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Religion, Health, and the Spiritual But Not Religious

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Religion, Health, and the Spiritual But Not Religious

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by

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ABSTRACT

Religion, Health, and the Spiritual But Not Religious

by

Alexander L. Smith

Previous literature shows an overwhelmingly positive relationship between religiosity and health. Researchers theorize that service attendance, social capital, and group identity verification mediates this positive relationship. There is an upward trend in secularity in the U.S. with more individuals describing themselves as spiritual but not religious (SBNR). Current research does not clearly depict who comprises the SBNR or how varying degrees of secularity fit into the relationship between religion and health. Using data from the GSS, this study examines basic sociodemographic characteristics of the SBNR and compares the SBNR to other religious and secular groups on various health measures. This study finds that the SBNR are younger, unmarried, and more educated than others, and the SBNR fare better on some measures of health. Future research should investigate the potential protective health factors of being SBNR and how this fits into the overall relationship between religion and health.

DEDICATION

I dedicate this thesis to those ephemeral souls we meet throughout our lives who bless

and love us for a short time then push us *onward.*

ACKNOWLEDGEMENTS

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CHAPTER 1

INTRODUCTION

The current trend towards religious disaffiliation requires more precise distinctions regarding the identities, social networks, and collective associations of these populations (Hastings 2016; McDowell 2018). There is a notable increase in those claiming to be "spiritual but not religious" (SBNR) (Hastings 2016; Willard and Norenzayan 2017), but there is little research outlining this group and how they relate to other groups within current studies of religiosity and secularity. Moreover, while there is an abundance of health research on religious groups, research is lacking on health outcomes of the religiously unaffiliated and particularly the spiritual but not religious. An investigation of this population will aid in future research regarding overall differences between the SBNR compared to other secular and religious groups and further the understanding of health outcomes of the religiously unaffiliated.

The relationship between religion and health overall is complicated. Research often overlooks precise distinctions between religiosity, spirituality, and varying forms of secularity making the relationship between religion and health difficult.

This literature review analyzes established research on the complex relationship between religion and health and the main factors that influence this association. Furthermore, this review examines distinctions of religiosity and spirituality in disaffiliated groups and the implications these distinctions may aid in the research on health outcomes of this population.

Traditional religious practices have been found to reduce incidences of premature mortality (Li et al. 2016; Musick, House, and Williams 2004; VanderWeele et al. 2016), depression, and anxiety (Koeing 2001; Gonçalves et al. 2015), and benefit psychological

adjustment (Hackney and Sanders 2003) as well as overall self-reported well-being (Fenlon and Danielsen 2016).

A primary factor that influences the beneficial relationship between religion and health is the social support derived from traditional religious affiliation (Baker, Stroope, and Walker 2018; Fenlon and Danielsen 2016; VanderWeele et al. 2016; Li et al. 2016). However, in recent decades, there has been a growing disenchantment with traditional religiosity, and a trend toward religious disaffiliation and alternative forms of religiosity and spirituality (Baker and Smith 2009; Fenlon and Danielsen 2016; Hastings 2016; McDowell 2018; Pew Research Center 2015; Willard and Norenzayan 2017).

With a notable increase in those claiming to be spiritual but not religious, this research attempts to outline those who fall into the spiritual but not religious category by comparing them to other secular and religious groups on basic sociodemographic characteristics. Moreover, this research seeks to compare how the spiritual but not religious perform on various measures of health outcomes. Current research illustrates that disaffiliated religious groups (such as nonaffiliated theists) perform worse on health outcomes overall compared to both atheists and other religious groups, and researchers hypothesize that both identity uncertainty and lack of group structure facilitate this relationship (Baker et al. 2018). However, there is currently no research outlining how the spiritual but not religious differ from other unaffiliated and religious groups on health outcomes. This research investigates the relationship between the spiritual but not religious on health outcomes and will aid in the overall understanding of the relationship between religiosity and health.

CHAPTER 2

LITERATURE REVIEW

Background

Historically, social theorists have attempted to describe the function that religion serves a society (Beckford 1990). Defining religion can be a challenging endeavor for social research. Historically, social theorists have attempted to describe the function that religion serves a society (Beckford 1990). For example, sociologist Emile Durkheim ([1912] 1995) classically described religion as an intersubjective and ritualistic group practice associated with sacred figures, objects, and places which arouse feelings of connectivity and meaning beyond that of the individual.

Contra Durkheim, psychologist William James (1902:32) defined religion as ". . .the feeling, acts and experience of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they consider to be divine," placing an emphasis on the individual's experience of religion rather than that of group practices. The bifurcation of Durkheim's and James's conceptions of religiosity does not capture the richness of the history in the social scientific study of religion, but it serves well to illustrate the branching of terminological distinctions between religion (as a group phenomenon) and spirituality (as an individual experience).

Studies of religious phenomena generally include group practices; however, they may also encompass individual acts of spirituality and rituals such as prayer or meditation. Researchers often distinguish religion and spirituality as entirely different entities with studies of religion comprising of group aspects, and studies of spirituality including mostly individual endeavors. Although, one can study individual spirituality within a collective perspective (Bender 2007:2). While there can be a definitional issue for generalizing studies of religiosity

within the different perspectives of the social sciences, the distinction between religion and spirituality can be valuable for researching different types of religious phenomena (Bender, 2007).

In recent decades, social and biological scientists have also appealed to evolutionary theories to attempt to explain the function of religion (Henrich et al. 2010; see also Wilson and Wilson 2007). Henrich et al. (2010) illustrated that those that adhere to traditional world religions (such as Christianity) seem to place a higher value on concepts of fairness regarding unfamiliar individuals or strangers. This research suggests that the institution of religion may hold evolutionary mechanisms that help to glue together large social groups by allowing for the facilitation of altruistic behaviors within a society (Henrich et al. 2010). Religion may also inherently function to promote prosocial behaviors that aid in the stabilization of communities through reinforcements of concepts such as fairness. (Bennett and Einolf 2017).

Measuring religiosity and spirituality can be difficult. Self-reported attendance rates serve as the conventional standard for measuring religious affiliation (Brenner 2011). This can be problematic for many reasons: first, social desirability may play a role on attendance response in survey research. However, researchers are aware of this fact, and they can generally offer unbiased estimates of church attendance. Moreover, church attendance seems to be a good indicator of religiosity overall (Brenner 2011).

However, the typical distinction between religiosity and spirituality in survey research may conflate findings. Religious service attendance surely plays a large role in spirituality. Indeed, churches house spiritual teachings and propagate them (Bender 2007). However, the focus on attendance in research on religiosity may have led researchers to overlook many

varieties of religious experience, trends in spiritual morphology, and the importance of secularity in shaping religious beliefs and social life.

Moreover, measuring religious disaffiliation can pose similar issues. Researchers often overlook varieties of secularity and religious disaffiliation. Baker and Smith (2015) offer a model on varieties of secularity and disaffiliation by highlighting the differences between atheists (those who do not adhere to organized religiosity or privatized spirituality), agnostics (those who do not believe that we can answer religious and spiritual questions), culturally religious (those who do not believe but attend religious organizations or practices for cultural reasons), and nonaffiliated believers (those who do not attend organized religious practices but adhere to a form of privatized spirituality). Hastings (2016:64) offers a similar model by differentiating between "Religious Non-attenders (RNA), the Spiritual but Not Religious (SBNR), and the Neither Spiritual Nor Religious."

While definitional issues surrounding research into religiosity and spirituality may be, on the surface, purely semantic representations of religious and spiritual phenomena, these conceptions are important in shaping research methodology, and consequently, findings in scientific studies of religion. For example, the Spiritual but Not Religious category is very general. An adherent of New Age belief and a disaffiliated Christian could both fall into the category of Spiritual but Not Religious (Hastings 2016) and the many differences between these spiritual viewpoints certainly deserve consideration in future research.

<div align="center">Social Isolation and Health</div>

Social isolation, in general, is a high-risk factor for adverse physical health outcomes (Holt-Lunstad et al. 2015; Valtorta 2016). Social isolation is also a significant risk factor for coronary heart disease, stroke (Valtorta 2016), and premature mortality, comparable to other

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highly adverse risk factors such as obesity and a lack of insufficient healthcare (Holt-Lunstad et al. 2015:235). Furthermore, Haslam et al. (2016:192-193) note the adverse effects of social isolation on mental health and provide evidence that group-based social identity intervention methodologies may alleviate a wide range of psychological distress or disorders caused by social isolation.

