

When Religion Hurts: Structural Sexism and Health in Religious Congregations

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Abstract

An emerging line of research has begun to document the relationship between structural sexism and health. This work shows that structural sexism—defined as systematic gender inequality in power and resources—within U.S. state-level institutions and within marriages can shape individuals' physical health. In the present study, we use a novel dataset created by linking two nationally representative surveys (the General Social Survey and the National Congregations Study) to explore the health consequences of structural sexism within another setting: religious institutions. Although religious participation is generally associated with positive health outcomes, many religious institutions create and reinforce a high degree of structural sexism, which is harmful for health. Prior research has not reconciled these seemingly conflicting patterns. We find that among religious participants, women who attend sexist religious institutions report significantly worse self-rated health than do those who attend more inclusive congregations. Furthermore, only women who attend inclusive religious institutions exhibit a health advantage relative to non-participants. We observe marginal to no statistically significant effects among men. Our results suggest the health benefits of religious participation do not extend to groups that are systematically excluded from power and status within their religious institutions.

Keywords

structural sexism, religion, gender, inequality, health

Despite the gains made by women over the past 50 years, gender inequality remains a persistent problem in the United States. In 2017, the United States ranked only 49th (out of 144 countries) for gender equity (World Economic Forum 2017). Women have made significant progress—particularly in the educational realm, where their college graduation rates now exceed men's (Goldin, Katz, and Kuziemko 2006)—but they remain underpaid in the labor market and underrepresented in positions of political and economic power. On average, women's earnings were 81 percent of men's, among full-time, year-round workers

in 2018 (U.S. Bureau of Labor Statistics 2019). In 2019, the average percentage of state legislature seats held by women was 28.9 percent, with some U.S. states as low as 13 percent (CAWP 2019), although women comprise more than half of the U.S. population.

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Furthermore, only 5.2 percent of S&P 500 company CEOs were women as of December 2019 (Catalyst 2019). Even in media and entertainment, where women are somewhat better represented than in other sectors, only 27 percent of executive-level management (i.e., C-suite) positions are held by women (Beard et al. 2020). After becoming more egalitarian for more than two decades, U.S. gender role attitudes have changed little since the mid-1990s, suggesting a stalled gender revolution (Cotter, Hermsen, and Vanneman 2011; England 2010).

This persistent gender inequality in large-scale social institutions is only one manifestation of a discriminatory gender system. Contemporary sociological perspectives characterize gender as a *multilevel* social structure or system that produces difference and inequality in large-scale social institutions at the macro level, in interactional settings at the meso level, and in individual identities, beliefs, and bodies at the micro level (Ridgeway and Correll 2004; Risman 2004; Scarborough and Risman 2018). *Structural sexism* refers to the degree of systematic gender inequality in power and resources characterizing a given gender structure, and it can manifest in processes occurring at each level (Homan 2019). Structural sexism is distinct from overt sexist behaviors and interpersonal discrimination because it is systemic and does not require individual actors with awareness or intent (Bonilla-Silva 1997; Homan 2019; Krieger 2014). Individuals may not necessarily perceive structural sexism, or they may not conceptualize it as unfair, unequal, or discriminatory, because observed gender inequalities in power and resources are often rationalized as natural results of inherent gender differences (Fenstermaker Berk 1985; West and Zimmerman 1987). Nevertheless, the unequal distribution of power and resources characterizing a society's gender structure can have consequences for the health and well-being of its members. Recent research has developed measures of structural sexism at the macro (U.S. state) and meso (marital dyad) levels and shown

that structural sexism exposure at each level is associated with both men's and women's physical health (Homan 2019).

In the present study, we use a novel dataset created from two nationally representative surveys (the General Social Survey and the National Congregations Study) to explore the health consequences of structural sexism in another meso-level setting: religious institutions. This setting is particularly instructive because research suggests religious institutions are beneficial for health and well-being (Ellison and Levin 1998; Hill, Burdette, and Idler 2011; Koenig, King, and Carson 2012; Strawbridge et al. 1998), yet many have rigid gender-based status hierarchies that generate a type of meso-level structural sexism that is likely harmful for women's health. Previous research has not yet considered how these seemingly contradictory patterns relate to one another. Therefore, we examine how structural sexism within religious congregations shapes women's and men's self-rated health and how their health compares to that of non-participants. Our results indicate that the long-recognized health benefits of religious participation are contingent on equal access to power and status within religious institutions.

STRUCTURAL SEXISM AND HEALTH

Gender scholars have long explored the contours and consequences of gender inequality in the United States, but the measurement of structural sexism and its health consequences is a relatively recent development. A structural sexism approach combines contemporary gender theory with the emerging racism and health literature to look beyond perceived individual mistreatment (e.g., sexual harassment and other overt behaviors) to investigate how discriminatory social systems affect health (Homan 2019). Individuals may not directly perceive structural sexism, but it has the potential to powerfully influence population health by shaping the distribution of health-promoting resources and health-harming risk factors.

Because women are the marginalized group, living in a society with a high degree of structural sexism can restrict their access to quality health care, material resources, and psychosocial resources (e.g., self-esteem, sense of control, autonomy, social support) (Homan 2019; Krieger 2014). High levels of structural sexism may also increase women's exposure to violence, harassment, perceived discrimination, low subjective social status, and stress (Aizer 2010; Homan 2019; Krieger 2014). All of these factors are known to be critical social determinants of health (Adler 2009; Braveman and Gottlieb 2014; Link and Phelan 1995; Marmot 2005, 2006; Pascoe and Richman 2009; Pearlin et al. 1981; Yang, Schorpp, and Mullan Harris 2014). The impact of structural sexism on men's health is more complex and likely to be mixed. As the dominant group, men stand to benefit from greater status, power, and resources in more sexist environments; however, research and theory also indicate that patriarchal social structures promote toxic versions of masculinity that undermine men's health (Connell 2012; Courtenay 2000).

In a multilevel examination of the relationship between structural sexism and health, Homan (2019) measured systematic gender inequality in power and resources within U.S. state-level political, economic, and cultural institutions at the macro level, and within heterosexual marriages at the meso level. Homan identified two distinct patterns in the health effects of structural sexism. In state-level institutions, structural sexism exhibited a pattern of *universal harm* because it was negatively associated with physical health among both men and women. However, within marriages, the relationship between sexism and health exhibited a *zero-sum* pattern, with women experiencing worse health and men experiencing better health in more sexist marriages. It remains unclear whether this zero-sum pattern extends to meso-level settings that are not characterized by a dyadic relationship where the gains of one partner can directly translate to losses for the other. Thus, Homan (2019:508) called for future research

to examine structural sexism and health in other meso-level contexts such as neighborhoods, workplaces, and organizations.

