switching and the benefits of staying, most people will not leave a high-cost religion. However, under certain circumstances poor health may also lead some members to disaffiliate. While religions vary in their costs, they also vary in their actual or

potential rewards (Stark and Finke 2000). When examining the continuum of religious groups from high-cost to low-cost, one will also recognize a continuum of promised religious rewards. That is, those groups that tend to have many costs often tend to be the groups that promise powerful and inimitable religious rewards, including a personal and active God, a distinct afterlife, and other benefits advertised as exclusive and potent. Along with other promises, some members may feel that devotion to and involvement in a high-cost faith should lead to better health. If religious faith and involvement do not improve their health, they may become disillusioned with their religion and choose to leave.

The high demands of a strict religious faith could also lead people with poor health to disaffiliate. High-cost religious groups encourage active involvement in weekly meetings, services, and social events in which people with poor health may have difficulty participating. Those members who are not able to fully participate for health-related reasons (i.e., elderly, disabled, obese) may get fewer rewards from membership and therefore decide to switch religions. Additionally, some health-related conditions (e.g., lung cancer, STDs) may result from behaviors that high-cost religions proscribe (e.g., smoking, extramarital sex). As a result, membership in a high-cost religious group could exacerbate the negative effects of a health-related condition on an individual's well-being, which could also motivate switching (Strawbridge et al. 1998). Finally, if high-cost congregations view a health-related condition as a reflection of the individual's character, then they may encourage or tacitly condone withdrawal of congregational support (Sorenson, Grindstaff, and Turner 1995).

Poor health may, therefore, be the reason for leaving a high-cost religious group, or it may be the result of disaffiliation, which leads to our second hypothesis:

- H2: Individuals who switch from high-cost religious groups will have worse health than individuals switching from other religious groups.

## **METHODS**

### **Data**

To examine the association between religious switching and health, we utilize data from the

General Social Survey (GSS) from 1972 through 2006. Conducted annually or biennially by the National Opinion Research Center since 1972, the GSS is a nationally representative survey of English-speaking adults in the United States. Each GSS consists of core items repeated every year, as well as new items, some of which represent rotating special topics.

Although high-cost religions are growing, groups such as Latter-day Saints and the Jehovah's Witnesses still have a relatively small membership base compared to other American religious groups. Additionally, most people stay in the religion in which they were raised (Stark and Finke 2000; Loveland 2003). Hence, we need a very large sample to adequately conduct an analysis of religious switching into and out of such groups. The GSS can provide us with a large enough sample for examining small religious groups and switching. Indeed, many studies have relied on the GSS to study religious switching (e.g., Hout, Greeley, and Wilde 2001; Sherkat 2001).

Our analysis examines 30,523 cases after excluding those with missing data on variables of interest. We discuss now how those variables were identified and constructed.

## Measures

**Health.** Our outcome measure is a self-reported health item. This question asks, "Would you say your own health, in general, is excellent, good, fair, or poor?" Given its ordered nature, we initially explored utilizing ordinal logistic regression to examine this outcome, but we found that the analysis did not meet the proportional odds assumption required by this method. As a result, we use multinomial logistic regression. However, there are not enough cases in the "poor" health category to allow us to estimate all of our predictors and leave this response as a stand-alone outcome. Therefore, we combine the fair and poor categories into a single response in the analysis.

**Switching status.** From its beginning, the GSS has asked individuals their current religious affiliation and their religious affiliation at age 16. To assess whether an individual has switched we compare their current affiliation with the affiliation they were at age 16. We examine three possible switching statuses. First, the individual may have stayed in the same denomination or group that they were at age 16 (i.e., "stayers").

Second, they may have switched to any other denomination or group. This includes switching within the same religious tradition, such as from one conservative Protestant denomination to another. Finally, to provide an end-point that is comparable for all groups, our third switching status represents those who became entirely unaffiliated or switched to "none" (e.g., Catholic at age 16, currently at "none").