<div align="center">Religiosity and Physical Health</div>

A large amount of the research on the relationship between religiosity and health defines religion as involving a group component unless a study is directly looking at some individual aspect of religiosity (Hackney & Sanders 2003). Isolating for a moment the variables of social support and group networks, much of the literature illustrates that group participation or religious attendance may play an essential role in the relationship between religiosity and physical health (Baker et al. 2018; Fenlon and Danielsen 2016; Koeing 2001; Li et al. 2016; Musick et al. 2004; VanderWeele et al. 2016).

VanderWeele et al. (2016) analyzed a sample of 59,000 generally healthy African-American women in the US and concluded that frequent religious attendance seemed to mitigate incidences of mortality in this population. Furthermore, a longitudinal study of female nurses concluded that religious service attendance suppressed incidents of mortality significantly compared to non-attendees (Li et al. 2016). It seems that positive behavioral influences, such as decreased smoking habits, may result from religious attendance (Li et al. 2016; VanderWeele et al. 2016). Additionally, Musick, House, and Williams (2004) concluded that attendance at religious services, even occasional attendance (as little as once a month), reduced incidences of premature mortality. This effect was also mediated by positive health behaviors that are correlated with service attendance, specifically increased physical activity (Musick et al. 2004).

Social support and adherence to a religious identity also aid in the relationship between religion and premature mortality (Musick et al. 2004; VanderWeele et al. 2016). However, various forms of privatized religious practices, such as prayer, seem to inhibit the relationship between service attendance and mortality, which may display the prominence that social support plays in the relationship between religiosity and health; although, it is unclear as to why privatized religious practices inhibit the beneficial health effects of service attendance (Musick et al. 2004; VanderWeele et al. 2016).

However, there may be more to the relationship between religiosity and physical health than social support. Interestingly, when controlling for the variable of social support, some research has found that those who attended religious services still have a lower risk of premature mortality (Li et al. 2016). Further comparative research is needed to better understand the specific variables that work to inhibit mortality in religious service attendance (Musick et al. 2004; Li et al. 2016:783; VanderWeele et al. 2017).

Conversely, a meta-analysis of 74 studies examining the mortality risks associated with religious attendance and nonreligious group activity did not find a significant difference between the variables of religious and secular social involvement on mortality (Shor and Roelfs 2013). This particular study presents a different point in the established relationship between religious attendance and health. The researchers in this study stressed that group participation seemed to be the largest, and possibly only, component mediating the relationship between religiosity and positive health outcomes (Shor and Roelfs 2013:135).

Frequent and stable attendance at religious services has been shown to be the prominent factor in predicting mortality in some populations when compared to other privatized aspects of religiosity (Musick et al. 2004; Li et al. 2016; VanderWeele et al. 2017). Furthermore, some of

the behavioral factors that may correlate with this relationship include physical activity (Musick et al. 2004), smoking, and depression (Li et al. 2016; VanderWeele et al. 2017). However, no single behavioral health factor seems to have more of an effect on morality than others (Li et al. 2016). Further research is needed in order to distinguish between the external variables associated in the relationship between religious service attendance and physical well-being (Musick et al. 2004; Li et al. 2016:783; VanderWeele et al. 2017).

<div align="center">Religiosity and Mental Health</div>

Religiosity can also have a positive influence on self-reported psychological well-being, optimism, and life purpose, and there seems to be a mitigating relationship between religiosity and psychological disorders such as depression and anxiety. A comprehensive meta-analysis which proposes that the beneficial relationship between religiosity and health arises from religious coping mechanisms, the sense of purpose and meaning religion provides, and the social support that derives from religious participation (Koeing 2001:105-106).

Further research reinforces the claim of a beneficial relationship between religiosity and mental health. Another meta-analysis concluded that religiosity seems to benefit overall psychological adjustment, with religious identity and intense devotion to religious belief being the most prominent indicators in this relationship (Hackney and Sanders 2003). However, the frequency of religious service attendance seemed to negatively impact measures of psychological adjustment. Religious attendance may not fully encompass the relationship between religiosity and psychological adjustment by stating that, "the 'shared cultural worldview' may need to be internally, even privately, 'shared' by the adherent to be existentially relevant" (Hackney and Sanders 2003:51). The many variables found in religious practices may work together

holistically as a meta-systematic process in which each variable may not individually show a beneficial relationship with well-being (Hackney and Sanders 2003).

Religion may also have a beneficial effect on mental health in a clinical setting. For example, a meta-analysis on religious interventions in mental health practices found that clinical methods that appealed to religiosity seemed to reduce the severity of anxiety and depression (Gonçalves et al. 2015). However, they note the limitations of accessible data on this particular subject and the lack of research into the nature of spirituality on mental health in clinical practice (Gonçalves et al. 2015:2946).

Religiosity may benefit mental health by reducing existential anxieties regarding death. Norenzayan and Hansen (2006:183) assessed the relationship between the existential anxieties of death on religious belief experimentally and concluded that "the awareness of mortality reliably increased the tendency to believe in supernatural agency" across a range of scenarios. When religious individuals (primarily Christian) were placed in scenarios where the topic of death was salient, they appealed to religious concepts and figures, and even religious ideologies they did not personally hold, when attempting to mitigate the existential angst of death (Norenzayan and Hansen 2006). These findings shed light on the role that the psychological concept of spirituality, devoid of one's beliefs and practices, may play in decreasing the existential anxieties associated with death (Norenzayan and Hansen 2006:183-185).

Furthermore, other privatized forms of religious coping mechanisms, like prayer, may influence negative cognitive factors such as aggression. Experimental research shows that prayer mitigates cognitive and behavioral aggression (Bremmer, Koole, and Bushman 2011:835). The mechanisms for which prayer seem to reduce aggression are not well understood and may be reducible to the "cognitive reappraisal" derived from prayer (Bremmer et al. 2011:836).

Moreover, Dein and Littlewood (2008) outline the methodological issues for the conceptualization and empirical study of prayer concerning the qualitative and subjective interpretations for what constitutes prayer. The relationship between privatized religious practices and health, in general, seem to be inconclusive (Musick et al. 2004; VanderWeele et al. 2017).

However, some research adds conflict to the established relationship between religiosity and mental health showing mixed results when studying levels of distress between those that identify as religious, atheists, and agnostic. Nonreligious individuals reported higher levels of distress when faced with existential anxieties, such as the fear of death, and may experience stress due to the "perceptions of nonbelievers by others" (Weber et al. 2011:81). It appears that the distress that arises due to religiously-mediated anxieties, in the nonreligious, is propagated by the presence of religion in society (Weber et al. 2011). In distress arising from general anxieties about life and overall satisfaction, there were minimal differences between the religious and nonreligious (Weber et al. 2011:81). Although a strong religious identity may alleviate the angst arising from existential and spiritual stressors, their nonreligious counterparts fare just as well when it comes to other types of distress, highlighting the complexity of the relationship between religion and mental health (Weber et al. 2011:84).

Furthermore, specific studies indicate that religiosity may worsen mental health issues in some situations. For example, those who believed that their adverse life events were due to a divine power's frustration with them were at a higher risk for developing post-traumatic stress disorder (Harris et al. 2012). Some religious individuals might suffer from existential stressors due to negative ideological assumptions and coping mechanisms, and they note the lack of research on individuals with disorders mediated by religious stress (Harris et al. 2012).

While there are some inconsistencies in the findings discussed, particularly with issues arising from religious ideology (Harris et al. 2012; Weber et al. 2011), there seems to be widespread support of the beneficial relationship between religiosity and mental health (Hackney and Sanders 2003; Gonçalves et al. 2015; Koeing 2001). However, the factors involved are not entirely understood, particularly on privatized practices (Bremmer et al. 2011), and the anxieties derived directly from religious identities (Harris et al. 2012; Weber et al. 2011).

<u>Trends Toward Alternative Approaches to Traditional Religiosity</u>

Current research on the religiously unaffiliated does not account for alternative ways some religiously unaffiliated theists are collectively assembling. McDowell (2018) illustrates this with qualitative research into the Christian punk rock culture as a means in which adolescents are seeking spirituality with established religious beliefs in non-traditional ways. McDowell notes these individuals describe themselves as "Christian but not religious" in which he elaborates on this category by noting:

> "Christian" represents a commitment to Christ and proselytization in culture; "religion" stands for a conventional set of beliefs and practices that is erroneously secluded from everyday life and relationships. Therefore, to be "Christian but not religious," these youths insist on the collective act of integrating church into their everyday life and cultural sensibilities (McDowell 2018:74).