In the present study, we therefore examine the association between self-rated health and meso-level structural sexism in religious congregations. A focus on religious congregations is particularly illuminating for several key reasons. First, religious congregations provide an opportunity to examine a middle ground in terms of scale between marriages and U.S. states, where the balance of costs and benefits to subordinating women may be unique. Second, religious beliefs, practices, and organizations are deeply gendered. Much variation exists across religious traditions and institutions, but religious organizations have historically disadvantaged women. Finally, religious participation influences health in varied and significant ways.

RELIGION, HEALTH, AND GENDER INEQUALITY

Over the past three decades, numerous studies have shown that religious involvement—indicated by observable feelings, beliefs, activities, and experiences in relation to spiritual, divine, or super-natural entities—tends to favor health and longevity across the life course. These general patterns can be seen across a range of outcomes, including depression, anxiety, cellular aging, allostatic load, physical functioning, and all-cause and cause-specific mortality (Ellison and Levin 1998; George, Ellison, and Larson 2002; Hill, Bradshaw, and Burdette 2016; Idler 2004; Koenig et al. 2012; Krause and Hayward 2016). More recently, scholars have focused on the dark side of religion. For example, research shows that religious involvement may also contribute to morbidity and mortality when individuals experience religious struggles, such as doubts about God, social conflicts within religious groups, or threatening beliefs about the devil (Ellison and Lee 2010; Exline and Rose 2013; Hill et al. 2017; Hill and Cobb 2011; Krause and Wulff 2004; Pargament et al. 2001).

There is also compelling evidence that the association between religion and health may vary by gender. A few exceptions exist (e.g., McFarland 2010), but the general weight of the evidence suggests religion has a greater impact on women's health than on men's health. Several studies show that church attendance is more strongly associated with better mental health (Mirola 1999; Norton et al. 2006; Schieman, Bierman, and Ellison 2010; Strawbridge et al. 2001) and physical health (Koenig 1999; McCullough et al. 2000; McCullough and Laurenceau 2005; Strawbridge et al. 1998) among women. Research also suggests institutional factors may condition gender differences in the impact of religious involvement on health. Maselko and Kubzansky (2006) show that religious activity is negatively associated with psychological distress among Catholic men and positively associated with psychological distress among Catholic women. They also report that religious activity is associated with better self-rated health, higher levels of happiness, and lower levels of psychological distress among evangelical Protestant men but not among evangelical Protestant women. Maselko and Kubzansky (2006) speculate that women may benefit less from regular religious activity because religious institutions, like most institutions, are often sexist in nature.

How might sexism in religious institutions disproportionately undermine women's health? Religion may differentially affect the health of men and women through several institutional and non-institutional mechanisms. Indeed, religious institutions often dictate that men and women occupy separate domains both inside and outside of the church. Despite making up the majority of religious affiliates (Baker and Whitehead 2016), women are often prohibited from top organizational leadership positions, particularly within gender-traditional religions like conservative Protestantism, Orthodox Judaism, and Mormonism (Burke 2012). Currently, only around 15 percent of U.S. congregations are led by a woman (Chaves 2017; Chaves and Anderson 2008). The vast majority of these

congregations are within the mainline Protestant tradition, which includes denominations such as The United Church of Christ, The United Methodist Church, American Baptist Churches USA, The Episcopal Church, the Presbyterian Church (U.S.A.), and the Christian Church (Disciples of Christ) (Ferguson 2018).

Some religious traditions may be "feminized" in terms of valorizing traits associated with femininity (e.g., cultivating relationships, sharing, comforting) (Perry 2019:92), but most are "gendered" masculine because men control access to resources and dominate positions of power (adams 2007; Baker and Whitehead 2016; Cadge 2004; Whitehead 2013). Feminist scholarship has examined reasons why women participate in conservative religious groups—often asking why women subscribe to religious regimes, traditions, ideologies, and practices that reproduce gender inequalities and undermine personal agency (Avishai 2016)—yet few studies have examined the impact of religious institutional sexism on the health of religious adherents.

Within conservative Christian traditions, those who argue that congregational leadership should not be accessible to women frequently draw support from the Bible (adams 2007; Chaves 1997); and the Bible translations most likely to be read in these churches contain language endorsing the subordination of women (Perry 2020). To justify excluding women from church headship, some religious leaders read certain passages as supporting the submissiveness of women within the congregation (e.g., 1 Corinthians 14:34; Timothy 2:11–12). These gendered interpretations of sacred texts are rooted in notions of *complementarianism*, which are prominent within conservative Christian congregations. Complementarianism is centered on the idea that gender is essential, that is, gender is fundamental and inherent (Diefendorf 2019; Perry 2020). Conservative Christians generally believe men and women are fundamentally different from one another, naturally endowed with diverse drives, desires, and capabilities, and therefore suited to different social roles as

part of God's grand plan (Perry 2019:90). Part of this complementarian conviction includes the belief that men are particularly suited for leadership, whereas women are designed to serve as helpers (Bartkowski and Shah 2014; Ellison and Bartkowski 2002). The two genders complement one another because they are fundamentally different. In the evangelical Protestant view, God had a practical purpose in making men and women diverse, with women intended to be supporters for their spouses, as well as men more generally (Perry 2019:91). Thus, complementary gender roles are necessary for the proper functioning of the family, the church, and society at large (Diefendorf 2019; Griffith 1997).

Complementarianism provides a clear guide for the acceptable roles of men and women within gender-traditional religious groups, but the reality is more complicated. Rather than being simple-minded victims of patriarchy, numerous studies show that conservative religious women display a great deal of agency within church and home (Avishai, Gerber, and Randles 2013; Bartkowski 2001; Burke 2012; Gallagher 2004a, 2004b). The conflict between adherence to religiously based traditional gender ideologies and commitment to the gender egalitarian ideals held by broader U.S. society leads to a high degree of "messiness" within conservative religious congregations (Diefendorf 2019). Although few religious conservatives identify as feminist, qualitative research clearly shows that many evangelical Protestants uphold certain aspects of gender equality, such as equity in pay and employment opportunities (Gallagher 2004a, 2004b). Thus, within many evangelical Christian churches there is an apparent tension between deep-rooted beliefs in gender essentialism and beliefs in gender equality (Diefendorf 2019).

