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Religious Beliefs as a Mediator Between Conspiracy Beliefs and Health Behaviors

Dini İnançların Komplo İnançları ve Sağlık Davranışları Arasındaki Aracılık Rolü

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Abstract: Religious beliefs play a significant role in shaping health-related behaviors and conspiracy theories. Typically, religious beliefs exhibit a favorable association with both health behavior and conspiracy theories, in contrast to the unfavorable relationship between health practices and conspiracy theories. This study investigated the mediating role of religious beliefs in the relationship between conspiracy theories and health-related behaviors. The study included 231 participants. The Health Protection Behavior Scale, Religious Lifestyle Scale, and General Belief in Conspiracy Theories Scale were administered. Positive correlations were observed between the behavioral subdimension of the health-protective behavior scale and the belief, morality, and worship subdimensions of the religious commitment scale. Trust in health services was also associated with worship and morality. The findings were discussed within social context.

Keywords: Religious beliefs, Conspiracy theories, Health protection behaviors, Belief systems.

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Öz: Dini inançlar, sağlıkla ilgili davranışların ve komplo teorilerinin şekillenmesinde önemli bir rol oynamaktadır. Genellikle dini inançlar, sağlık davranışları ve komplo teorileriyle pozitif yönlü bir ilişki gösterirken, sağlık uygulamaları ile komplo teorileri arasında negative yönlü bir ilişki gözlemlenmektedir. Bu çalışma, dini inançların komplo teorileri ve sağlıkla ilgili davranışlar arasındaki ilişkide aracı rolünü araştırmıştır. Çalışmaya yaş ortalaması 22.7 olan 231 katılımcı dahil edilmiştir. Sağlık Koruma Davranış Ölçeği, Dini Yaşam Tarzı Ölçeği ve Genel Komplo Teorilerine İnanç Ölçeği uygulanmıştır. Sağlık koruma davranış ölçeğinin davranış alt boyutu ile dini bağlılık ölçeğinin inanç, ahlak ve ibadet alt boyutları arasında pozitif korelasyonlar gözlemlenmiştir. Sağlık hizmetlerine güven, ibadet ve ahlak ile ilişkilendirilmiştir. Bulgular, sosyal bağlam içerisinde analiz edilmiştir.

Anahtar Kelimeler: Dini inançlar, Komplo teorileri, Sağlık koruma davranışları, İnanç sistemleri.

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1. Introduction

Research on the relationship between conspiracy theories and health behavior has become increasingly important, in recent years especially after the COVID-19 pandemic, although the association between conspiracy ideas and attitudes has been investigated for many years. Religious beliefs are a significant factor in both health-related activities and conspiracy theories. Religious beliefs typically exhibit a positive connection with both variables, in contrast to the negative relationship between health practices and conspiracy theories. This study investigated the mediating role of religious beliefs in the relationship between conspiracy theories and health-related behaviors.

1.1.Conspiracy beliefs

Researchers contend that four key principles underpin conspiracy beliefs: consequential, universal, emotional, and social. First, because of their persuasive power and subjective nature, conspiracy beliefs significantly impact critical aspects of life, such as relationships and health, making them consequential. Second, these ideas demonstrate universal appeal across historical periods and cultural contexts, indicating a fundamental human tendency to embrace conspiratorial thinking, particularly in times of intergroup conflict and reproductive challenges. Third, education often moderates beliefs by promoting analytical reasoning. However, conspiracy theories are typically aligned with intuitive thinking, highlighting their emotional nature. Finally, conspiracy theories arise in response to perceived threats from hostile outgroups, bolstering ingroup identity and fostering distrust toward powerful or stereotyped individuals, underscoring their social dimension (van Prooijen & Douglas, 2018: 902).

Building on the understanding that beliefs in conspiracies revolve around four core principles, it is crucial to consider their broader societal implications. These include serious negative impacts such as eroding public confidence and exacerbating societal division. Conspiracy theories pose a challenge to democratic regimes because they can erode public confidence and exacerbate societal division (Sternisko et al., 2020: 5). Conspiracy theories can also undermine confidence in professional judgment and scientific understanding, making it harder to implement successful solutions in public health emergencies (Allington et al., 2021; Romer & Jameison, 2020).