These findings outline the need for research that focuses on the alternative ways people who are disengaged with traditional religion are practicing and identifying themselves and calls for researchers to not fall into blanket categories when studying the religiously unaffiliated.

The Pew Research Center (2014) reports a steady decline in traditional religious affiliation, particularly Christianity, and an increase in unaffiliated and non-Christian faiths in the

United States. Those who disestablish from traditional religious affiliation while retaining private spiritual interests are generally known as "spiritual but not religious" (Fuller 2001), adherents of privatized religion (Greer & Roof 1992), or noted as some form of unaffiliated believer (Baker and Smith 2009). Furthermore, some researchers often describe New Age followers and unstructured or exploratory spiritual belief in these categories; however, these terms are often conflated, and these distinctions are not clearly made. The distinction between unaffiliated normative religious belief and unstructured spirituality certainly warrants more attention.

Baker and Smith (2009:721) outline the distinction of nonaffiliated believers as those who claim disaffiliation with religiosity but may adhere to a divine authority or supernatural beliefs usually associated with a traditional religion. These individuals may become unaffiliated because of issues with religious authority, or the organization of the church, rather than the beliefs associated with their religion; and they are more likely to describe themselves as spiritual rather than religious (Baker and Smith 2009:722-731.)

<div align="center">The Spiritual But Not Religious</div>

The individuals who hold supernatural beliefs but are not affiliated with a traditional religious organization may label themselves as "spiritual but not religious" (Baker and Smith 2009). There is a prevalent trend of the "spiritual but not religious" in the United States with "estimates as high as 1 in 3 North Americans and Europeans" identifying as "spiritual but not religious" (Willard and Norenzayan 2017:138). Hastings (2016:66) defines this category as, "those who consider themselves to be spiritual, do not consider themselves to be religious, and do not attend religious services on a regular basis" (also see Fuller 2001). Hastings (2016:64) contrasts this category with "religious non-attenders" and "neither spiritual nor religious."

Fuller's (2001) historical analysis of the spiritual but not religious seeks to clarify this category by tracing currents of unstructured spirituality throughout the history of the United States. Fuller argues that America is no stranger to alternative forms of spirituality beginning with a budding interest in mysticism, astrology, divination, and witchcraft in the Colonial period (the late 1600's). Fuller traces forms of spirituality throughout American history noting a "Great Metaphysical Awakening" that occurred following the Enlightenment era around the time of the Revolutionary War in the United States. Throughout the Victorian era, forms of spiritual belief popular such as Swedenborganism, Transcendentalism, and Mesmerism gained popularity leading to a more general interest in Spiritualism. New Thought and Self-Help movements, along with Eastern influences and Theosophy, prevailed around the late 1800s to the early 1900's with an interest in paranormalism becoming widespread around the mid to late 1900's. Fuller argues that twentieth-century New Age beliefs, which may attract those that are spiritual but not religious, are a collective admixture of a resurgence in the interest of a long line of alternative spiritualities within America. A historical timeline tracing Fuller's historical analysis of spirituality can be found below, in Figure 1.

| Colonial Period (Late 1600's) | Unstructured Colonial Interest in Mysticism, Astrology, Divination, Witchcraft, etc. |

Late 1700's (Time surrounding Revolutionary War) — *The Enlightenment*

Early 1800's — Deism/Freemasonry, Unitarianism, Universalism

The Great Metaphysical Awakening

Early to Mid 1800's — Swedenborganism, Transcendentalism, Mesmerism

Spiritualism

New Thought/Self-Help/"harmonial religion"

Late 1800's Early 1900's — Esoteric Theosophy (Blavantsky) (Eastern Influences; At odds with Christianity)

Mid to Late 1900's — Paranormalism/Angelology/Trance-channeling

Late 20th Century — New Age

Figure 1. Timeline Adapted from Fuller's (2001) Spiritual But Not Religious

Current social scientific research on the "spiritual but not religious" has found them to have social networks comparable to religious service attendees (Hastings, 2016). SBNR individuals report similar assumptions regarding supernaturalism as those who adhere to established religious traditions, and there are noticeable similarities between the perspectives of the religiously affiliated and the "spiritual but not religious" (Willard and Norenzayan 2017:143).

Hastings (2016) investigates the differences in the quantity of social connections between those that attend religious services, and appeal to an organized religion, compared to those that do not, or label themselves spiritual but not religious, concluding that while those that attend religious services have more reported social connections, those that are SBNR seem to have a larger social network than others who are not affiliated with spirituality or religion altogether. This research challenges the notion that the spiritual but not religious have fewer social ties than those who attend a religious organization.

However, Hastings' (2016) research does not capture the nature of these social connections and how they affect the spiritual but not religious:

> Although studies that explore the social networks of individuals often determine whether or not a connection is through a religious organization (e.g., a fellow church member), they do not examine how spiritual beliefs may enhance or otherwise alter the nature of one's relationship with their neighbors, friends, and family members (Hastings 2016:75).

When studying religiosity and spirituality, researchers should regard social-connectedness in terms of how beliefs shape interactive experiences rather than more obvious measures such as

religious attendance; and studies should include more categorical variety when studying religious identities for more precise measurements of these groups.

<div align="center">Health Outcomes of the Religiously Unaffiliated</div>

Little research has been conducted on the health outcomes of those that are religiously unaffiliated (Fenlon and Danielsen 2016). Fenlon and Danielsen (2016) note that the religiously unaffiliated seem to have worse self-reported health outcomes in general, and this relationship seems to be mediated by religious attendance. Furthermore, Baker, Stroope, and Walker (2018) found that those that were religiously unaffiliated, but still adhered to a theistic ideology, scored poorest on a battery of self-reported general mental and physical health metrics compared to both atheists and the religiously affiliated. This study presents a conflicting point to past research on the relationship between religion and health (Baker et al. 2018). The researchers conclude that identity assurance and group membership seem to play a vital role in general self-reported health outcomes for both secular and religious individuals, and they note that more research is needed to assess the nature of this relationship (Baker et al. 2018).

However, these findings may not be taking into account groups like those outlined by McDowell (2018) that are religiously unaffiliated but collectively assemble in nuanced ways or those that are spiritual but not religious. Further distinctions of unaffiliated religious groups need to be addressed in research on religiosity, spirituality, and secularism (Baker and Smith 2009; Baker et al. 2018; Hastings 2016; McDowell 2018).

Overall, a wealth of research illustrates that social connectedness through religious affiliation is a significant contributor to the beneficial relationship between religiosity and health (Baker et al. 2018; Fenlon and Danielsen 2016; Musick et al. 2004; Shashan Li et al. 2016; VanderWeele et al. 2017). Furthermore, previous research on religiosity seems to analyze the

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factor of social connectedness only from the perspective of organized religious attendance rather than interactive experiences outside of a traditional place of worship (Hastings 2016).

In recent decades, there has been a growing disenchantment with traditional religious affiliation (Baker and Smith 2009; Fenlon and Danielsen 2016; Hastings 2016; McDowell 2018; Pew Research Center 2015; Willard and Norenzayan 2017). However, the religiously unaffiliated as a group are not sufficiently distinguished in current research (Baker and Smith 2009; Baker et al. 2018; Hastings 2016; McDowell,2018). Research into this phenomenon does not seem to account for those who adhere to traditional religious identities but assemble in nuanced ways (McDowell 2018) or those that are spiritual but not religious.

Precise distinctions of the religiously unaffiliated are not available in the literature (Baker and Smith 2009; Baker et al. 2018), especially regarding their social networks (Hastings 2016; McDowell 2018) and health outcomes. With an upward trend in those who report being spiritual but not religious (Hastings 2016; Willard and Norenzayan 2017), a better understanding of this category may present novel insights to social scientific studies of religiosity and factors related to health outcomes of the religiously unaffiliated.

Considering the relationship between religiosity and health outcomes, the increase in those claiming to be spiritual but not religious, and the lack of current research detailing the characteristics of this group, this study seeks to outline the demographic characteristics of this group and to investigate various health outcomes of the spiritual but not religious.