This tension between egalitarian ideals and gender essentialist beliefs is not confined to conservative religious institutions. Indeed, scholars have noted that the belief that men and women are innately and fundamentally different is common in the U.S. population, contributing to a stalled gender revolution

(England 2010; Pepin and Cotter 2018). Cotter and colleagues (2011) show that after becoming more egalitarian for more than two decades, gender role attitudes among U.S. adults plateaued during the mid-1990s. They attribute this trend to the rise of a new cultural frame, "an egalitarian essentialism that blends aspects of feminist equality and traditional motherhood roles." Although beliefs in gender essentialism are part of the broader culture in the United States, they are more pronounced within conservative religious institutions and are imbued with a sacred quality. Furthermore, conservative religious institutions contribute to the stalled gender revolution by sanctifying these traditional gender role ideologies.

Given that both broader cultural ideals of gender equality and gender essentialism influence members of conservative religious organizations, what does this mean for the health of women situated within gender-traditional religious groups? Women who are members of conservative religious groups are more likely to experience religious structural sexism, meaning they are denied access to key leadership roles and decision-making within the organization. Exposure to religious structural sexism may undermine women's mental and physical health by creating a stressful source of internal conflict. Women who are members of gender-traditional churches may espouse the beliefs of strict gender roles and hierarchy. Yet, many of these women are also committed to ideals of gender fairness. It may be fundamentally distressing to be denied access to the most basic levels of organizational decision-making, as is the case in the most structurally sexist congregations. Structural sexism may be particularly detrimental to women's health within religious organizations, given that churches are "greedy" institutions that often demand high levels of time, energy, and commitment (Ellison and Lee 2010).

Religious institutions can also reinforce gender inequality in ways that undermine health via other institutional domains. As Bartkowski and Shah (2014) note, the institutional influence of religion is perhaps most

pronounced within the family. Throughout U.S. history, religion and family have been linked through relationships of dependency and control (Edgell 2013). Many conservative faith traditions valorize women's domesticity, thus providing institutional support for gender-stratified roles within the home (Bartkowski 2001, 2007; Ellison and Bartkowski 2002; Ghazal Read 2004). Consequently, housework and childcare become ideologically defined as the natural providence of women, and there is little incentive for men to participate in mundane household tasks. As a result, women within conservative religious institutions may face a significant degree of work-family conflict, given that most evangelical Protestant women work outside of the home (Ellison and Bartkowski 2002).

Similarly, women in gender traditional churches are unequally tasked with maintaining and enforcing sexual morality. These gendered notions of sexuality may undermine health and well-being when translated into unrealistic standards of sexual purity or undesired sexual encounters within marriage (DeRogatis 2015). For example, in his work on pornography use among evangelical Christians, Perry (2019) notes that women in conservative religious communities often do not feel free to discuss topics like lust, pornography, or masturbation because these are assumed to be masculine issues. Therefore, women in these communities may feel shame for both violating community norms of sexual morality and not living up to ideals of femininity. In more extreme cases, religious institutional sexism may contribute to intimate partner violence, given evidence that men who hold more conservative theological views than their partners are especially likely to perpetrate violence against their partners (Ellison, Bartkowski, and Anderson 1999), and women in very closed religious communities are especially vulnerable when abused (Nason-Clark 2000). As these examples illustrate, the reach of religious institutionalized gender ideologies can extend far beyond places of worship to influence a variety of other social institutions in ways that may

disproportionally undermine women's mental and physical health.

In summary, although religious participation has been linked to improved health and well-being, many religious institutions have rigid gender-based status hierarchies that prohibit women from occupying meaningful leadership roles. This religious structural sexism is likely to harm women's health in a variety of ways. Scholars have speculated that women may benefit less than men from regular religious activity because institutions of religion are sexist (Maselko and Kubzansky 2006), but this assertion has not been explicitly tested. Thus, it remains unclear whether the health benefits of religious participation are contingent on equal access to power and status within congregations. We therefore ask the following research questions:

1. Is attending a sexist religious institution that excludes women from power and leadership associated with health among women and men?
2. If so, how does the health of attendees at inclusive religious institutions and sexist religious institutions compare to that of individuals who do not regularly participate in organized religion?

Based on previous research and theory, we expect that among women who attend religious services, congregational sexism will be associated with worse self-rated health. We also expect that women who attend inclusive churches will have better self-rated health than both attendees of sexist churches and non-attenders because they enjoy the health-promoting benefits of religious participation without the potentially harmful exposure to additional sexism. Depending on the extent to which congregational sexism negates the benefits of religious participation, we may expect that women who attend sexist churches have equal or worse self-rated health than non-attenders.

Previous scholarship suggests clear expectations for how congregational sexism may affect women's health as the marginalized

group, but this work is theoretically and empirically ambiguous as to how religious institutional sexism may affect men's health. On one hand, because men are the dominant group in sexist congregations, they may benefit from greater status, power, and resources in ways that improve their health and well-being. If this is the case, congregational sexism may be associated with better self-rated health among men who attend religious services. On the other hand, congregational sexism may promote toxic versions of masculinity that undermine men's health and cause strife within other institutional domains. If this is true, congregational sexism may be associated with worse self-rated health among men, although perhaps to a lesser degree than among women. Finally, it is also possible that exposure to congregational sexism benefits men in some ways and harms them in others such that the net effect is zero.

METHODS

Data and Sample

To answer these questions, we draw on a unique dataset created by linking two large nationally representative studies: the General Social Survey (GSS) and the National Congregations Study (NCS). The GSS is an individual-level survey of attitudes, behaviors, and characteristics of U.S. residents conducted yearly by NORC since 1972 (Smith et al. 2018). The NCS is a hypernetwork¹ sample of religious congregations in the United States conducted in conjunction with the GSS in 1998, 2006, and 2012² (Chaves, Anderson, and Eagle 2014). The NCS sample was generated by asking GSS respondents how frequently they attended religious services in the past year. Individuals who attended more than once in the previous year were asked to provide the name and location of their congregation. This process generated nationally representative congregation-level samples for each of the three waves of the NCS. The NCS interviewed one key informant (usually a priest or rabbi) from each congregation in the sample.