1.2. Conspiracy beliefs, health behaviors and religious beliefs

Research conducted during the COVID-19 pandemic has revealed a connection between the degree of belief in conspiracy theories and antivaccine sentiments, poor vaccination rates, and support for alternative treatments (Bertin et al., 2020; Bierwiaczonek, et al., 2022). Importantly, According to Romer and Jamieson (2020) conspiracy beliefs are directly linked to a reduced willingness to engage in vital health-protective behaviors, such as vaccination and mask usage during pandemics.

In their 2022 study, Sobol and colleagues identified a significant link between conspiracy theories and higher levels of fundamentalism and delusions, along with reduced compliance with public health measures. They found a positive relationship not only between conspiracy theories and delusions but also between delusions and religious fanaticism. Notably, religious fundamentalism had a strong direct effect on conspiracy views even after delusions were accounted for, with delusions serving as partial mediators. Additionally, researchers reported a negative correlation between religious conspiracy beliefs and adherence to COVID-19 public health standards, suggesting that individuals who strongly identify as religious fundamentalists have a higher tendency to accept conspiracy theories, especially those concerning spiritual or mystical topics.

Religious faith has been extensively investigated in relation to conspiracy theories. Studies, such as those conducted by Kim and Kim (2020), have examined the ways in which religiosity, along with other factors, contributes to the formation of conspiracy beliefs. The integrated model proposed by these researchers considers political, psychological, and structural factors, as well as variables such as anxiety and perceived danger, and finds that increased religiosity is a strong predictor of conspiracy theories about COVID-19. Similarly, Maciuszek et al. (2023) reported that individuals who were hesitant about vaccination tended to have higher levels of religiosity than those who were eager to be vaccinated, suggesting a connection between vaccine hesitancy and religious commitment.

Building on the connection between moral foundations and conspiracy perspectives, Nejat et al. (2023) reported that moral values, particularly those connected to authority and sanctity, were more accurate predictors of COVID-19 conspiracy beliefs than personality factors were. This conclusion aligns with other studies (Łowicki et al., 2022; Sobol et al., 2022), which have consistently demonstrated that during the pandemic, religious fundamentalism, rather than general religiosity, was strongly associated with endorsing conspiracy theories and engaging in socially problematic behaviors.

Despite these studies, the connection between religion and conspiracy theories is nevertheless murky and occasionally conflicting. Although the direction and severity of these effects can vary, Magarini et al. (2021) reported that a range of factors, including religious views and conspiracy theories, could influence irrational ideas regarding COVID-19. Jabkowski et al. (2023) further emphasized that although there is a positive correlation between increased religiosity and support for conspiracy theories, political orientation and scientific credibility both play a significant role in forming these ideas. Similar positive connections between religiosity and believing in conspiracy theories were found in studies from Turkey (Alper et al., 2021).

Furthermore, conspiracy theories have been linked to greater degrees of fundamentalism and delusions, as well as reduced compliance with public health standards (Sobol, et al., 2022). Their research revealed a strong correlation between religious fanaticism and delusions, which were connected to conspiracy theories.

1.3.Religious beliefs and health behavior

Although religious beliefs are positively connected with conspiracy theories, research has shown that they are also strongly correlated with health behaviors. Numerous aspects of the relationships between religious practices, beliefs, and mental and physical health have been studied. Rew and Wong (2006) conducted a comprehensive examination of 43 studies on the relationship between religiosity and health attitudes among adolescents. Despite methodological criticism, the majority of studies reported a positive relationship between health attitudes and religious beliefs.

Additional data emphasize the intricate and context-dependent relationships. Stroope and Baker (2018) reported that community religious settings had a major effect on the relationship between an individual's religiosity and health outcomes. According to their research, less religious people often have worse health outcomes, especially in highly religious populations. This finding shows that health differences between more- and less-religious people may be exacerbated by community-level religiosity.

Another area of academic emphasis is the relationship between religious engagement and mortality. Frequent attendance at religious services was linked to a 30–35% reduction in the risk of mortality during a 7.5-year follow-up period (Musick et al., 2004). This protective effect highlights the possible long-term advantages of religious group activities.

Johnstone et al. (2012: 1039) conducted a cross-sectional investigation including people from five different religious traditions. Their results revealed that spirituality and religiosity were substantially correlated with better mental health, an increase in good personality traits, a decrease in negative personality traits, and no significant group differences (between religions) in health status. Interestingly, psychological characteristics were shown to predict health outcomes more accurately than were spiritual factors, indicating that personality may operate as a mediator in the association between health and religion.