CHAPTER 3

METHODOLOGY

Data

The data for this study comes from the pooled data of the cumulative file of the General

Social Survey, using the survey waves taken from 1998 to 2018. These years were chosen

because the GSS began asking "do you consider yourself a religious person?" and "do you

consider yourself a spiritual person?" in the 1998 wave of the survey. The National Opinion

Research Center (NORC), a division of the University of Chicago, has conducted the General

Social Survey (GSS) since 1972. The GSS is a large, nationally-representative sample of U.S.

adults which assesses a wide variety of social, behavioral, and health related variables. Since

1994, a new wave of the GSS has been performed every two years. Respondents are drawn based

on stratified sampling by area, and survey interviews are conducted in person.

Measures

Dependent Variables

A total of four dependent variables were analyzed to asses health-related outcomes. Three

variables assessed frequency of health-related problems asking respondents how often in the past

30 days they experienced: 1) days of poor mental health (M = 1.52, SD = 5.41); 2) days of poor

physical health (M = 1.21, SD = 4.92); 3) days which poor physical or mental health keep them

from doing their usual activities (activity limitation) (M = 0.53, SD = 3.02). Response choices to

these health-related questions were: none (coded as 0), 1-10 days (1), 11-20 days (2), 21-29 days

(3), 30 days (4). Self-rated condition of health (M = 1.98, SD = 0.84) was also analyzed which

asked participants to rate their condition of health on a four-point ordinal scale ranging from

excellent (coded as 1), good (2), fair (3), and poor (4).

<u>Independent Variables</u>

The key independent variable for this study is religious identity. The *religious tradition* measure in this study is based off of a modified version of the RELTRAD classification scheme (Steensland et al. 2000) to include four categories of secularity (Baker and Smith 2015).

Atheists, agnostics, and nonaffiliated believers were recoded according to how they responded to a question which assessed their belief in God. Those who responded "I don't believe in God" and chose "nonaffiliated" on the RELTRAD classification scheme were coded as *Atheists*. Those who responded "I don't know whether there is a God and I don't believe there is any way to find out" and chose "nonaffiliated" on the RELTRAD classification scheme were coded as *Agnostics.* Those who responded that they believed in God or a higher power by either choosing "I don't believe in a personal God, but I do believe in a Higher Power of some kind; I find myself believing in God some of the time, but not at others; While I have doubts, I feel that I do believe in God or I know God really exists and I have no doubts about it" and chose "nonaffiliated" on the RELTRAD classification scheme were coded as *Nonaffiliated Believers*.

The *Spiritual But Not Religious* category was determined by combining two questions which asked respondents "To what extent do you consider yourself a spiritual person?" and "To what extent do you consider yourself a religious person?" Those that chose that they considered themselves to be spiritual to any degree (very spiritual, moderately spiritual, or slightly spiritual), and also answered that they were not religious, were recoded as *Spiritual But Not Religious* (SBNR). The SBNR category was then applied to the modified RELTRAD scheme. Preference for SBNR was taken so that those who reported they were Spiritual But Not Religious (regardless of whichever religious or secular category they fell into from the modified RELTRAD scheme) were classified into the *Spiritual But Not Religious* category.

The final modified RELTRAD classification scheme had ten categories including all religious and secular categories. Binary dummy variables were created for each religious category so that respondents either belonged to a religious/secular category (1) or did not (0): Evangelical (M = 0.24, SD = .43); Mainline (M = 0.12, SD = 0.33); Black Protestant (M = 0.07, SD- 0.26); Catholic (M = 0.25, SD = 0.43); Jewish (M = 0.01, SD = 0.11); other faith (M= 0.05, SD = 0.22); atheist (M = 0.03, SD = 0.16); agnostic (M = 0.04, SD = 0.18); nonaffiliated believer (M = 0.08, SD = 0.27); spiritual but not religious (M = 0.12, SD = 0.32).

Control Variables

Several control variables were assessed to account for any sociodemographic differences that may influence the relationship between religious identity and health outcomes. *Race* is measured as categorical with white (reference category) (M = 0.80, SD = 0.40) and dummy variables for Black (M = 0.14, SD = 0.34) and other races (M = 0.06, SD = 0.24). *Gender* (M = 1.54, SD = 0.50) is measured as either male (reference category) or female. *Age* (M = 44.70, SD = 17.09) is measured on an interval/ratio scale in years. *Education* (M = 1.35, SD = 1.16) is measured on an ordinal scale as *highest degree achieved* ranging from "less than high school," "high school," "junior college," "bachelor degree," and "graduate degree." *Income* (M = 33,022.39, SD = 33,350.89) is measured on an interval/ratio scale in terms of constant dollars. As a proxy for health insurance, *employment* (M = 0.50, SD = 0.50) was recoded into a binary variable as either "Employed Full-Time" or "Not Employed Full-Time." *Marital status* is measured as "Married" (reference category) (M = 0.60, SD = 0.49) with a dummy variable which combined "Divorced/Separated" (M = 0.12, SD = 0.33) and dummy variables for "Never Married" (M = 0.22, SD = 0.41) and "Widowed" (M = 0.06, SD = 0.25). *Urbanicity* (M = 0.87, SD = 0.33) was recoded as a binary variable so that respondents were classified as either living

in an "Urban" are or "Not Urban/Rural Areas" (reference category). *Religious service attendance* (M = 3.79, SD = 2.72) is measured on a 9-point ordinal scale ranging from "less than once a year" to "more than once a week."

<div align="center">Analytic Strategy</div>

Preliminary Analyses

I first provide descriptive information on the percentage of Americans classified as SBNR over time, to provide a look at the growth in this category. I also conduct a multinomial logistic regression model that compares SBNR respondents to those who are religiously affiliated and those who are affirmatively secular. This provides a look at whether or not there is a unique demographic profile for people who are SBNR.

For bivariate analysis between religion/spirituality and health, ANOVAs were conducted to determine mean differences between the four dependent variables assessing health-related outcomes and religious identities taken from the modified RELTRAD scheme which included the SBNR category. Tukey's post hoc tests were conducted to assess differences between religious/secular categories on measures of health.

Primary Analyses

Three-stages of ordinal regression models were conducted to determine predicted health outcomes based on religious categories while controlling for sociodemographic influences. In the first stage, only religious identity taken from the modified RELTRAD scheme including the SBNR category was tested. In the second stage, sociodemographic variables including race, gender, age, education, income, employment, marital status, and urbanicity was tested. Religious service attendance was added for the completed third-stage model to assess the effects that attendance may have separately on health outcomes.

To investigate sociodemographic attributes of the spiritual but not religious category, a multinomial logistic regression model was conducted to examine differences comparing the SBNR to religious individuals, and the SBNR to other secular nones, on race, gender, age, education, income, employment, marital status, and urbanization.