This sampling procedure allows us to link³ individual-level data from the GSS (i.e., health, demographics, and religious attendance) with contextual data about respondents' religious congregations from the NCS to assess how exposure to structural sexism within a religious group may affect attendees' health. To date, only two studies have used data created by this linkage. Ellison and colleagues (2009) used linked GSS-NCS data to examine the relationship between church characteristics (e.g., size) and participants' social interactions; Cobb, Üsküp, and Jefferson (2017) examined the link between congregational composition and beliefs about racial inequality. For the present study, we use two cross-sectional waves of GSS-NCS linked data in 2006 and 2012 because the baseline wave of the NCS (i.e., 1998) did not include the questions we use to measure the role of women in congregational leadership. We pool the linked GSS-NCS data from these two waves to derive a nationally representative sample of individuals within religious congregations in 2006 and 2012. Sixty percent of cases in our sample are from the year 2006 ($N = 1,354$), and 40 percent are from 2012 ($N = 880$). The sample size is reduced in 2012 because the GSS switched to a rotating panel design with smaller cross-sectional samples beginning in 2010.

To answer our research questions, we examine two subsamples of GSS respondents: a sample of religious attenders and a non-attenders sample. Figure 1 is a flow chart illustrating our sample selection criteria. The religious participant subsample (i.e., respondents who indicated they attend religious services more than once a year) is limited to individuals who have complete data for focal variables in both the NCS and GSS ($N = 1,390$). Because the NCS response rate is 73 to 78 percent for both waves, there are some GSS respondents who indicated they attend religious services more than once a year but are missing congregation information ($N = 744$, which is 32 percent of attenders). Comparing this group to the religious participants included in our study, the missing individuals

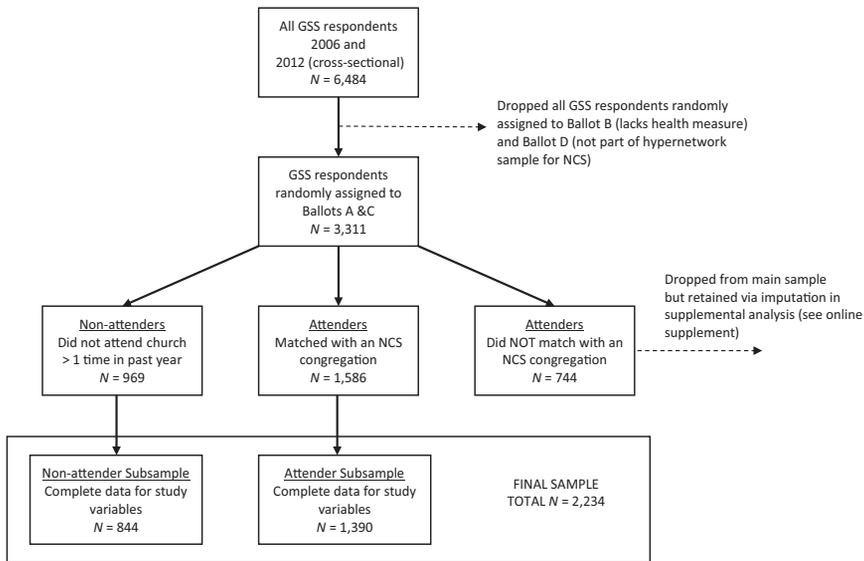


Figure 1. Sample Description Flow Chart

have equivalent levels of self-rated health and are generally similar to the non-missing religious attenders with the exception of being 2.6 years younger, having .5 fewer years of education, and earning \$200 less per year in annual household income. Attenders missing congregation information also attend places of worship less frequently than religious participants who are not missing congregation information. In fact, attenders who are missing congregational information most likely did not attend regularly enough to accurately name a congregation, and thus excluding them is unlikely to introduce meaningful bias.

Nevertheless, to test the robustness of our results to potential non-response bias, we conducted additional analyses in which we used multiple imputation with chained equations to impute the missing congregational data (i.e., church structural sexism variables and church setting: urban, suburban, or rural) for this group based on respondents' other characteristics. Results of these supplemental analyses are substantively identical to those we present (see Tables S1 and S2 in the online supplement). The non-attending subsample consists of the GSS respondents who said they did not attend a religious service more

than once in the past year and have complete data for the relevant study variables ($N = 844$). Item missingness was minimal (less than .2 percent for all variables except for income, which was missing in 12 percent of cases) and is therefore handled using listwise deletion. However, we also replicated our main analyses using multiple imputation for income and found similar results (see Tables S1 and S2 in the online supplement).

Measures

Self-rated health. Our key dependent variable for both samples is self-rated health (SRH). Decades of research have established SRH as a valid and reliable indicator of current health status as well as a strong predictor of mortality (Idler and Benyamini 1997; Jylhä 2009). Self-rated health is measured yearly in the GSS by asking respondents, “Would you say your own health, in general, is excellent, good, fair, or poor?” Responses are coded on a four-point scale where 1 is poor and 4 is excellent. For ease of interpretation, we show results from OLS models, which treat this outcome as linear. However, an ordinal logistic regression approach yields substantively

similar results for all analyses (see Tables S1 and S2 in the online supplement), and Brant tests indicate that the proportional odds assumption is not violated.

Church structural sexism. We conceptualize structural sexism as *systematic gender inequality in power and resources* within religious congregations, and we measure it with three different congregation-level variables based on a series of questions answered by each congregation's leader. First, we use a dichotomous measure (labeled "board") indicating whether an "otherwise qualified woman" in the congregation would be permitted to "serve as a full-fledged member of the congregation's main governing body or coordinating committee" (0 = yes, 1 = no). This measure of women's representation in governance is particularly important for assessing the relationship between structural sexism and health given the accumulating evidence showing women's political representation is vital for population health both in the United States and in the developing world (Homan 2017; Quamruzzaman and Lange 2016). Furthermore, although restricting women from governing boards is less common than other forms of religious institutional sexism, it is perhaps the most dangerous for health as it indicates a complete lack of decision-making power for women within the congregation.

Second, we use another dichotomous measure (labeled "leader") indicating whether an "otherwise qualified woman" would be permitted to serve as the head clergy person or primary religious leader of the congregation (0 = yes, 1 = no). Restricting women from the top rung on the congregational leadership ladder is a potentially powerful form of religious institutional sexism, as head clergy hold a great deal of power within a congregation. Additionally, much of the scholarship on gender inequality within places of worship centers on the gender-based prohibition on clergy positions, or what has been termed "the stained-glass ceiling" (e.g., Adams 2007; Bartkowski and Shah 2014). Third, we created a sexism scale, treated as a continuous

measure, which is a summary measure indicating how many of the following things women are prohibited from doing in the congregation: teaching co-ed classes, preaching at a main worship service, serving on the governing body, and being the head clergy person/leader. Scores range from 0 (indicating no restrictions on women's roles) to 4 (indicating women are prohibited from all four activities). The four items used in the sexism scale are all moderately correlated (correlation coefficients range from .29 to .69, see Table S3 in the online supplement) and the scale alpha is .71, indicating that the index reflects a valid construct. In addition to this straightforward index approach to creating a sexism scale, we also conducted supplemental analyses using a latent variable approach with structural equation modeling (see Tables S4 and S5 in the online supplement). Results from these supplemental analyses did not meaningfully differ from the main results presented here. We chose the sum index approach using OLS as the main model for simplicity, ease of interpretation, and compatibility with other analyses conducted herein.