**Religious tradition of origin.** We categorize the religious tradition of the individual's group or denomination of origin into one of eight categories. The first category consists of Latter-day Saints and Jehovah's Witnesses. We single these two groups out because previous research has argued that they are among the most distinctive, unconventional, (Schaefer and Zellner 2008), high-cost (Iannaccone et al. 1995), and "subcultural" religious groups in the U.S. religious market (Mauss 1984; Smith 1998). For short-hand purposes, we label this category "sectarian," a term that has been used in past research in reference to these groups (e.g., Ammerman 2005:32). The other seven categories for group or denomination of origin are (1) conservative, (2) mainline and (3) black Protestant, (4) Catholic, (5) Jewish, (6) other religion, and (7) no religion. In coding these categories we relied on a standard denominational classification system (Steenland et al. 2000).<sup>2</sup>

**Controls.** We include a variety of control variables that could be related to an individual's health, religious affiliation, and/or the likelihood of religious switching. Since research (Sherkat and Ellison 1991; Roof 1989) has found that men are more likely to switch religions than women, we include gender, which is coded 1 for females, 0 for males. Some studies (Roof 1989; Sherkat 1991) have also found that education is associated with religious switching. We measure education on a five-point scale where 0 = less than high school degree, 1 = high school degree, 2 = junior college degree, 3 = bachelor's degree, and 4 = graduate degree. We include a measure of race because blacks tend to have poorer health outcomes than whites, they are more likely to lack health insurance and more likely to live in places of concentrated poverty where opportunities for healthy eating and exercise are limited (Metro Chicago Information Center [MCIC] 2005; Brown et al. 2000). We measure race with three dummy indicators of whether the respondent stated he or she was white (omitted reference in regressions), black, or some other race. Since marital status is



associated with religious switching (Musick and Wilson 1995; Sherkat and Ellison 1991), we include a set of dummy variable indicators that assess whether the respondent is currently married (reference), widowed, divorced, separated, or has never been married.

Because age is associated with mortality and researchers (Rogers, Hummer, and Nam 2000; Krueger et al. 2003) have found relationships among health, income, and employment status, we include measures of age, income, and employment status. We measure age on a continuous scale ranging from 18 to 89.<sup>3</sup> We measure income in thousands of constant 1986 dollars,<sup>4</sup> and a set of dummy variables indicate respondents' employment status: employed full-time (reference), part-time, unemployed, retired, or has some other working status. Finally, because we are using multiple waves of the GSS, we include a measure that accounts for the year of the survey. We present descriptive statistics for all measures in Table 1.

## RESULTS

We begin by examining the frequency of religious switching by religious tradition. As can be seen in Table 2, those raised Jewish, Catholic, or in a black Protestant group are the least likely to switch religious affiliations. This replicates previous research showing "quasi-ethnic" religious groups having higher rates of retention (Sherkat 2001:1467). However, a high percentage of those raised in these traditions who do switch affiliations end up having no religious affiliation at all (i.e., become "nones"). The sectarian category has a slightly higher retention rate than the conservative or mainline Protestant traditions, but a higher percentage of those raised within a sectarian group end up without any religious affiliation.<sup>5</sup> Those raised without a religious affiliation show the lowest rate of retention, as over 47 percent of these individuals end up switching to a religion later in life.

Table 3 displays the self-reported health of respondents by the religious tradition of the group or denomination in which they were raised. We find that those raised Jewish have the best reported health, with 40 percent saying their status is "excellent." Those raised in a sectarian group are more likely to report excellent health than those raised in the conservative, mainline, or black Protestant traditions. Clearly, though, there are many factors not taken into account here, including

variation across these traditions in income, race, and other important predictors of health. Furthermore, and most importantly given our particular interest in this research, this analysis does not take into account whether these individuals switched from the traditions in which they were raised and what association that may have in their current self-reported health.

To consider these issues, we now turn our attention to the multinomial logistic analysis examining self-reported health by origin tradition and switching status, the results of which are shown in Table 4. In this analysis the "excellent" response is the reference category. The coefficients for each predictor represent how it increases or decreases the likelihood, or "relative risk," of the respondent picking the "good" or "fair-poor" health responses over the reference outcome. Coefficients over 1 represent a higher risk of choosing either the "good" or "fair-poor" response over the "excellent" outcome, while coefficients below 1 represent a lower risk.