CHAPTER 4

FINDINGS

Longitudinal data from the GSS shows that there has been a steady increase in secularity in the United States, with 27.4% of the population reporting that they are either atheist, agnostic, or nonaffiliated believers in 2018 (Figure 2). When accounting for the SBNR as a category within the religious classification scheme, nonaffiliated believers were the largest secular category reported, making up 9.9% of the population, a steady increase from 5.6% in 1998 (Figure 3). Those claiming to be spiritual but not religious make up 13.7% of the population and have also steadily increased from 7.3% in 1998 (Figure 4). When grouping the spiritual but not religious with the other secular categories, they make up 30.7% of the population (Figure 5).
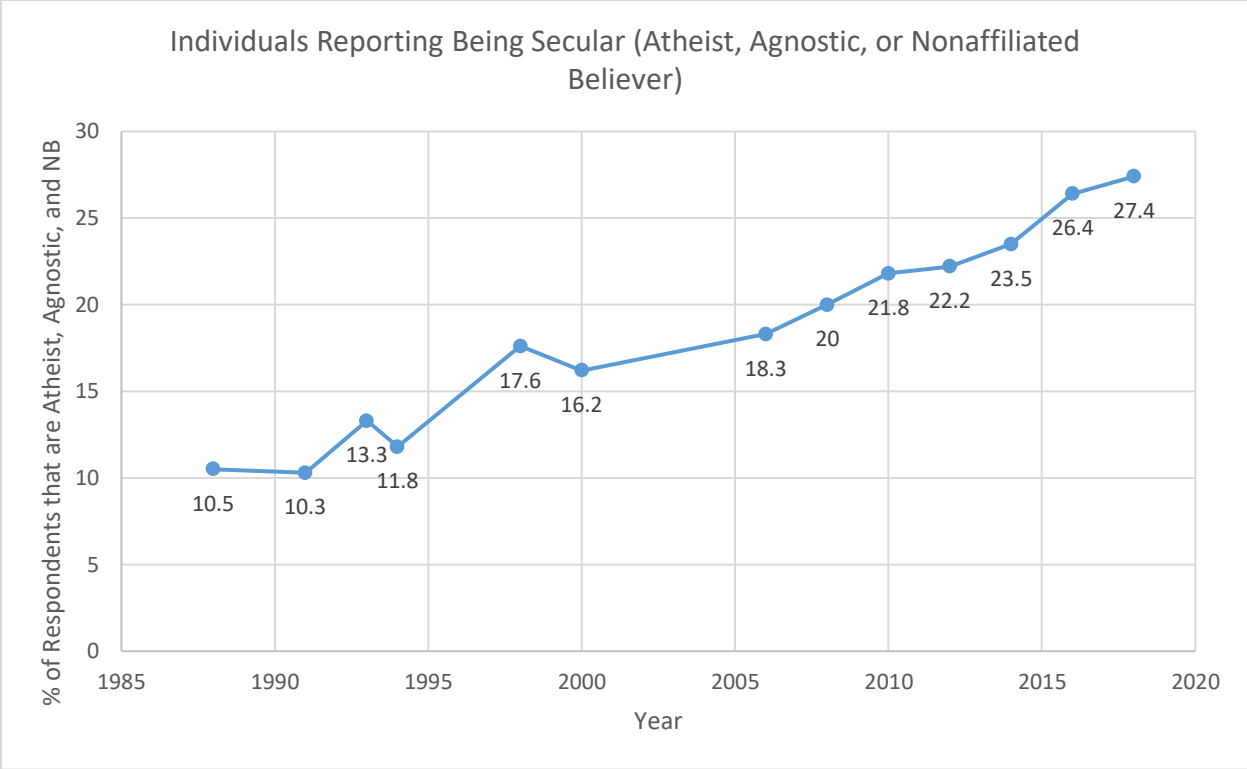
Figure 2. Individuals Reporting Being Secular (Atheist, Agnostic, or Nonaffiliated Believer)
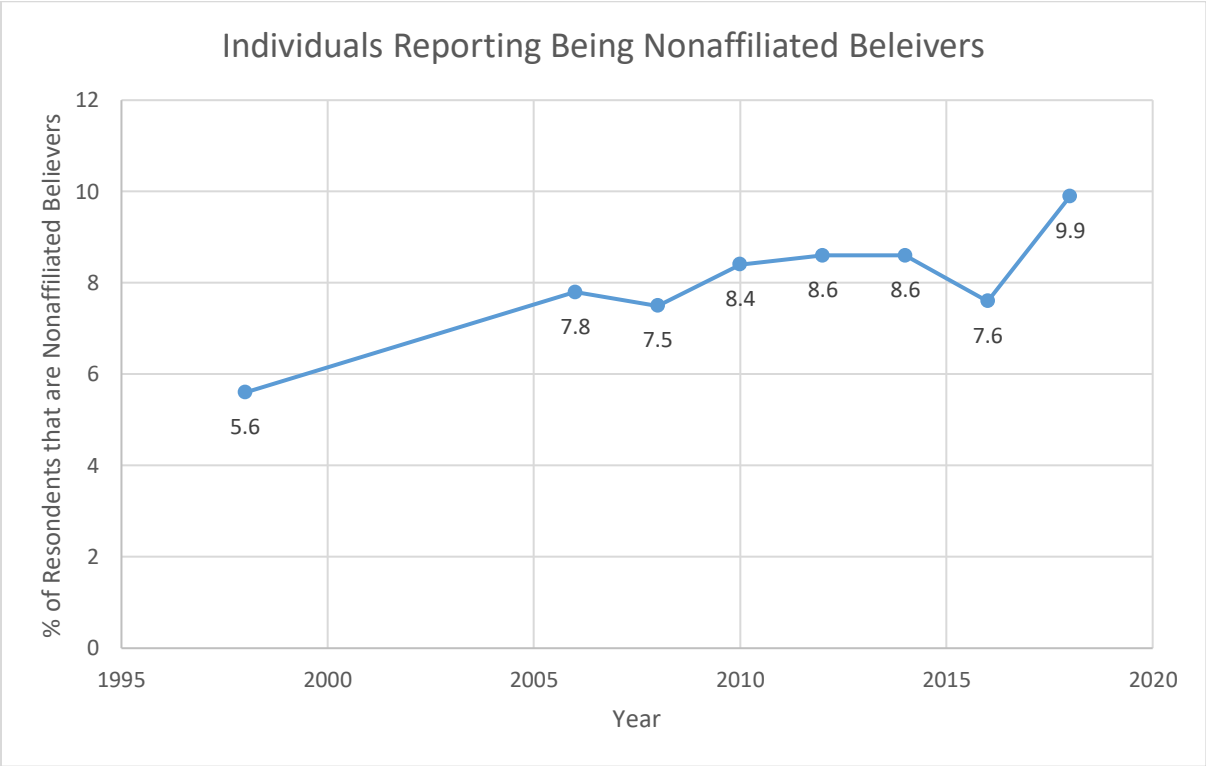
Figure 3. Individuals Reporting Being Nonaffiliated Believers
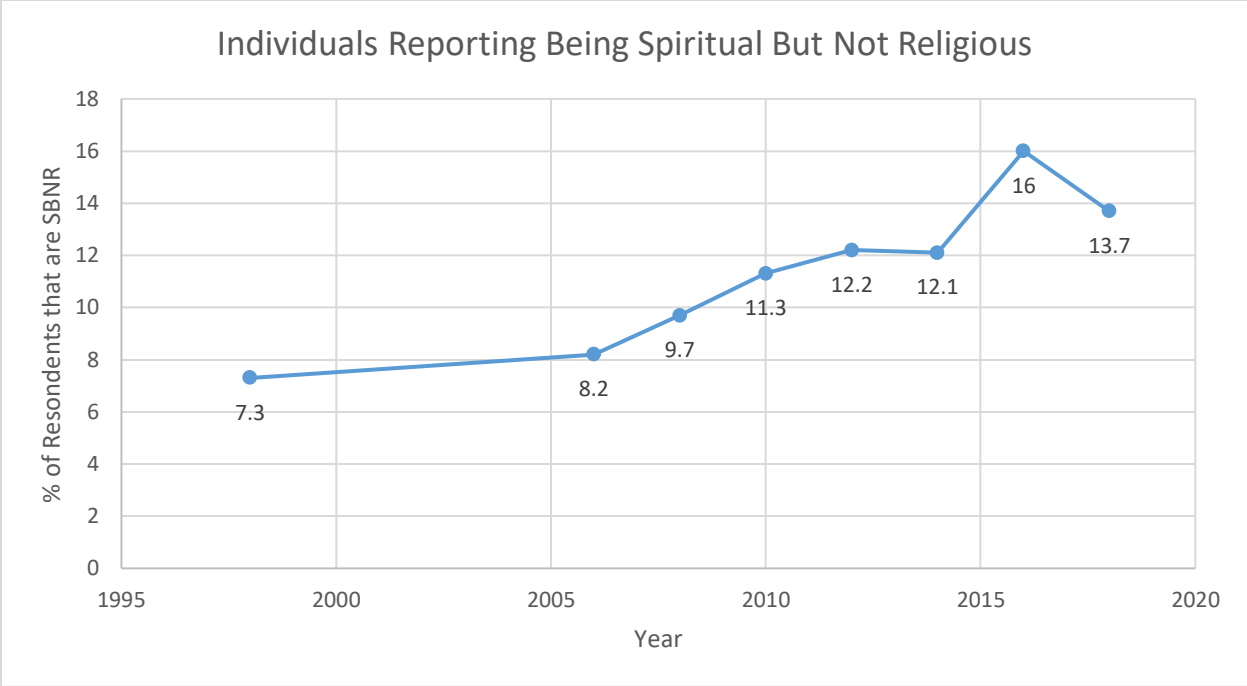
Figure 4. Individuals Reporting being Spiritual But Not Religious
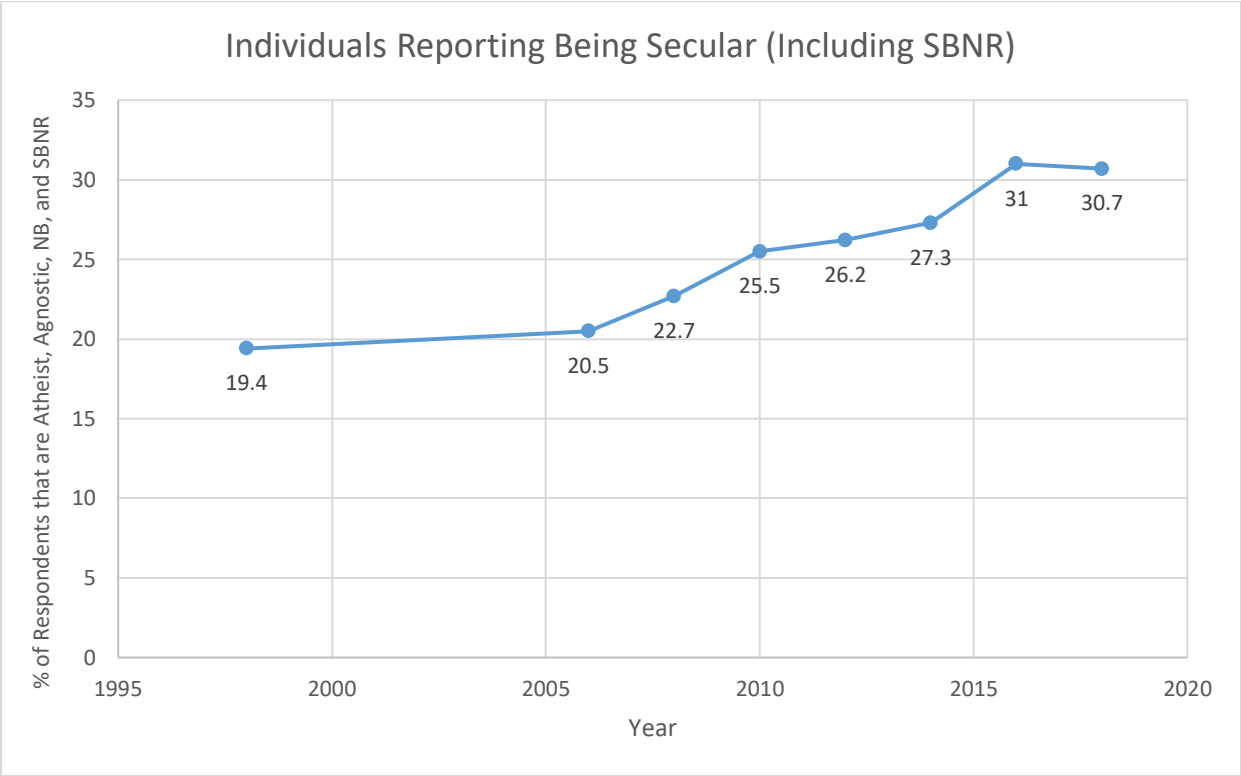
Figure 5. Individuals Reporting being Secular (Including SBNR)