All three structural sexism measures are coded such that high values indicate greater sexism in congregations. Our first two measures are important because they center on the most salient and perhaps most detrimental forms of religious institutional sexism and allow us to individually evaluate their effects. Our scale measure is useful because it combines these measures with two additional indicators to provide a more comprehensive assessment of the degree to which women are excluded from a variety of meaningful leadership roles within places of worship. Including all three measures allows us to account for women's power and status in governance, clergy, and across a range of leadership positions.

Other covariates. Our models include several individual and congregation-level covariates. At the individual level, we adjust for age, race (White = 1, non-White = 0), education (in years), household income (in thousands of inflation adjusted U.S. dollars,

base year 2000), marital status (married = 1, not married = 0), and frequency of church attendance (on a nine-point scale ranging from 0 = never to 8 = more than once a week). At the congregation level, we adjust all estimates for church regional setting (urban, suburban, or rural). In supplemental models (see Table S6 in the online supplement), we investigate the role of congregational adherence to the doctrine of biblical inerrancy (0 = no, 1 = yes) and religious tradition, with dummy variables for each of the following categories: Conservative Christian, Roman Catholic, other Christian, and non-Christian. Conservative Christian includes evangelical Protestants and Mormons. Other Christian includes several liberal, mainline, and Black Protestant denominations. Non-Christian includes Jewish, Muslim, and other religious traditions. Note that only 3 percent of our sample ($N = 41$) attended a non-Christian congregation. To adjust for time, all models also include a dummy variable for the year 2012 (with 2006 as the reference year). Because prior research and theory suggest each of these factors may vary by gender and differentially affect health along gender lines (Denton, Prus, and Walters 2004; Geronimus et al. 2007; McCullough and Laurenceau 2005; Ross, Masters, and Hummer 2012; Umberson and Kroeger 2016), all analyses are stratified by gender. We also include, for comparison, models that combine the samples of men and women and include a gender by sexism interaction term.

Analytic Approach

To answer our first research question, we estimated a series of linear regression models among our subsample of religious participants predicting individuals' self-rated health as a function of the levels of sexism in the congregation they attended (and other covariates). We estimated separate models for each of the three religious institutional sexism measures. To answer our second research question, we included our entire sample and categorized individuals as either non-attenders, attendees

of sexist congregations, or attendees of inclusive congregations, and again used linear regression to predict self-rated health based on these categories and other covariates.

In these models, we categorized congregations as sexist or inclusive based on the following criteria. For the dichotomous "board" and "leader" measures, congregations are defined as sexist if they do not allow women to serve in these roles. For the sexism index measure, congregations are defined as sexist if they score higher than 2 on our scale, meaning women are prohibited from serving in more than two of the four possible roles. Forty-two percent of religious participants in our sample attended a church categorized as sexist based on this metric (compared to 14 percent for "board" and 59 percent for "leader"). All models use robust standard errors clustered by congregation⁴ to account for heteroskedasticity.

We conducted a series of robustness checks that can be found in Tables S1 to S6 in the online supplement. These analyses demonstrate that our results are robust to alternative modeling strategies (OLS versus ordered logistic regression), alternative missing data handling (multiple imputation versus list-wise deletion), alternative weighting approaches (GSS weights versus unweighted), alternative measurement approaches (SEM latent variable versus sum index), and the inclusion of additional congregation-level variables ("inerrancy" and religious tradition). Supplemental analyses (not shown) also indicated that the health effects of congregational sexism do not vary according to respondents' race or frequency of attendance.

To better understand the pattern of results among men, we also conducted Bayesian linear regression modeling using a random-walk Metropolis-Hastings sampling algorithm (MCMC sample size = 10,000; burn-in = 2,500). We conducted three Bayesian analyses, one for each sexism measure, all with separate slopes for the effects of sexism for women and for men, similar to a combined-gender model with an interaction term for sexism \times male. The models used independent

normal priors with zero mean and variance of 10,000 for regression coefficients and an inverse-gamma prior with shape and scale parameters of .01 for the variance.

RESULTS

Descriptive Statistics

Descriptive statistics are shown in Table 1. The average age of the sample is 47, with religious attenders being slightly older than non-attenders. The average level of education is roughly 14 years, with attenders being slightly more educated than non-attenders. The average family income of the sample is \$49,700, with attenders and men having higher incomes than non-attenders and women, respectively. The average SRH score is 2.96, with religious attenders reporting better health than non-attenders. There are no statistically significant gender differences in SRH. The religious participant subsample has fewer White individuals, more women, and more married individuals, compared to the non-attending sample.

The average frequency of attendance in the religious participant sample is 5.2, which corresponds to slightly above two to three times per month. Women attend religious services more frequently than men. The majority of respondents attend congregations in locations classified as urban (68 percent); 13 percent attend suburban congregations and 18 percent attend rural congregations. Fourteen percent of the sample of religious attenders are in congregations that prohibit women from serving on the leadership/governing board, and the remaining 86 percent attend congregations that allow women to serve in this role. Fifty-nine percent of religious service attenders are in congregations that prohibit women from being the head clergy person/leader, and the remaining 41 percent attend congregations that would allow a woman to serve as the primary leader. Finally, the mean score on the sexism scale is 1.30 (SD = 1.23), which represents the number of restrictions (out of four possible) on women's roles in the average congregation.

Do Attendees of Sexist Congregations Have Worse Health Than Attendees of Inclusive Congregations?

Table 2 shows the results of regression models predicting self-rated health among women and men who are religious participants. Models 1 through 3 are identical except that each uses a different measure of religious institutional sexism. First, in gender stratified models, all three measures of structural sexism have statistically significant negative effects on women's self-rated health, such that women who attend more sexist congregations have worse health than women who attend less sexist congregations. The effects of congregational sexism among men are not statistically significant for any of the three sexism measures. Sensitivity analyses suggest that the relatively smaller size of the men's sample does not drive this lack of significant findings through diminished statistical power, as a random sample of the same size produced similar or larger statistically significant effects for women compared to those we report in Table 2 (see Table S7 in the online supplement).