Model 1 examines only the relationships among religious tradition, switching status, and self-reported health. We can begin by looking at the coefficients for the religious tradition measures. Because of the inclusion of the interaction terms, these coefficients represent only individuals who do not switch affiliations. The analysis shows that those raised and staying in a group within the conservative, mainline or black Protestant religious traditions are significantly more likely than those raised and staying in a sectarian group to choose the "good" and "fair-poor" responses instead of the "excellent" response. Those raised and staying Catholic are more likely than those raised and staying in a sectarian group to report "fair-poor" health instead of "excellent." Those raised and staying without a religious affiliation are more likely than those raised and staying in a sectarian group to report "good" health instead of "excellent" health. Although those staying in Jewish and groups of "other" religious traditions do not significantly differ from their sectarian counterparts, these results generally show that those raised and staying in sectarian religious groups report better health than those raised and staying in groups of other religious traditions.

We now turn our attention to the coefficients for switching status. Again, because of the inclusion of the interaction measures, these two coefficients represent only the effects of switching for those raised in one of the sectarian groups. We see

**Table 1.** Descriptive Statistics (General Social Surveys, 1972–2006; *N* = 30,523)

	Percent/Mean	SD	Minimum	Maximum
<b>Health</b>				
Excellent	31.7			
Good	44.8			
Fair\Poor	23.5			
<b>Religious Tradition of Origin, Denomination or Group</b>				
Sectarian	1.8			
Conservative Protestant	26.5			
Mainline Protestant	22.3			
Black Protestant	9.5			
Catholic	25.3			
Jewish	1.8			
Other	3.1			
No affiliation	9.7			
<b>Switching Status</b>				
Stayed	66.4			
Switched to a different denomination or group	26.4			
Switched to no affiliation	7.2			
<b>Sex</b>				
Male	44.8			
Female	55.2			
<b>Marital Status</b>				
Married	55.3			
Widowed	9.3			
Divorced	12.2			
Separated	3.6			
Never married	19.6			
<b>Race</b>				
White	82.1			
Black	13.8			
Other	4.1			
<b>Work Status</b>				
Full-time	51.3			
Part-time	10.1			
Unemployed/temporary, not working	5.1			
Retired	12.1			
Other	21.4			
<b>Education</b>				
Less than high school	22.8			
High school	51.8			
Junior college	5.1			
Bachelor's	13.8			
Graduate	6.5			
Age	44.8	17.1	18	89
Income (in \$1,000s, constant 1986 dollars)	31.0	27.5	.275	162.6
Year	1989		1973	2006



**Table 2.** Prevalence of Religious Switching by Religious Tradition of Origin, Denomination or Group (General Social Surveys, 1972–2006)

	Religious Tradition of Origin, Denomination or Group								Total
	Sectarian	Conservative Protestant	Mainline Protestant	Black Protestant	Catholic	Jewish	Other	None	
Stayed	64.3%(-.91)	60.6%(-12.26)*	57.6%(-19.04)*	72.9%(8.44)*	78.4%(28.38)*	82.7%(8.61)*	58.7%(-4.29)*	52.3%(-11.55)*	66.4%
Switched to a different denomination or group	22.9%(-1.62)	33.3%(15.68)*	34.7%(19.28)*	22.7%(-5.06)*	12.8%(-34.59)*	6.3%(-11.37)*	26.4%(1.00)	47.7%(18.72)*	26.4%
Switched to no affiliation	12.8%(4.43)*	6.1%(-4.30)*	7.7%(1.91)	4.4%(-6.79)*	8.8%(7.09)*	11.0%(3.65)*	14.9%(7.82)*	n.a.	7.2%
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%
N	423	7,446	7,719	3,318	8,893	608	686	1,430	30,523

Notes: Numbers in parentheses represent adjusted residuals.