Bivariate

Table 1 displays descriptive characteristics of the sample. On health measures, the mean score of mental health outcomes was 1.52 (SD = 5.41), physical health outcomes was 1.21 (SD = 4.92), activity limitation was 0.52 (SD = 3.02), and condition of health was 1.98 (SD = 0.84). Looking at religious identity, Protestant traditions (evangelicals, mainline, and black protestants) made up 43% of the sample, and Catholics made up 25% of the sample. Atheists, agnostics, and nonaffiliated believers made up 15% of the sample while the spiritual but not religious made up 12% of the sample. The mean age of respondents was 44 years old (SD = 17.09). The sample was 80% white with males and females roughly equally represented.

Table 1. *Descriptive Statistics*

Variables	Mean	SD	Min	Max
Health Measures				
Mental Health	1.52	5.41	0	4
Physical Health	1.21	4.92	0	4
Activity Limitation	0.53	3.02	0	4
Condition of Health	1.98	0.84	1	4
Religious Identity				
Evangelical	0.24	0.43	0	1
Mainline	0.12	0.33	0	1
Black Protestant	0.07	0.26	0	1
Catholic	0.25	0.43	0	1
Jewish	0.01	0.11	0	1
Other Faith	0.05	0.22	0	1
Atheist	0.03	0.16	0	1
Agnostic	0.04	0.18	0	1
Nonaffiliated Believer	0.08	0.27	0	1
SBNR	0.12	0.32	0	1
Demographics				
White	0.80	0.40	0	1
Other Race	0.06	0.24	0	1
Black	0.14	0.34	0	1
Gender	1.54	0.50	1	2
Age	44.70	17.09	18	89
Highest Degree	1.35	1.16	0	4
Income	32,022.39	33,350.89	351	434,612.42
Employed Full-Time	0.50	0.50	0	1
Married	0.60	0.49	0	1
Widowed	0.06	0.25	0	1
Divorced/Separated	0.12	0.33	0	1
Never Married	0.22	0.41	0	1
Lives in Urban Area	0.87	0.33	0	1
Religious Service Attendance	3.79	2.72	0	8

Source: 1998-2018 Pooled General Social Survey

Table 2 details the multinomial logistic regression model comparing SBNR to those that are religious and those that are secular to assess demographic characteristics of the SBNR compared to these groups. Overall, there are less differences between seculars and the spiritual but not religious than those that are religious and those that are spiritual but nor religious.

SBNR are more likely to be white compared to other races (Exp B = 1.65, p < .001) and blacks (Exp B = 1.97, p < .001) than those that are religious. SBNR are also more likely to be male (Exp B = 1.18, p < .01) than those that are religious. SBNR are less likely to be older (Exp B = 1.01, p < .001) and more likely to have higher education (Exp B = .76, p < .001) than those that are religious. Those that are religious are more likely to be married, than never married (Exp B = .52, p < .001), and are more likely to live in a rural area, as opposed to an urban area, than those that are spiritual but not religious (Exp B = .71, p < .01).

Seculars compared to the SBNR are more likely to be white than black (Exp B = .59, p < .05), and are more likely to be male (Exp B = .40, p < .001). SBNR are also more likely to have higher levels of education than seculars (Exp B = .88, p < .01). Seculars are also more likely to be married, as opposed to never being married, than the SBNR (Exp B = .74, p < .05). Overall, the spiritual but not religious are highest in education and least likely to be married. African-American seculars are more likely to be spiritual but not religious than non-theist. The spiritual but not religious are also younger overall, so the group should increase in size over time.

Table 2. *Multinomial Logistic Regression Models Predicting SBNR Characteristics*

Predictors	**Religious**[a]	**Secular**[a]
Demographics	Exp B	Exp B
Other Race[b]	1.65***	1.06
Black[b]	1.97***	0.59*
Female	1.18**	0.40***
Age	1.01***	1.00
Highest Degree	0.76***	0.88**
Income	1.00	1.00
Employed Full-Time	0.98	0.89
Widowed[c]	0.92	1.42
Divorced/Separated[c]	0.61	0.77
Never Married[c]	0.52***	0.74*
Lives in Urban Area	0.71**	1.05
Model Stats		
N	8149	622

Source: 2018 General
Social Survey
***p<.001; **p<.01; *p<.05 (two tailed tests)
[a]: SBNR is reference category
[b]: White is reference category
[c]: Married is reference category

Table 3 presents a one-way ANOVA analyzing differences of health outcomes by religious identities. There was a statistically significant difference between religious identity and mental health (F = 2.019, p < .05). On the condition of health measure there was a statistically significant difference between religious identities (F = 11.182, p < .001). A Tukey post-hoc test showed that that SBNR (1.91) reported significantly better on the condition of health measure compared to evangelicals (2.10), black protestants (2.18), Catholics (2.01), other faiths (2.14), and nonaffiliated believers (2.10).