The same patterns are evident in the combined models with a gender by sexism interaction term. For all three sexism measures, we see a significant effect of sexism on health among women, but not among men. However, note that both the Wald tests of the interaction terms in combined models and Chow tests of coefficients in gender stratified models indicate that *the difference* between the sexism coefficients for women and for men is not statistically significant at the $p < .05$ level.⁵ Thus, the effect of sexism among men does not significantly differ either from zero or from women's effect, *which does* significantly differ from zero.

What then can we conclude about whether sexism in religious congregations is related to men's self-rated health? Depending on which null-hypothesis we consider most important (i.e., does men's effect differ from zero or does men's effect differ from women's) we would come to different conclusions (i.e., sexism is not associated with men's health in

Table 1. Descriptive Statistics

Variable	Total		Attender		Non-attender		Women		Men		Min.	Max.
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD		
Age	47.4	17.2	48.4	17.1	45.7	17.1	48.0	17.6	46.7	16.7	18.0	89.0
Education (years)	13.6	3.0	13.8	3.0	13.3	3.0	13.7	2.8	13.6	3.1	.0	20.0
Income (thousands)	49.7	44.2	52.1	44.4	45.8	43.7	46.8	42.8	53.4	45.6	.0	178.7
Self-rated health	2.96	.84	3.00	.82	2.88	.86	2.96	.84	2.95	.83	1	4
% White	.76		.74		.80		.76		.76			
% Women	.55		.59		.50		1.00		.00			
% Married	.47		.53		.36		.46		.47			
Religious attendance frequency	3.32	2.92	5.21	2.05	.22	.41	3.62	2.96	2.96	2.83	0	8
Institutional setting												
% Urban			.68				.69		.68			
% Suburban			.13				.12		.15			
% Rural			.18				.19		.17			
Congregation prohibits women board members			.14				.13		.14			
Congregation prohibits women head pastor/leader			.59				.58		.61			
Sexism scale (number of prohibitions on women's roles in congregation)			1.30	1.23			1.26	1.21	1.37	1.26	0	4
N	2,234		1,389		844		1,237		997			

Note: Income is inflation adjusted family income in thousands of U.S. dollars. Self-rated health is measured on a four-point scale (1 = poor, 4 = excellent). Church attendance is measured on a nine-point scale (0 = never, 8 = more than once a week). Bold denotes differences between church categories or gender categories that are significant at the $p < .05$ level (two-tailed tests).

Table 2. Regression Estimates Predicting Self-Rated Health among Attending Women and Men

	Women			Men			Combined Gender Interaction Models		
	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3
Church Sexism									
Board	-.238** (.084)			-.134 (.094)			-.230** (.082)		
Leader		-.128* (.056)			-.124 (.066)			-.136* (.055)	
Sexism scale			-.061** (.023)			-.049 (.026)			-.060** (.023)
Board × Male							.094 (.123)		
Leader × Male								.033 (.086)	
Sexism × Male									.015 (.034)
Male								-.029 (.067)	-.026 (.062)
Age	-.008*** (.002)	-.008*** (.002)	-.008*** (.002)	-.010*** (.002)	-.010*** (.002)	-.010*** (.002)	-.009*** (.001)	-.009*** (.001)	-.009*** (.001)
Education	.044*** (.011)	.043*** (.011)	.043*** (.011)	.033** (.011)	.030** (.012)	.031** (.011)	.039*** (.008)	.037*** (.008)	.037*** (.008)
Income	.003*** (.001)	.003*** (.001)	.003*** (.001)	.002* (.001)	.002* (.001)	.002* (.001)	.002*** (.001)	.002*** (.001)	.002*** (.001)
White	.160* (.067)	.152* (.066)	.167* (.067)	.057 (.075)	.054 (.075)	.060 (.075)	.119* (.050)	.114* (.050)	.124* (.050)
Married	.087 (.061)	.081 (.061)	.085 (.061)	.034 (.070)	.037 (.070)	.034 (.070)	.075 (.045)	.074 (.045)	.074 (.045)
Frequency of attendance	.026 (.014)	.025 (.014)	.026 (.014)	.059*** (.016)	.059*** (.016)	.058*** (.016)	.038*** (.011)	.037*** (.011)	.037*** (.010)

(continued)

Table 2. (continued)

	Women			Men			Combined Gender Interaction Models		
	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3
	Church setting (Ref.: rural)								
Suburban	.091 (.100)	.090 (.100)	.095 (.100)	-.039 (.115)	-.023 (.114)	-.035 (.114)	.032 (.075)	.039 (.075)	.036 (.075)
Urban	-.033 (.072)	-.009 (.072)	-.018 (.072)	.092 (.089)	.116 (.087)	.101 (.088)	.022 (.056)	.046 (.055)	.035 (.055)
Year 2012 dummy (Ref.: 2006)	-.045 (.056)	-.044 (.056)	-.040 (.056)	-.074 (.066)	-.076 (.066)	-.075 (.066)	-.055 (.043)	-.055 (.043)	-.052 (.043)
Constant	2.404*** (.189)	2.456*** (.194)	2.445*** (.192)	2.549*** (.197)	2.631*** (.204)	2.624*** (.203)	2.491*** (.139)	2.554*** (.144)	2.546*** (.142)
N	814	814	814	575	575	575	1,389	1,389	1,389

Note: Standard errors are in parentheses. Income is inflation adjusted (to year 2000) family income in thousands of U.S. dollars. Church attendance is measured on a nine-point scale (0 = never, 8 = more than once a week). Each of the three models uses a different measure of sexism.
 * $p < .05$; ** $p < .01$; *** $p < .001$ (two-tailed tests).

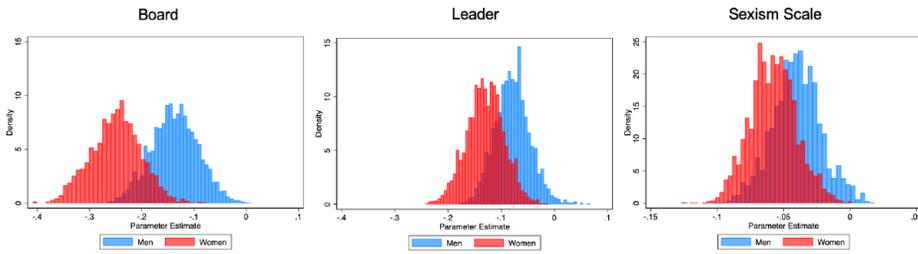


Figure 2. Posterior Distributions of Effects of Sexism on Self-Rated Health among Women and Men from Bayesian Linear Regression

the first case; sexism is associated with men's health in the second). This type of situation reveals the limits of frequentist statistics, with its somewhat arbitrary cut-off points and hypothesis testing procedures. A Bayesian approach can provide more information about the possible effects among men.