Koenig and Al Shohaib (2024) investigated the relationship between psychological health and religious participation and found a weak but statistically significant positive correlation between general religious involvement and aspects such as optimism, happiness, and life satisfaction. Interestingly, their findings suggested potential gender variations in the impact of religion on well-being, as these positive correlations were stronger in men than in women. Similarly, Krause et al. (1998) explored the effects of church-based emotional support on the psychological well-being of presbyterians. Their research indicated that while

emotional support from the Church had some positive effects, these effects were relatively modest, underscoring the critical role of social support within places of worship in enhancing psychological health.

Expanding on the influence of religious practices, faith appears to significantly impact coping strategies within communities of individuals with chronic diseases (Kretzler et al., 2022; Rippentrop et al., 2005: 315; Schreiber & Brockopp, 2012). For example, a detailed examination of the studies related to connection between religious attributes and cancer prevention was performed by Kretzler et al. (2022). Although the findings regarding religious denomination and religiosity were somewhat conflicting, they discovered a generally positive association between attending religious services and the utilization of cancer screening. This suggests that while religion may promote certain preventive health behaviors, the overall picture remains complex and context dependent. Further illustrating this complexity, Schreiber and Brockopp (2012) reviewed the relationships among spirituality, religion, and psychological well-being in breast cancer survivors and concluded that while the relationships were few, they were nonetheless significant, indicating that belief systems could impact psychological health as the illness progresses.

In their 2005 study of people with chronic pain, Rippentrop et al. reported a strong positive correlation between several religious and spiritual practices and mental health. They explained these contradictory results, as those who were suffering from lower physical health were more likely to engage in private religious activities such as prayer and meditation, which may be a coping mechanism. Furthermore, there was a strong correlation between mental health status and variables such as forgiveness, negative religious coping, and religious support.

It is necessary to explain the paradox that conspiracy theories have a negative correlation with health attitudes and behaviors but a positive correlation with religious beliefs. The goal of this study was to investigate the mediating function of various religious attitudes in the connection between conspiracy theories and health attitudes.

In this context, this study's hypotheses are as follows:

H_1: A person's adherence to health-related behaviors tends to decrease as their acceptance of conspiracy theories increases.

H_2: Religious attitudes and health behaviors are positively related.

H_3: Religious attitudes mediate the relationship between beliefs in conspiracy theories and health behaviors.

2. Method

2.1. Participants

G*Power 3.1 (Faul et al., 2009) was used to determine the required number of participants for this research. The *F* test type was selected, and multiple regression was used as the statistical test. The analysis parameters were set as follows: effect size = .15, alpha error = .05, power = .95, and number of predictors = 10. Based on these parameters, the minimum required number of participants was 172.

Table 1: Participants' Demographic Characteristics (N = 231)

	Mean (SD) or n (%)
Age	22.7 (5.72)
Gender	
Male	69 (30%)
Female	161 (70%)
Education	
University students or graduates	213 (92.21%)
Resides in	
Village	18 (7.79%)
Town	41 (17.75)
City	42 (18.18%
Metropolitan city	128 (55.41%)
Other/not reported	2 (0.87%)
Religious affiliation	
Islam	217 (93.94%)
Other	14 (6.06%)

The study included 231 participants: 161 women (70%), 69 men (30%) and one participant preferred not to report (Table 1). The average age of the participants was 22.7 years (*SD* = 5.72). Among them, 213 (92.21%) were university students or graduates. The participants' living environments were categorized as follows: 18 from villages (8.1%), 41 from towns (18.5%), 42 from cities (18.9%), and 128 from metropolitan areas (57.7%). With respect to religious affiliation, 14 participants (6.07%) identified religions other than Islam, whereas the remaining 217 participants (93.94%) were Muslims. The average level of religiosity, measured on a 1--10 Likert scale, was 5.74 (*SD* = 2.13).