Table 3. *One-Way ANOVAs for Health Outcomes and Religious or Secular Identities*

Religious/Secular Identity	Mental Health	Physical Health	Activity Limitation	Condition of Health
Evangelical	1.70	1.42	.635	2.10a
Mainline	1.25	1.25	.389	1.96
Black Protestant	1.01	1.39	.491	2.18a
Catholic	1.25	1.12	.423	2.01a
Jewish	1.76	1.20	.186	1.94
Other Faith	1.60	1.64	.551	2.14a
Atheist	2.44	1.13	.472	2.03
Agnostic	1.44	.701	.310	2
Nonaffiliated Believer	1.46	.908	.433	2.10a
SBNR	1.42	1.02	.520	1.91
F stat for ANOVA	2.019*	1.066	.735	11.182***

Source: 1998-2018 Pooled General Social Survey
***p<.001; **p<.01; *p<.05 (two tailed tests)
a: Significant difference from SBNR (Tukey post-hoc test, p<.05)

Multivariate

Tables 4, 5, 6, and 7 summarize results from the three-stage ordinal logistic regression models which analyzed religious identities and health outcomes while controlling for sociodemographic and health related variables. For each of the four health outcome measures (mental health in the past 30 days, physical health in the past 30 days, activity limitation in the past 30 days, and condition of health in the past 30 days), model 1 consists only of religious

identities (Evangelical, mainline, Protestant, Catholic, Jewish, other faith, atheist, agnostic, and nonaffiliated believers, with SBNR as the reference category). Model 2 for each health outcome adds sociodemographic controls (race, gender, age, education, income, employment, marital status, and urbanicity), and the final model adds religious service attendance. Results were converted to odds ratios for more intuitive interpretations.

Table 4 presents mental health in the past 30 days. After controlling for all sociodemographic variables including religious service attendance, model 3 shows that Catholics ($b = -.307$, $p < .01$) were 26% less likely to report poor mental health outcomes (less unhealthy days) than SBNR. Both Jewish ($b = .536$, $p < .05$) and other faiths ($b = .320$, $p < .05$) were more likely to score worse on the mental health measure (more unhealthy days), with Jewish being 71% more likely to score worse and other faiths being 38% more likely. There were no other significant differences in religious identity on mental health outcomes.

Looking at demographics, blacks were more likely to score better than whites on mental health ($b = -.302$, $p < .01$), females were more likely to score worse than males ($b = .461$, $p < .001$). Both divorced/separated ($b = .371$, $p < .001$) and never married ($b = .220$, $p < .01$) were more likely to score worse on the mental health outcome compared to those that were married. An increase in the frequency of attending religious services made it less likely to score worse on the mental health outcome ($b = -.026$, $p < .05$).

Table 4. *Multiple Stage Ordinal Logistic Regression Models Predicting Poor Mental Health in Past 30 Days*

Predictors	Poor Mental Health in Past 30 Days		
	Model 1	Model 2	Model 3
Religious Identity[a]	b	b	b
Evangelical	-.282***	-.220*	-.121
Mainline	-.327***	-.122	-.059
Black Protestant	-.434***	-.185	-.120
Catholic	-.419***	-.369***	-.307**
Jewish	.116	.490*	.536*
Other Faith	.142	.246	.320*
Atheist	.008	.041	.028
Agnostic	-.133	.062	.063
Nonaffiliated Believer	-.096	-.189	-.193
Demographics			
Other Race[b]	-	-.072	-.059
Black[b]	-	-.335**	-.302**
Female	-	.454***	.461***
Age	-	-.012***	-.012***
Highest Degree	-	.019	.024*
Income	-	.000*	.000
Employed Full-Time	-	.016	.009
Widowed[c]	-	.274	.276
Divorced/Separated[c]	-	.391***	.371***
Never Married[c]	-	.236**	.220**
Lives in Urban Area	-	.029	.029
Religious Service Attendance	-	-	-.026*
Model Stats			
N	7399	5943	5939
Cut 1	.095	-.035	-.056
Cut 2	2.002	1.993	1.973
Cut 3	2.921	2.944	2.924
Cut 4	3.166	3.176	3.156
Nagelkerke R^2	.010	.045	.046
-2 Log Likelihood	247.523	11594.446	11363.404

Source: 1998-2018 Pooled General Social Survey

***p<.001; **p<.01; *p<.05 (two tailed tests)

[a]: SBNR is reference category

[b]: White is reference category

[c]: Married is reference category

Table 5 presents physical health in the past 30 days. After controlling for all sociodemographic variables including religious service attendance, model 3 shows that there were no significant differences between religious identities on outcomes of physical health. Looking at demographics, other races were less likely to report poor physical health than whites (b = -.311, p < .01) and women were more likely to report poorer physical health than men (b = .288, p < .001). Those that were divorced or separated were more likely to report poorer physical health (b= .225, p < .05). Those that lived in an urban compared to a rural area were also more likely to report poorer physical health outcomes (b = .223, p < .05). An increase in religious service attendance again decreased the odds of reporting poor physical health (b= -.028, p <.05).

Table 5. *Multiple Stage Ordinal Logistic Regression Models Predicting Poor Physical Health in Past 30 Days*

	Poor Physical Health in Past 30 Days		
Predictors	Model 1	Model 2	Model 3
Religious Identity[a]	b	b	b
Evangelical	-.141	-.092	.003
Mainline	-.005	.087	.159
Black Protestant	.019	.183	.254
Catholic	-.261**	-.222*	-.148
Jewish	-.623*	-.607	-.558
Other Faith	.132	.226	.312
Atheist	-.224	-.100	-.105
Agnostic	-.002	.198	.204
Nonaffiliated Believer	-.087	-.057	-.061
Demographics			
Other Race[b]	-	-.293**	-.311**
Black[b]	-	-.204	-.169
Female	-	.283***	.288***
Age	-	.000	.000
Highest Degree	-	-.059*	-.052
Income	-	.000	.000
Employed Full-Time	-	-.132	-.126
Widowed[c]	-	.039	.049
Divorced/Separated[c]	-	.236**	.225*
Never Married[c]	-	.101	.092
Lives in Urban Area	-	.238*	.233*
Religious Service Attendance	-	-	-.028*
Model Stats			
N	5275	4414	4411
Cut 1	.516	.707	.696
Cut 2	2.573	2.802	2.798
Cut 3	3.266	3.506	3.511
Cut 4	3.441	3.670	3.677
Nagelkerke R^2	.005	.021	.022
-2 Log Likelihood	210.680	7540.779	7525.691

Source: 1998-2018 Pooled General Social Survey

***p<.001; **p<.01; *p<.05 (two tailed tests)

[a]: SBNR is reference category

[b]: White is reference category

[c]: Married is reference category

Table 6 presents activity limitations reported in the past 30 days. After controlling for all sociodemographic variables including religious service attendance, model 3 shows that Catholics were less likely than the SBNR to report poor physical health outcomes (b = -.261, p < .05). There were no other significant differences in religious identity on activity limitation. Looking at demographics, females were more likely to report instances of activity limitation than males (b = .238, p < .01) and those higher in education were also slightly more likely to report instances of activity limitation (b = .079, p < .05). Those that were employed full time were less likely to report instances of activity limitation (b = -.383, p < .001). Those that were divorced or separated (b = .320, p < .01) and those that have never married (b = .335, p < .01) were both more likely to report instances of activity limitation in the past 30 days than those that are married. Those that live in an urban compared to a rural area were more likely to report instances of activity limitation (b = .309, p < .05). Again, an increase in religious service attendance decreased the odds of reporting poor health outcomes with those who attend more being less likely to report instances of activity limitation (b = -.043, p < .01).