\*indicates that cell percentage is significantly different ( $p < .05$ ) from expected percentage based on overall population.

**Table 3. Self-Reported Health by Religious Tradition of Origin, Denomination or Group (General Social Surveys, 1972–2006)**

	Religious Tradition of Origin, Denomination or Group								Total
	Sectarian	Conservative Protestant	Mainline Protestant	Black Protestant	Catholic	Jewish	Other	None	
Excellent	35.2%(1.55)	29.3%(-5.23)*	33.9%(4.68)*	22.5%(-12.08)*	34.2%(5.85)*	40.0%(4.40)*	37.6%(3.34)*	31.8%(.07)	31.7%
Good	46.1%(.56)	44.9%(.32)	44.4%(-.69)	43.6%(-1.36)	45.1%(.82)	40.1%(-2.31)*	44.9%(.07)	47.6%(2.18)*	44.8%
Fair-Poor	18.7%(-2.36)*	25.8%(5.36)*	21.7%(-4.33)*	33.9%(14.85)*	20.7%(-7.38)*	19.9%(-2.12)*	17.5%(-3.76)*	20.6%(-2.64)*	23.5%
Total %	100%	100%	100%	100%	100%	100%	100%	100%	100%
N	423	7,446	7,719	3,318	8,893	608	686	1,430	30,523

Notes: Numbers in parentheses represent adjusted residuals.

\*indicates that cell percentage is significantly different ( $p < .05$ ) from expected percentage based on overall population.

**Table 4.** Multinomial Logistic Regression Predicting Self-reported Health by Switching Status and Religious Tradition of Origin Group (General Social Surveys, 1972–2006;  $N = 30,523$ )

	Model 1			Model 2		
	Good (Reference = Excellent)		Fair–Poor (Reference = Excellent)	Good (Reference = Excellent)		Fair–Poor (Reference = Excellent)
	Odds Ratio	95% Confidence Interval	Odds Ratio	95% Confidence Interval	Odds Ratio	95% Confidence Interval
<b>Religious Tradition of Origin, Denomination or Group</b>						
Sectarian (reference)	—	—	—	—	—	—
Conservative Protestant	1.53**	1.17–2.01	2.32**	1.62–3.32	1.46**	1.11–1.92
Mainline Protestant	1.30*	1.001–1.71	1.70**	1.19–2.44	1.36*	1.04–1.79
Black Protestant	1.92**	1.45–2.54	4.07**	2.82–5.87	1.63**	1.20–2.23
Catholic	1.29	.99–1.68	1.58*	1.11–2.25	1.31*	1.01–1.72
Jewish	.96	.69–1.32	1.26	.82–1.92	1.28	.92–1.79
Other	1.17	.83–1.64	1.10	.70–1.73	1.26	.89–1.79
No affiliation	1.49*	1.09–2.02	1.42	.94–2.14	1.47*	1.08–2.01
<b>Switching Status</b>						
Stayed (reference)	—	—	—	—	—	—
Switched to a different denomination or group	1.93*	1.12–3.30	1.86	.93–3.69	1.85*	1.07–3.19
Switched to no affiliation	2.36*	1.12–5.00	3.70**	1.59–8.60	2.33*	1.09–4.97
<b>Switching Status x Religious Tradition of Origin, Denomination or Group</b>						
Different group x sectarian (reference)	—	—	—	—	—	—
Different group x conservative Protestant	.48**	.27–.83	.50	.25–1.01	.49*	.28–.87
Different group x mainline Protestant	.49*	.28–.85	.52	.26–1.05	.50*	.28–.87
Different group x black Protestant	.47*	.26–.84	.44*	.21–.91	.48*	.27–.87
Different group x Catholic	.47**	.27–.83	.49*	.24–.99	.48*	.27–.85
Different group x Jewish	.45	.17–1.15	.72	.24–2.13	.38	.14–1.00
Different group x other	.52	.26–1.01	.68	.29–1.60	.48*	.24–.95
Different group x no affiliation	.48*	.26–.86	.71	.33–1.51	.48*	.26–.88
No affiliation x sectarian (reference)	—	—	—	—	—	—