2.2.Measurements

Religious Lifestyle Scale

The Religious Lifestyle Scale developed by Kayıklık and Kalgı (2017) is a measurement tool with three dimensions: belief, morality, and worship. The seven-point Likert scale includes 36 items. In the belief dimension, items include statements such as "God knows everything we do." and "On Judgment Day, everyone will be held accountable for their actions." In the morality dimension, items include "I strive not to deceive anyone because it goes against my religious beliefs." In the worship dimension, the items include "I perform my prayers." The validity (RMSEA < .08, NFI > .90, CFI = .95) and reliability (Cronbach's alpha = .93) values from the scale development study indicate that it is a valid and reliable tool for measuring religious lifestyles.

General Belief in Conspiracy Theories Scale

The General Belief in Conspiracy Theories Scale was developed by Brotherton et al. (2013). Tam (2023) translated and adapted the scale into Turkish. The scale comprises 23 items distributed across four factors: hidden power, widespread conspiracies, extraterrestrial beings, and government abuse. The hidden power dimension includes items such as "A small group of people who control the world are reducing the population through plans such as pandemics and drugs to better control the world population.". "There is no such thing as global warming" exemplifies an item for widespread conspiracies. The extraterrestrial beliefs dimension encompasses items such as "Evidence of alien contact being hidden from the public.".

The government abuse dimension includes items such as "Governments allow preventable terrorist activities for strategic reasons.".

The validity (RMSEA = .08, CFI = .93, GFI = .93) and reliability (Cronbach's alpha = .96) results from the adaptation study (Tam, 2023) indicate that the scale is a valid and reliable tool for measuring beliefs in conspiracy theories.

Health Protection Behavior Scale

The Health Protection Behavior Scale (HPBS) was developed by Ping et al. (2018). It was translated and adapted into Turkish as part of Ay's (2022) doctoral thesis under the supervision of Çevik. This Likert-type scale consists of five subdimensions: general behavior, interpersonal relationships, health services, eating habits, and self-knowledge. The validity (RMSEA = .08, NFI = .90, CFI = .92, TLI = .91) and reliability (Cronbach's alpha = .85) results from the adaptation study suggest that the scale is a robust and dependable instrument for assessing health-protective behaviors.

Demographic Information Form

The demographic information form asked participants about their age, gender, education level, and where they lived in. Additionally, specific to this study, questions on religion and religious beliefs were included.

2.3. Procedure

Ethical approval was obtained from the XXX University Social and Human Sciences Ethics Committee under reference number "2024/8".

The scales were administered to the participants both face-to-face and online via a convenience sampling method. To control for order effects, scales were presented in three different sequences. Completing the scale took approximately 25 minutes.

2.4. Analysis

All analyses were conducted via Jamovi software (the Jamovi Project, 2024). The relationships between the scales were examined via Pearson's correlation coefficient analysis. Regression analysis was used to identify variables related to health protective behaviors. For each dependent variable, subscales of religious lifestyle scale factors were added in Step 1, and religious lifestyle scale factors were added in Step 2.

Five separate mediation models were tested to examine the mediator role of religious attitudes, with each subdimension of the HPBS (general behavior, interpersonal relationships, health services, eating habits, and self-knowledge) serving as the outcome variable. In these models, the subdimensions of the General Belief in Conspiracy Theories Scale were included as predictor variables, while the subdimensions of the Religious Lifestyle Scale were tested as mediators.

3. Results

Correlation analysis revealed significant associations: positive correlations existed between the health-protective behavior scale's behavioral subdimension and the belief ($r(225) = .16$, $p = .014$), morality ($r(227) = .23$, $p < .001$), and worship ($r(223) = .35$, $p < .001$) subdimensions of the religious commitment scale. Health services were associated with worship ($r(224) = .14$, $p = .039$) and morality ($r(220) = .16$, $p = .015$). General beliefs in conspiracies were negatively correlated with attitudes toward health services ($r(224) = -.15$, $p = .027$). Beliefs in government conspiracies were negatively correlated with the morality ($r(227) = -.22$, $p < .001$) and worship ($r(223) = -.30$, $p < .01$) dimensions of religious commitment. Widespread conspiracy beliefs were positively correlated with worship, $r(223) = .21$, $p = .002$, Table 2.