Figure 2 shows the posterior distributions (MCMC sample size = 10,000) of coefficient estimates for the effects of sexism on self-rated health among women and men from the Bayesian linear regression analyses (see Tables S8a, S8b, and S8c in the online supplement). These distributions clearly show a negative effect of sexism on health among women, given that 0 is outside the distributions of likely values. The distributions indicate the most likely scenario for men is that they also exhibit a negative effect of sexism on health, but the magnitude of the effect is smaller than that of women. Based on these distributions, the probability that the effect of sexism among men is less than zero is 99 percent for the board measure, 99 percent for the leader measure, and 98 percent for the sexism scale. Furthermore, the probability that the negative effect for men is smaller in magnitude than the effect for women is 99 percent, 84 percent, and 79 percent for the board, leader, and sexism measures, respectively.

Are the Health Benefits of Religious Participation Contingent on Congregational Sexism?

To answer this question, we focus on women because they exhibit an unambiguous negative

effect of congregational sexism on health. Figure 3 shows the predicted self-rated health of non-religious women compared to women who attend sexist congregations and women who attend inclusive congregations. These estimates were produced using OLS regression of SRH on the religious attendance category holding other covariates (age, education, income, race, marital status) constant at their means (see Table S9 in the online supplement for complete regression results). Women who attend inclusive congregations have better self-rated health than non-attenders and women who attend sexist congregations. There is no statistically significant difference in self-rated health between non-attenders and women who attend sexist congregations. These results indicate that women only experience a health benefit from religious participation when they attend religious institutions that are gender inclusive and allow women to hold meaningful leadership roles within the congregation.

DISCUSSION

As researchers are beginning to take seriously the impact of structural sexism on health (e.g., Homan 2019), it is important to understand how institutional sexism works at various levels. Religious institutions are prime for scholarly exploration at the meso-level given that research touts the salubrious effects of religious participation on health and well-being, yet studies consistently highlight the rigid gender-based status hierarchies within certain congregations. This study is among the first to show an association between

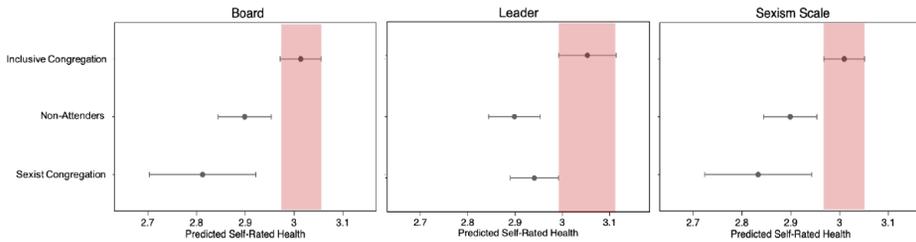


Figure 3. Women’s Self-Rated Health by Religious Attendance Category

Note: Estimates were produced using OLS regression of SRH on congregation category holding other covariates (age, education, income, race, marital status) constant at their means. Each panel represents a separate analysis with the definition of “sexist” based on one of the three sexism measures. Estimates shown with 84 percent confidence intervals, which are the appropriate intervals for determining significant differences between the estimates at the $p < .05$ level based on the ratio of their standard errors. Thus, groups are significantly different from one another if their confidence bands do not overlap. Accordingly, the figure shows that for all three sexism measures, attenders of inclusive congregations have better self-rated health than do the other two groups (who do not significantly differ from one another).

religious institutional sexism and health. Our findings indicate that the accepted health benefits of religious involvement do not extend to all groups, but are contingent on equal access to power and status within religious institutions.

Consistent with previous research on structural sexism (Homan 2019) and our theoretical expectations, our findings suggest religious structural sexism undermines women’s health. Our findings are perhaps most striking for our most restrictive measure of structural sexism: being able to serve on a congregation’s governing body. Women who are members of the most sexist congregations in our sample lack basic decision-making authority within their congregations. Alienating women from even rudimentary forms of institutional power appears to be particularly damaging to physical health.

Religious structural sexism likely affects health via a number of pathways—for example, undermining psychosocial resources, increasing psychological distress, and increasing sexism in other structural domains—but additional scholarship is needed to understand how religious institutional sexism influences mental and physical health. Ancillary analyses finding that the impact of religious structural sexism does not vary by frequency of church attendance (i.e., no dose-response pattern) hints that psychological distress may

not be the most important mechanism directly linking congregational sexism and health.

Instead, participation in a sexist church may be an indicator of exposure to a whole system of structural sexism because it is part of a constellation of positions within various other institutions and relationships. The family may function as a particularly important domain by providing institutional support for gender-stratified roles within the home. To the extent that structural sexism in religious congregations encourages a traditional gender division of household labor, such sexism may be particularly harmful in the context of the ongoing COVID-19 pandemic. Social distancing has limited the social support and engagement normally provided by religious congregations, and the lack of childcare has exacerbated existing gender inequalities in domestic labor and overburdened women, undermining their careers and mental health (Collins et al. 2020; Hamel and Salganicoff 2020). Thus, exploring the connections between structural sexism across varied structural domains and levels of analysis represents an important next step in understanding the mechanisms linking religious structural sexism and health.

Decades of research have documented the salutary effects of religious participation for individual health and well-being (Ellison and Levin 1998; Hill et al. 2011; Koenig et al. 2012; Strawbridge et al. 1998), so it is noteworthy

that the health of women who attend sexist congregations is not significantly different from the health of non-attenders. This finding suggests the negative effects of marginalization offset the beneficial impact of church attendance in the form of social support and advantageous health behaviors. Conversely, women active in inclusive religious groups, where they can serve on governing boards and lead the congregation, display better self-rated health than do women in sexist groups and non-attenders.

Why are women in inclusive congregations more likely to report better self-rated health than non-attending women? Our results suggest opportunities for leadership may be a central mechanism for understanding why women in inclusive churches benefit from religious involvement in ways that women in sexist churches or non-attenders do not. Sociologists of religion have long argued that church attendance benefits health in part because it allows individuals to be valued for non-material or non-physical qualities, that is, for their inherent uniqueness, service to others, and wisdom and morality (Ellison and Levin 1998). Key to displaying and being valued for these qualities may be assuming leadership roles within the church, be it through leading formal church services, religious study classes, or serving on governing boards. Scholars have also noted that opportunities for leadership within a church may be most beneficial to health and well-being for people who do not have opportunities to take on leadership roles in other domains of their lives (Ellison and Levin 1998). Women's opportunities for leadership in inclusive congregations may ameliorate effects of the exclusion they encounter in other domains (e.g., at work) or due to other social statuses (e.g., older adults). In summary, the results among women suggest the purported health benefits of religious attendance may only extend to those who have agency within religious institutions. Future scholarship in this area should examine the influence of religious institutional factors on the health of other marginalized groups (e.g., sexual minority populations).