(continued)

**Table 4.** (continued)

	Model 1				Model 2			
	Good (Reference = Excellent)		Fair-Poor (Reference = Excellent)		Good (Reference = Excellent)		Fair-Poor (Reference = Excellent)	
	Odds Ratio	95% Confidence Interval	Odds Ratio	95% Confidence Interval	Odds Ratio	95% Confidence Interval	Odds Ratio	95% Confidence Interval
No affiliation x conservative Protestant	.34**	.15-.74	.21**	.08-.51	.36*	.16-.79	.23**	.09-.58
No affiliation x mainline Protestant	.34**	.15-.74	.16**	.06-.38	.38*	.17-.84	.21**	.08-.55
No affiliation x black Protestant	.37*	.15-.87	.17**	.06-.45	.39*	.16-.94	.19**	.07-.53
No affiliation x Catholic	.40*	.18-.86	.23**	.09-.54	.45*	.20-.97	.29**	.11-.72
No affiliation x Jewish	.48	.19-1.24	.23*	.07-.71	.51	.20-1.33	.29*	.08-.95
No affiliation x other	.36*	.14-.88	.27*	.09-.78	.37*	.15-.92	.28*	.09-.85
Female	—	—	—	—	1.02	.95-1.08	.86**	.80-.93
Age	—	—	—	—	1.01**	1.01-1.02	1.03**	1.03-1.04
Education	—	—	—	—	.82**	.80-.84	.64**	.62-.66
Income (in \$1,000s, constant 1986 dollars)	—	—	—	—	.99**	.994-.996	.98**	.982-.986
Married (reference)	—	—	—	—	—	—	—	—
Widowed	—	—	—	—	.91	.81-1.03	.93	.82-1.06
Divorced	—	—	—	—	1.02	.93-1.12	1.32**	1.18-1.47
Separated	—	—	—	—	1.13	.96-1.33	1.56**	1.30-1.88
Never married	—	—	—	—	.98	.91-1.06	1.02	.92-1.13
White (reference)	—	—	—	—	—	—	—	—
Black	—	—	—	—	1.06	.92-1.23	1.33**	1.12-1.58
Other	—	—	—	—	1.21**	1.05-1.40	1.73**	1.45-2.07
Full-time (reference)	—	—	—	—	—	—	—	—
Part-time	—	—	—	—	1.04	.95-1.14	1.19*	1.05-1.34
Unemployed/temp. not working	—	—	—	—	1.15*	1.01-1.30	1.98**	1.70-2.30
Retired	—	—	—	—	.96	.85-1.08	1.64**	1.44-1.87
Other	—	—	—	—	1.05	.97-1.14	2.23**	2.03-2.45
Year	—	—	—	—	1.01**	1.009-1.014	1.00	.99-1.01
LR chi-squared	441.72 (44), $p = .000$							
Pseudo R <sup>2</sup>	.006							

5,178.74 (74),  $p = .000$   
.07

\* $p < .05$ ; \*\*  $p < .01$ .