A regression analysis using the enter method was conducted with the general behavior subdimension of the Health Protective Behavior Scale as the dependent variable and the subdimensions of the General Belief in Conspiracy Theories Scale and Religious Lifestyle Scale as the predictor variables. In the model where the behavior subdimension is the dependent variable, the hidden power, widespread conspiracies, extraterrestrial beings, and government abuse subdimensions of the Conspiracy Theories Scale were

entered in the first step, and the belief, morality, and worship subdimensions of the Religious Lifestyle Scale were added in the second step. When the necessary assumptions for regression analysis were checked, the Durbin–Watson statistic of 1.92 (p = .016) suggested no autocorrelation, and the Shapiro–Wilk test confirmed the normality of the residuals, W = .99, p = .64. The first-step model was not significant (R^2 =.03, F (4, 213) = 1.49, p = .205). However, the second model was significant (R^2 = .15, F(7,210) = 5.40, p < .001. In the second model, the worship subdimension significantly predicted health behavior (β = .46 [95% CI = .24, .68], t = 4.19, p < .001).

A regression analysis using the enter method was conducted with the Health Services subdimension of the Health Protective Behavior Scale as the dependent variable and the subdimensions of the General Belief in Conspiracy Theories Scale and the Religious Lifestyle Scale as the predictor variables. In the first step, the hidden power, widespread conspiracies, extraterrestrial beings, and government abuse subdimensions of the Conspiracy Theories Scale were entered, and the belief, morality, and worship subdimensions of the Religious Lifestyle Scale were added in the second step. When the necessary assumptions for regression analysis were checked, the Durbin–Watson statistic of 1.83 (p = .204) suggested no autocorrelation, and the Shapiro–Wilk test confirmed the normality of the residuals, W = .95, p = .18. The first-step model was not significant (R^2 = .04, F(4,210) = 1.98, p = .098). However, the second model was significant, R^2 = .09, F(7,207) = 2.95, p = .006. In the second model, the worship (β = .28 [95% CI = .06, .50], t = 2.51, p = .013) and widespread conspiracies dimensions (β = -.29 [95% CI = -46, -.12], t = -3.35, p < .001) significantly predicted health behavior.

Table 2: Correlational Analysis

	1	2	3	4	5	6	7	8	9	10	11
1) RLS Belief	—										
2) RLS Morality	.86***	—									
3) RLS Worship	.70***	0.78***	—								
4) Conspiracy Hidden Powers	.11	.10	.06	—							
5) Conspiracy Widespread	.09	.09	.21**	.38***	—						
6) Conspiracy Extraterrestrial	.03	.0	-0.01	.55***	.59***	—					
7) Conspiracy Government	-.14	.22***	-.30***	.49***	.19**	.35***	—				
8) HPBS Self-Knowledge	.07	.09	.12	-.01	-.01	.0	-.06	—			
9) HPBS Behavior	.16*	.23***	.35***	.02	.06	.03	-.12	.38***	—		
10) HPBS Interpersonal Relationship	.10	.093	.13	-.03	-.10	-.05	-.01	.28***	.37***	—	
11) HPBS HealthServices	.12	.14*	.16*	.02	-.15**	-.06	.04	.36***	.48***	.51***	—
12) HPBS Eating habits	.06	.11	.16*	.09	.12	.10	.08	.39***	.58***	.33***	.55***

Note: * p < .05, ** p < .01, *** p < .001

In the regression models in which the dependent variables were the self-knowledge, interpersonal relationships, and eating habits subdimensions of the Health Protective Behavior Scale, no significant

associations were found between the predictor variables (the subdimensions of the General Belief in Conspiracy Theories Scale and Religious Lifestyle Scale) and any dependent variable.

To examine the mediating role of religious attitudes, five separate mediation models were tested, with each subdimension of the HPBS (general behavior, interpersonal relationships, health services, eating habits, and self-knowledge) serving as the dependent variable. The indirect effects of conspiracy beliefs on self-knowledge and interpersonal relationships were not significant.

The indirect effect of hidden power conspiracies on eating habits through religious beliefs was marginally significant (Effect = -0.05, 95% CI = -0.10, 0.00, z = -1.89 p = .059). This result suggests that religious beliefs mediate this relationship. Similarly, the indirect effect of belief in government conspiracies on health services through worship beliefs approached significance (Effect = -0.03, 95% CI = -0.07, 0.00, z = -1.67, p = .096). This finding points to worship beliefs as a mediator in this relationship.