Consistent with previous research suggesting that religion has a greater impact on women's health than on men's health (Mirola 1999; Norton et al. 2006; Schieman et al. 2010; Strawbridge et al. 2001), we find marginal to no statistically significant effect of religious structural sexism for men's self-rated health across the three measures. Our findings are consistent with scholarship examining gender variation in the religion-health connection, but they stand in contrast to scholarship on structural sexism within U.S. state-level institutions, which harms men's health, or structural sexism within marriages, which benefits men. We do not find clear evidence that sexism in religious congregations is either harmful or beneficial for men's health.

Future research should examine why sexism within religious institutions may affect men's health differently than do other forms of structural sexism. As meso-level institutions, sexism within religious congregations may not erode men's health via similar mechanisms as state-level institutional sexism. Unlike macro-level structural sexism, congregational sexism does not decrease investment in state-level social programs that may improve population health, nor does it likely increase masculine risk-taking behaviors (particularly given religious prohibitions). Conversely, men may not directly benefit from religious institutional sexism, as this form of sexism does not confer the dyadic qualities of marital relationships on health. Finally, although the health effects of congregational sexism appear unlike those of either state-level sexism or inter-marital sexism, congregational sexism likely contributes to *both* of these countervailing influences on men's health. The complementarian gender ideology that supports the exclusion of women from leadership in most sexist congregations (1) creates and sustains gender inequality within marriages, and (2) upholds the ideal of male leadership, thereby perpetuating gender inequality in large-scale political and economic institutions outside the religious realm. Thus, to the extent that congregational sexism

reinforces these other types of sexism, their respective benefits and harms may cancel out.

Sociologists of religion have increasingly called for scholars to take an intersectional approach that views religion as providing cultural repertoires that individuals invoke differently depending on their location within the social hierarchy (Edgell 2012). As Yukich and Edgell (2020) note, religious beliefs and practices are developed within a specific institutional context and acted upon in various ways in different social settings and by people from different social locations (Yukich and Braunstein 2014; Yukich, Fulton, and Wood 2020). Yet sociologists of religion often ignore how religious repertoires are chiefly about race, and this dominant approach reinforces White privilege (Yukich and Edgell 2020). We did not find compelling evidence in our data of a difference in the relationship between religious institutional sexism and health along racial lines, but this may have been a function of the relatively small sample sizes. Thus, it remains an important task for future research to explore sexism in religious congregations with an intersectional lens.

We centered our study on the United States and thus it is unclear whether our findings would be similar outside of this context. Scholarship on evangelicalism in Colombia suggests a complex relationship between religion, gender, and health, whereby some women and men may benefit from gender traditional religious communities because they stand in opposition to “machismo” culture (Brusco 1995). Within this context, as within the United States, some women may embrace gender traditional religious groups because they require their husbands to abstain from substance use, infidelity, and violence (Brusco 1995; Garcia et al. 2013). Because some conservative religious institutions lead men to avoid these risky health behaviors, particularly when they stand in contrast to the dominant culture, participation may yield health benefits for certain men and women associated with these traditions. Future research on congregational sexism, gender, and health should examine these relationships in a variety of international contexts.

Additionally, although we find no evidence of an interaction between frequency of attendance and structural sexism, indicating that even minimal exposure to religious structural sexism is harmful to health, service attendance is but one measure of religious involvement. Other indicators of involvement within religious institutions may yield different results. For example, people who regularly participate in other activities at their place of worship (e.g., singing in the choir, attending Bible studies, or holding informal leadership positions) may be particularly affected by structural sexism. Future research in this area should examine the interaction between congregational sexism and other forms of religious participation on health, and studies should include additional measures of gendered institutional involvement. Our study includes a range of measures of institutional sexism, but there are certainly additional indicators of religious structural sexism that would shed light on the gendered nature of the religion–health connection.

There are two important limitations to the current study. First, our data are cross-sectional, so we cannot infer causality. Second, it is important to consider the influence of omitted variables on our key results. For example, Hill and colleagues (2011) note that if individuals with certain conventional and risk-averse personality types are attracted to or selected into religious activities, personality selection processes could account for at least some of the effects of religious attendance. In our case, it may be that women who select into sexist religious environments are in some way different from women who opt out of these contexts in ways that influence their physical health. However, it is also likely that the women whose health would be most harmed by sexist institutional arrangements are those who perceive them as particularly unfair and oppressive and who therefore are likely to leave this type of congregation or never select into one to begin with. In that case, our estimates of the relationship between institutional sexism and health would be conservative.

Despite these limitations, our study presents novel evidence regarding the relationship

between structural sexism and health. Even in religious congregations, where engagement has well-known health benefits, structural sexism can undermine women's well-being. Scholars should continue to examine the connections between religious structural sexism and health.

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Notes

1. Hypernetwork sampling is a technique used to generate a random sample of organizations for which no sampling frame exists by beginning with a random sample of individuals and asking them to name organizations to which they are connected (see McPherson 1982, 2001; National Congregations Study 2019).
2. An additional wave was conducted in 2018 to 2019.
3. Linked data used in this analysis are derived from Sensitive Data Files of the NCS, obtained under special arrangements designed to minimize the risk that participating congregations will be publicly identified. These data are not available from the authors. Persons interested in obtaining NCS Sensitive Data Files should contact Mark Chaves at mac58@soc.duke.edu.
4. The majority of congregations contained only one GSS respondent, but some contained more. Our sample of attenders contains 814 women representing 770 unique congregations, with an average of 1.4 women per congregation (range = [1, 4]), and 575 men representing 557 unique congregations, with an average of 1.0 men per congregation (range = [1, 3]).
5. Chow test results: $t = -.82$, $p = -.56$ for board; $t = -.05$, $p = .97$ for leader; and $t = -.35$, $p = .79$ for sexism scale. Wald Test of interaction term: $F = .59$, $p = .44$ for board; $F = .15$, $p = .70$ for leader; and $F = .19$, $p = .66$ for sexism scale.

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