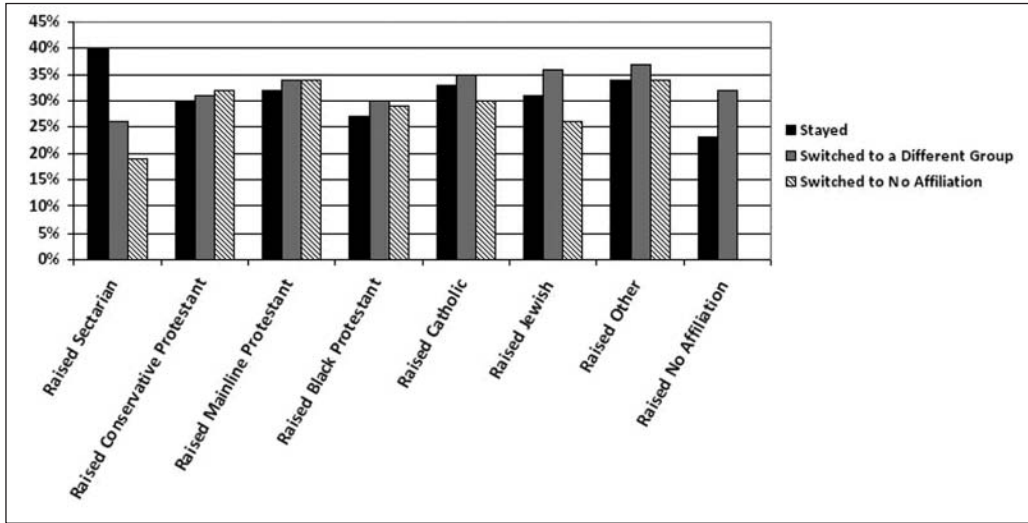


Figure 1. Predicted Probability of Reporting "Excellent" Health by Tradition of Origin Group and Switching Status

that those raised in a sectarian group who switch to a different group are significantly more likely than those who stay within a sectarian group to choose the "good" response over the "excellent" response when asked about their health status. Sectarians who switch to an unaffiliated status are significantly more likely than those who are raised in a sectarian group and who stay within that group to choose the "good" and "fair-poor" response. Specifically, they are over twice as likely to pick "good" and almost four times as likely to choose "fair-poor" over "excellent." Both of these results show an association between switching from a sectarian group and reporting worse health relative to those who stay within the sectarian group.

Does the negative association between switching and health among individuals raised in a sectarian group exist for individuals raised in groups within different religious traditions? To answer this we must examine the terms for the interaction between religious tradition of origin and switching status. We found that sectarians who switch to a different group are almost twice as likely as sectarians who stay in their origin group to choose the "good" response over the "excellent" when asked about their health. To see what the relative risk would be for individuals switching from groups in other religious traditions we must multiply the risk ratios. For example, the relative risk for sectarians switching to a different group was 1.93. If we multiply that by the .48 relative risk ratio for those switching from conservative groups, as seen in the

interaction terms, we find a total relative risk of .92. This is close to 1, which would represent no effect of switching for conservative Protestants. The interaction terms for mainline and black Protestants, Catholics, and the unaffiliated are similar. We find similar counteracting effects when looking at those switching to no affiliation (note that we cannot estimate a coefficient for those raised with no affiliation and who switch to no affiliation, as this group overlaps perfectly with the group that was raised and stayed affiliated).

In model 2 we introduce the other social and demographic controls. For the most part these predictors show their expected results. Females are less likely than males to report "fair-poor" health. Age increases the likelihood of picking either "good" or "fair-poor" health over "excellent," while education and income decreases the likelihood. Divorced and separated individuals are more likely than married individuals to report "fair-poor" health, as are those who are not working fulltime relative to those who are. Black respondents and those of other racial backgrounds generally report worse health than white respondents.

Our main findings of interest concerning the role of religious switching, though, remain largely the same even after introducing these other controls. Among those who stay in their origin group, sectarians report better health than conservative, mainline, and black Protestants, as well as the unaffiliated. However, those raised in a sectarian group who switch to a different group or to an unaffiliated status report worse health than sectarians who stay

in their origin group. This association, however, is much weaker or nonexistent for individuals switching away from groups belonging to other religious traditions.

The results shown in Table 4 are admittedly difficult to interpret given the number of coefficients and the moderating effects involved. We therefore present Figure 1, which shows predicted probabilities based on the multinomial analysis. This graph shows the predicted probability of reporting "excellent" health by both the religious tradition of individuals' origin groups or denominations and their switching status. The social and demographic controls are set at their overall means. Looking first at those raised in a sectarian group, we see that those who stayed in their sectarian group have the highest predicted probability of reporting excellent health, at about 40 percent. However, this percentage drops to just over 25 percent for those who are raised in a sectarian group and switch to a different group, and it drops to under 20 percent for those sectarians who switch to an unaffiliated status. As seen in the rest of the chart, this pattern is significantly different from that seen in the other religious traditions where those switching either do not differ from those who stay in their origin group or denomination or show a slightly higher predicted probability of reporting excellent health.