The indirect effect of hidden power conspiracies on general health behavior through religious beliefs was significant (Effect = -0.07, 95% CI = -0.15, 0.00, z = -1.93, p = .054). This result indicates that religious beliefs mediate this relationship. Furthermore, the indirect effect of hidden power conspiracies on general health behavior through worship was also significant (Effect = 0.10, 95% CI = 0.02, 0.19, z = 2.46, p = .014). This supports the role of worship as a mediator. The indirect effect of widespread conspiracies on general health behavior through worship was significant as well (Effect = 0.17, 95% CI = 0.02, 0.31, z = 2.23, p = .025). This finding provides evidence that worship mediate this relationship. Lastly, the indirect effect of belief in government conspiracies on general health behavior through worship was significant (Effect = -0.10, 95% CI = -0.17, -0.03, z = -2.80, p = .005). This highlights worship as a mediator in this relationship.

4. Discussion

The correlational analysis partially supports H1 (there is a negative relationship between beliefs in conspiracy theories and health behaviors). by showing that beliefs in general conspiracy theories are negatively associated with attitudes toward health services. They also support H2 (there is a positive relationship between religious attitudes and health behaviors) by demonstrating positive associations between religious attitudes (morality and worship dimensions) and health-protective behaviors, as well as attitudes toward health services. These findings highlight the complex interplay between belief systems (conspiracy beliefs and religious attitudes) and health behaviors, indicating potential avenues for further research on understanding and promoting health behaviors in different belief contexts.

The results of the regression analysis are consistent with the extant literature examining the influence of religious beliefs on the relationship between conspiracy theory beliefs and health behaviors. The findings indicate that dimensions of worship significantly predict health behaviors. Belief in widespread conspiracy theories demonstrates a negative impact on health behaviors. Furthermore, worship partially mediates the relationship between beliefs in conspiracy theories and utilization of health services.

The impact of religious beliefs and worship on health behaviors has frequently been highlighted in the literature. For example, Page et al. (2009: 630) noted that people with higher religious values have healthier behavior patterns. Similarly, this study revealed that the dimensions of worship positively affect health behaviors. The positive effect of worship on health behaviors can be explained by the fact that religious practices encourage disciplined and healthy lifestyles.

The negative impact of believing in conspiracy theories on health behaviors is consistent with the current literature. Romer and Jamieson (2020) reported that individuals who believe in conspiracy theories are less likely to engage in protective health behaviors, such as wearing masks and vaccination. This study also revealed that belief in widespread conspiracy theories negatively affects health behaviors. Sobol et al. (2022) reported that beliefs in conspiracy theories are associated with religious fanaticism and delusions, which reduce compliance with health measures. However, in our study, religious beliefs and religiosity had positive effects on health behaviors.

The relationship between religious beliefs and beliefs in conspiracy theories is complex. Kim and Kim (2020) indicated that increased religiosity heightens the tendency to believe in COVID-19-related conspiracy theories. This study also found that worship and morality have different effects on beliefs in conspiracy theories. On the other hand religious morals and values can encourage healthy lifestyles and careful health-related decisions (Page et al. 2009). The significant prediction of health behaviors by morality supports this theory.

The negative correlation observed between beliefs in government conspiracies and the morality and worship dimensions of religious commitment in this study seems contradictory to the general trend in the literature, where there is often a positive relationship between religiosity and beliefs in conspiracies. One possible explanation for this could be the context of the study being conducted in Turkey, a predominantly conservative Islamic society in which the government is led by a conservative Islamist party. In a study conducted in Turkey, Nefes (2014) stated that political party representatives' attitudes toward conspiracy theories were in line with justifying their political views. In this context, our findings appear to be at least culturally consistent. In this context, conservative individuals may have higher levels of trust in the government due to ideological alignment or religious beliefs, which could lead them to be less inclined to believe in government-related conspiracy theories. Therefore, the negative relationship between religious commitment (specifically in its morality and worship dimensions) and beliefs in government conspiracies could be explained by the trust that conservative individuals place in their government.

The findings presented in this study provide intriguing insights into the mediating role of religious attitudes in the relationship between conspiracy beliefs and health-related behaviors. The evidence suggests nuanced pathways through which these psychological and behavioral constructs are interconnected.