Table 6. *Multiple Stage Ordinal Logistic Regression Models Predicting Activity Limitation in Past 30 Days*

	Activity Limitation in Past 30 Days		
Predictors	Model 1	Model 2	Model 3
Religious Identity[a]	b	b	b
Evangelical	-.300**	-.163	-.012
Mainline	-.282*	-.207	-.098
Black Protestant	-.359*	-.109	.004
Catholic	-.423***	-.373**	-.261*
Jewish	-.415	-.850	-.774
Other Faith	.138	.076	.205
Atheist	-.024	.035	.032
Agnostic	.101	.256	.263
Nonaffiliated Believer	-.216	-.235	-.227
Demographics			
Other Race[b]	-	-.046	-.063
Black[b]	-	-.298	-.247
Female	-	.231**	.238**
Age	-	-.003	-.002
Highest Degree	-	.068*	.079*
Income	-	.000	.000
Employed Full-Time	-	-.385***	-.383***
Widowed[c]	-	.038	.054
Divorced/Separated[c]	-	.342**	.320**
Never Married[c]	-	.352**	.335**
Lives in Urban Area	-	.313*	.309*
Religious Service Attendance	-	-	-.043**
Model Stats			
N	5277	4418	4414
Cut 1	1.099	1.362	1.342
Cut 2	3.133	3.471	3.449
Cut 3	4.247	4.533	4.511
Cut 4	4.509	4.814	4.793
Nagelkerke R_2	.007	.029	.031
-2 Log Likelihood	187.775	5380.172	5370.802

Source: 2018 General Social Survey

***p<.001; **p<.01; *p<.05 (two tailed tests)

[a]: SBNR is reference category

[b]: White is reference category

[c]: Married is reference category

Table 7 presents self-reported condition of health in the past 30 days. After controlling for all sociodemographic variables including religious service attendance, model 3 shows that Black Protestants (b = .445, p < .01), other faiths (b = .479, p < .001), and nonaffiliated believers (b = .226, p < .05) were all more likely than the SBNR to report poor conditions of health. There were no other significant differences in religious identity on self-reported condition of health. Looking at demographics, other races were more likely to report poor conditions of health (b = .255, p < .01). An increase in age was associated with higher odds of reporting poor health (b = .019, p < .001). Higher education (b = -.282, p < .001) and full-time employment (b = -.222, p < .001) were associated with a decrease in reporting poor health outcomes. Those that were either divorced/separated (b = .323, p < .001) or never married (b = .227, p < .001) were more likely to report poorer conditions of health than those who were married. Finally, religious service attendance again had a protective factor on health outcomes with those who attended more being less likely to report poor conditions of health (b = -.057, p < .001).

Across all measures of health, there was no evidence that being spiritual but not religious is associated negative health outcomes, and there was some evidence that being SBNR is associated with positive health outcomes when comparing the SBNR to other religious and secular groups. Overall, there were no significant differences between the spiritual but not religious on any of the healthy day measures compared to other religious and secular groups when controlling for all sociodemographic variables in the above three models. Therefore, the above analyses provides evidence that the spiritual but not religious are not at an elevated risk for poorer health conditions on measures of poor mental health days, physical health days, or days of activity limitation compared to other religious and secular groups. Moreover, because no

differences were found between groups, being spiritual but not religious does not carry any protective factors on measures of healthy days either.

However, on the overall self-reported condition of health measure, the SBNR performed better than some religious and secular groups. A bivariate analysis of the overall self-reported condition of health measure illustrates that, when comparing the SBNR to other seculars and religious groups, 80.5% of the SBNR reported having excellent or good health (compared to 76.4% for seculars and 73.4% for the religious). Only 3.8% of the SBNR reported having poor health (compared to 5.4% for seculars and 5.5% for the religious).

Table 7. *Multiple Stage Ordinal Logistic Regression Models Predicting Condition of Health in Past 30 Days*

	Condition of Health		
Predictors	Model 1	Model 2	Model 3
Religious Identity[a]	b	b	b
Evangelical	.406***	-.036	.168
Mainline	.101	-.123	.007
Black Protestant	.608***	.297*	.445**
Catholic	.229***	-.038	.099
Jewish	.043	.017	.122
Other Faith	.520***	.339**	.479***
Atheist	.258*	-.052	-.044
Agnostic	.213*	.059	.052
Nonaffiliated Believer	.446***	.233*	.226*
Demographics			
Other Race[b]	-	.239**	.255**
Black[b]	-	.003	.074
Female[c]	-	-.075	-.065
Age	-	.018***	.019***
Highest Degree	-	-.293***	-.282***
Income	-	.000***	.000***
Employed Full-Time	-	-.215***	-.222***
Widowed[c]	-	-.018	-.011
Divorced/Separated[c]	-	.361***	.323***
Never Married[c]	-	.267***	.227***
Lives in Urban Area	-	.019	.016
Religious Service Attendance	-	-	-.057***
Model Stats			
N	11433	6997	6984
Cut 1	-.714	-.690	-.750
Cut 2	1.365	1.665	1.615
Cut 3	3.188	4.079	4.029
Nagelkerke R_2	.010	.079	.084
-2 Log Likelihood	223.438	14868.204	14831.164

Source: 2018 General Social Survey

***p<.001; **p<.01; *p<.05 (two tailed tests)

[a]: SBNR is reference category

[b]: White is reference category

[c]: Married is reference category

CHAPTER 5

CONCLUSION

Discussion

With an almost 88% increase of those claiming to be spiritual but not religious since 1998 comprising nearly 14% of the total U.S. population, the spiritual but not religious are a relevant an expanding population that warrants attention in studies of religiosity and secularity. There is little information about the characteristics of this population in previous literature. Overall, this research outlines that, compared to other religious and secular groups, the spiritual but not religious are more likely to be younger, unmarried, and to have higher levels of education.

Given the abundance of research on the relationship between religiosity and health, and the growing number of those claiming to be spiritual but not religious, further inquiry into how this category fits into this relationship is needed. In this research, little health differences were found between the spiritual but not religious compared to other secular and religious groups across measures of the number of self-reported mental and physical healthy days in a month. However, on the overall condition of health measure, the spiritual but not religious reported significantly better health overall than nonaffiliated theists. Previous research has outlined that nonaffiliated theists do worse on self-reported health outcomes than other religious and secular categories (Baker et al. 2018). This suggests that privatized spirituality could play an important factor in health outcomes and behaviors among nonaffiliated populations.

There is a strong empirical relationship between identity verification with others (or a group) and positive health outcomes. When identities are verified (i.e. others confirm that what one believes about themselves is valid), this tends to have a positive effect on the identity holder

(Burke and Stets 2009). For example, religious service attendance offers congregation members ample opportunities to engage with others like themselves and to solidify their religious identities. However, there may be an exception to the negative effect of identity uncertainty on religious identity *if* one is certain and comfortable of their uncertainty and views spirituality or religiosity more from a *journey* perspective (Frost 2019) which the SBNR may be more likely to claim.

Overall, nonaffiliated theists and agnostics may have trouble in finding ways in which to verify their secular identities with others particularly because of the uncertain nature of their identities. Moreover, their uncertainty overall may add to negative health outcomes. Both religious individuals and atheists have a solidified identity to cling to and have more opportunities for identity verification with others (Baker et al. 2018). For the religious, service attendance gives individuals an opportunity to relate with others like themselves and accumulate social capital. In this research, across all measures of health, religious service attendance showed a protective factor on health outcomes. This is in line with the abundance of literature showing that religious service attendance is a main driver of the positive relationship between religion and health.

However, this raises the question of why the SBNR would perform better than nonaffiliated theists on the condition of health measure. Prior research has shown that the SBNR tend to have quality social connections comparable to those who belong to religious organizations (Hastings 2016). Future research should further investigate whether there are more opportunities for the SBNR to relate with others and whether there is more identity certainty in being spiritual but not religious that one would not experience in belonging to other secular categories.

One limitation of this study is the lack of knowledge the current literature has on what it means to identify as spiritual but not religious, especially across religious subgroups (i.e. being spiritual but not religious *and* a Protestant). Moreover, given the potential variance of beliefs and practices that come with claiming to be SBNR, future studies should investigate what individuals within this category overall have in common regarding beliefs and practices. Future research should also investigate more about the spiritual but not religious overall as a group and outline more specific differences in what constitutes being spiritual but not religious. There is also lack of information regarding the social network structures and relations of people who are SBNR. The quality of their networks should be studied, given the protective factors of belonging to social groups and verifying identities.

A main limitation of this study comes from the self-reported measures used to analyze health outcomes. While self-reported measures of health have been found to have valid and increasingly higher predictive capabilities (Schnittker and Bacak 2014), they do not capture all aspects of health. Moreover, the discrepancy in these findings regarding healthy days and the condition of health warrants further attention. Future studies on the relationship between religiosity, spirituality, and health should also analyze what protective factors may come with being SBNR and should analyze the role of varying levels of secularity and certainty on health outcomes in general.

The spiritual but not religious is an expanding and prominent religious identity and should be taken seriously within social scientific studies of religion. This research illustrates that on measures of health the spiritual but not religious are not much different than others; however, there is evidence that there are protective factors on health outcomes in claiming to be SBNR in comparison to being a nonaffiliated theist. The findings in this report are a step toward outlining

what constitutes the spiritual but not religious as a group and how varying levels of spirituality

and secularity fit into the current literature on the relationship between religiosity and health.

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