## DISCUSSION

This study examined the relationship between religious switching and self-reported health. Consistent with our first hypothesis and previous research, we found that people who are raised in and stay in high-cost sectarian religions, in this case Jehovah's Witnesses and Latter-day Saints (Mormons), have better self-reported health, net of other demographic factors, than people who stayed in most other groups. This is likely due to a combination of factors found in such groups, including prohibitions against behaviors potentially damaging to health and social and psychological support beneficial to health.

However, there is clear evidence for our second hypothesis: we found that switching from such high-cost sectarian religious groups is associated with poorer health. This is a relationship that is much weaker or nonexistent among those who switch from other groups. There are likely selection and causation factors involved. Regarding the

former, high-cost religious groups typically promise strong religious benefits, such as a personal and active deity. Individuals in such groups who have poor health could become disillusioned with their beliefs if they do not appear to be addressing their health. Likewise, the active involvement that high-cost religions encourage could make it difficult for people with poor health to participate. For these reasons, people with poor health may leave high-cost groups at a higher rate than individuals in other groups.

There could be causation effects as well. Members of sectarian groups receive many potential health benefits including informal and formal networks of social support (Maton 1987; Brown and Adamczyk 2009), a shared worldview to make sense of problems (Krause 2006), and stricter religious behavioral proscriptions, many of which correspond to positive health outcomes (Cochran et al. 1988). People who leave sectarian religious groups not only lose these benefits but are likely to have trouble finding new sources that could provide them. Secular groups could, for example, provide social networks where positive health-related behaviors are encouraged and enforced. However, a shared religious worldview can make the ties within religious networks particularly strong (Ellison and Levin 1998), and religious proscriptions provide another layer of justification for avoiding some health-compromising behaviors. Additionally, because sectarian groups are so unique, people who leave them will also have more difficulty finding a compatible religion. The uniqueness of sectarian groups would explain why individuals switching away from them are more likely than people from mainline and conservative Protestant religious groups to disaffiliate from religion altogether, which previous research has also found (Albrecht and Bahr 1983). Finally, since sectarian groups are particularly tight-knit and unique, the loss of friends and identity related to leaving may be associated with poorer health, regardless of whether they are able to find some kind of replacement for what they lost. Indeed, those leaving these groups end up reporting the worst level of health.

While several studies have examined religious switching, almost no quantitative research has examined the role of health as either a consequence of or motivation for leaving religion. Aside from health, there are other factors, such as social capital, that switching from high-cost religious groups is likely to change. Other studies have suggested



that membership in higher-cost religious groups may have some negative effects, including a decrease in social capital (Schwadel 2005; Scheitle and Adamczyk 2009) and limited educational attainment (Sherkat and Darnell 1999). Our findings show some of the positive health benefits to remaining in sectarian groups, but also some of the negative health consequences of leaving them.

There are some limitations related to the data that warrant discussion. Most importantly, we used cross-sectional data and made health comparisons between religious groups and whether people stayed or switched religious faiths. As a result, we do not know whether health is more likely to be a motivating factor for leaving a high-cost religious group or the result of leaving a high-cost religious group. As noted in our theoretical discussion, there are reasons to believe that poor health could motivate disaffiliation or poor health could be the outcome of disaffiliation. The costs of leaving such groups could have a detrimental impact on health, while disillusionment with poor health in the face of strong theological promises could lead individuals to leave such groups. Longitudinal data are needed to establish whether switching leads to poor health or poor health motivates switching. Such research could also better examine the precise mediators (e.g., smoking, drinking, depressive systems) that explain why switching is associated with poor health. For example, because high-cost religious groups are more likely to discourage behaviors such as smoking and drinking, switching from a high-cost religious group could loosen religious proscriptions, making it easier to smoke and drink. Likewise, switching from a high-cost religious group could lead to social isolation, which could increase depression.