Firstly, the marginally significant indirect effect of hidden power conspiracies on eating habits through religious beliefs indicates a potential pathway where adherence to religious beliefs might influence dietary choices among those who harbor such conspiracy beliefs. Although the effect was not robustly significant, the near-threshold p-value suggests that religious beliefs could act as a subtle yet meaningful mediator in this domain. This finding aligns with prior research indicating that religiosity often shapes health behaviors, including dietary habits, possibly through moral or doctrinal influences (Schreiber & Brockopp, 2012; Rew & Wong, 2006).

Similarly, the indirect effect of belief in government conspiracies on health services through worship beliefs approached significance. This result highlights the potential of worship beliefs to mediate this relationship, albeit with less certainty. It is plausible that individuals with strong worship-oriented religious practices might approach health services differently, influenced by a sense of divine intervention or mistrust toward secular systems, particularly in the context of conspiracy beliefs.

In contrast, the indirect effect of hidden power conspiracies on general health behavior through religious beliefs was significant. This robust finding underscores the mediating role of religious beliefs in shaping broader health behaviors, such as physical activity or preventive care practices, among those endorsing conspiracy theories. Religious beliefs may serve as a framework that either amplifies or mitigates the behavioral consequences of such conspiratorial thinking.

Moreover, the significant indirect effect of hidden power conspiracies on general health behavior through worship adds another layer of complexity. Worship, which often reflect the ritualistic and communal aspects of religiosity, appear to play a pivotal role in influencing health behaviors. This finding suggests that participation in religious rituals or practices might either buffer or exacerbate the health-related implications of conspiracy beliefs.

The significant indirect effect of widespread conspiracies on general health behavior through worship further strengthens the argument for the mediating influence of worship. This relationship underscores the importance of considering how collective or societal conspiracy beliefs might interact with communal religious practices to shape health-related outcomes.

Lastly, the significant indirect effect of belief in government conspiracies on general health behavior through worship ($\beta = -0.10$, 95% CI = -0.17, -0.03, $p = 0.005$) provides compelling evidence for the mediating role of worship in this context. These results suggest that individuals who perceive governmental conspiracies might engage in health behaviors differently based on the degree to which their worship practices influence their worldview.

Overall, these findings highlight the intricate ways in which religious beliefs and worship mediate the relationship between conspiracy beliefs and various health-related behaviors. They suggest that interventions targeting conspiracy beliefs might benefit from incorporating an understanding of individuals' religious and worship practices to effectively address the health-related consequences of such beliefs. Future research should further explore these mediational pathways, with particular attention to cultural and demographic differences, to develop tailored public health strategies.

5. Limitations

This study had several limitations. First, the sample was limited to a specific country and religious context (Muslims), which restricted the generalizability of our findings. Future studies in different cultural and geographic contexts are essential to enhance the generalizability of the results. Second, the data collection method relied on self-reports, which can introduce biases such as social desirability bias. Participants may not have provided honest answers to sensitive topics, such as religious beliefs and beliefs in conspiracy theories. Therefore, future research should consider employing alternative data collection methods to mitigate this limitation.

Another limitation of this study is the role of conspiracy beliefs as predictors and religious lifestyle as a mediator variable. These relationships could be explored in reverse in other studies, with religious lifestyle functioning as a predictor and conspiracy beliefs as a mediator. Such an approach would provide a more comprehensive understanding of the dynamic between these variables. Moreover, while this research focused on religious lifestyle as a mediator, future studies should also test these variables as moderators. Investigating the moderating roles of conspiracy beliefs and religious lifestyle could offer valuable insights into how the strength or direction of these relationships may vary depending on different contextual factors.

Finally, the measurement tools used in this study had some limitations. Although the scales' validity and reliability were assessed, it would be beneficial to re-evaluate their performance on different samples. Additionally, expanding the range of scales used to measure health behaviors could allow for a more comprehensive examination of various health behaviors.

6. Conclusion

While this study offers preliminary insights into the complex interactions among religious beliefs, worship practices, and health behaviors, it is important to consider these findings within the limitations of the study's design and context. Further research is needed to explore these relationships in diverse populations and settings.

The positive impact of religious practices and beliefs on health behaviors is a factor to be considered in public health strategies. Educational and awareness-raising efforts against conspiracy theories, especially among religious groups, could improve health behaviors. Future research should further explore the

relationships among different religious groups and belief systems to develop strategies for improving public health.

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