The relationship between poor health and leaving a high-cost religious group could also be the result of a third unmeasured factor. Some parts of the country may have a particularly high proportion of members in high-cost religious groups (Ellison and Levin 1998). A move to another part of the country could make adherence to their faith less rewarding (Smith et al. 1998), and moving can be stressful, which could result in poorer health. Likewise, changes in religion and health could be explained by preexisting mental health issues, childhood trauma, and strained parental relations. For example, much research (Gottfredson and Hirschi 1990; Felton 2002) has suggested that people with low self-control are less likely to engage in healthier behaviors and may be less likely to find

religion appealing (Cochran, Wood, and Arneklev 1994; McCullough and Willoughby 2009). Individuals who were raised in sectarian faiths and have low self-control may not only be more likely to disaffiliate but also engage in health-compromising behaviors. More research is needed to examine these other explanations for the relationship between religious switching and health.

Finally, we were not able to determine the reasons why some sectarians chose to leave the religious faith in which they were raised. Because higher-cost religious groups strongly encourage religious participation, people raised in higher-cost religious groups are more likely to have parents who are also involved in their religion, which can discourage religious switching (Hout and Fischer 2002; Erickson 1992; Dudley 1999; Ozorak 1989). Additionally, research on religious switching has found that marriage is associated with switching into stricter religious faiths and remaining Mormon (Smith and Sikkink 2003). Finally, high-cost religious groups foster particularly strong social ties between group members, which can further discourage switching (Sherkat 2001). For all of these reasons, members of high-cost religious groups appear less likely than other people to switch religions. The majority of research done on religious switching has focused on switching among Catholicism, Protestant faiths, and no religion (e.g., Smith and Sikkink 2003). Regardless of whether health is a primary factor, there is likely to be more than one reason for leaving a high-cost religious group. More research is needed to understand why people leave high-cost religious groups, especially because their motivations may be different from the reasons why people leave other religious groups.

Despite data limitations, we were able to (1) establish that people who stay in high-cost religious groups report better self-reported health and (2) establish an association between self-reported health and switching from high-cost sectarian religious groups. This article moves us another step forward in understanding the costs for leaving religious groups and the potential motivators for joining. To date, much of the literature on religious change has focused on family change (Sandomirsky and Wilson 1990) and economic mobility (Ellison and Sherkat 1990) for explaining the consequences of or motivation for religious switching. This study shows that health may also play an important role on both sides of the equation.

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## NOTES

1. Some have framed this as constructing a “sub-cultural” identity around the religious group (see Smith 1998).
2. One adjustment had to be made concerning non-denominational Protestants. The Steensland et al. (2000) classification system relies on the frequency of religious service attendance to categorize these individuals, but this measure is not available at the “age of 16” time-point that we use for measuring the religious tradition of the origin group. As a result, these individuals are all classified as “conservative Protestant” in our analysis, since they tend “to resemble evangelical Protestants in many theological beliefs” (Steensland et al. 2000:295).
3. The 89 value represents “89 and older.”
4. Over time the GSS has altered the specific labels for the income categories to adjust for inflation. The variable used here is the REALINC measure divided by 1,000. It was computed by the GSS staff based on different income variables used over the years (e.g., INCOME72, INCOME, INCOME77, INCOME82, INCOME86, INCOME91, INCOME98, INCOME06). These were recoded in six-digit numbers and converted to 1986 dollars. Since this variable is based on categorical data, income is not continuous, but based on categorical mid-points and imputations. For details, see GSS Methodological Report 64.
5. The fact that the retention rate of the sectarian category is not higher may be surprising given past research (e.g., Sherkat 2001) showing sectarian groups’ success in keeping members. While strict or sectarian groups may generally have higher retention rates than other groups, there is still significant variation among such groups. The recent Pew Forum on Religion and Public Life’s U.S. Religious Landscape Survey (2008), for example, found that Mormons retained 70 percent of their children, while Jehovah’s Witnesses retained 37 percent. The source of such internal variation could be an interesting question for the larger high-cost or ‘strict’ church literature.

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