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The Effects of Religious Belongingness on Americans' Wellbeing Amid COVID-19

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Introduction

In the United States, many people experienced heightened distress in 2020 following the COVID-19 pandemic onset. Some of this distress is linked to necessary social distancing. Social distancing may help people's physical health, but it is known to carry significant psychological consequence.

Social distancing can exacerbate feelings of loneliness, cause people to feel that their belongingness needs are unmet, and can contribute to the development or worsening of psychiatric disorders. Are there factors that can help people avoid such detrimental effects during social distancing?

Theoretically, religion is one factor that may help people cope with social distancing and stress related to the ongoing pandemic (Koenig, 2020). This enhanced coping emerges from religion providing both meaning in life and a sense of belonging (e.g. Park, 2013).

Religion fosters a sense of belonging directly through the social support gained through religious community involvement and indirectly through transcendent beliefs that provide a sense of connection to a broader community and meaning system beyond one's own immediate reality.

Thus, religion contributes powerfully to people's belongingness needs, which benefits health and wellbeing (Brewer et al., 2014; Crescioni & Baumeister 2013; Ellison et al., 1989; Kim-Yeary et al. 2012).

This study aims to understand if religion helps people maintain a sense of belongingness that then enhances wellbeing during COVID-19. Based on this aim and theoretical rationale, the hypotheses include:

Hypothesis 1: people who report previously attending religious services experience a greater sense of belongingness, and this belongingness mediates the relationship between religious service attendance and wellbeing.

Hypothesis 2: the enhanced belongingness people gain from previous religious service attendance reduces perceived impact from the COVID-19 pandemic, which further contributes to wellbeing.

Method

Using survey methodology, data was collected from 645 American participants (50.7% women) in early June, 2020. Participants were recruited via Qualtrics panels and completed the following measures.

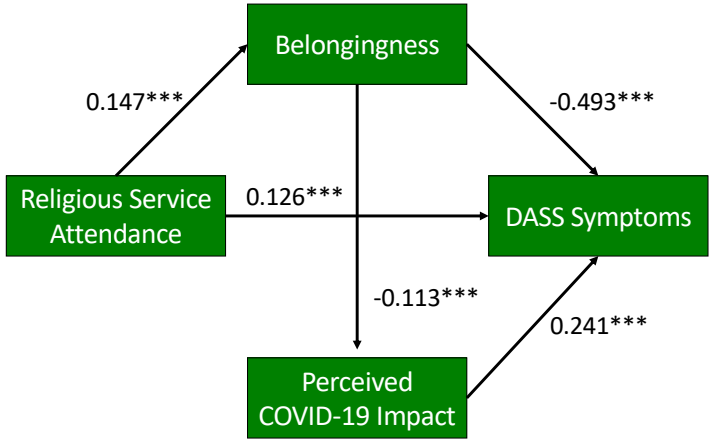
- **Frequency of religious service attendance** (annually for the period before the pandemic; 1 = never, 7 = more than once per week)
- **General Belongingness Scale** (Malone et al., 2012)
- **COVID-19 life impact** (1 = no impact, 4 = significant impact)
- **Depression, Anxiety, and Stress Scale (DASS)** (Antony et al., 1998)

Table 1: Model Coefficients & Fit Statistics

	Belongingness	COVID-19 Impact	DASS
Standardized Coefficients			
Religious service attendance	0.147***	-	0.126***
Belongingness	-	-0.113**	-0.493***
COVID-19 impact	-	-	0.241***
Model Fit Statistics			
RMSEA		0.079	
CFI		0.930	

Note. * $p < .05$, ** $p < .01$, *** $p < .001$. The coefficients at far right under the "DASS" column should be interpreted based on this scale capturing the extent to which a person experiences depression, anxiety, and stress-related symptoms. Thus, a ***negative*** coefficient means that the factor reduces these and thus relates to wellbeing.

Figure 1: Model Diagram with Coefficients



Note. * $p < .05$, ** $p < .01$, *** $p < .001$. The path coefficients from belongingness to DASS symptoms and from COVID-19 impact to DASS symptoms need to be interpreted based on higher DASS scores indicating *worse* wellbeing. So, negative numbers indicate that the factor is beneficial for coping and wellbeing as it suppresses depression, anxiety, and stress-related symptoms.

The model also controlled for gender. There were no significant relationships between gender and any of the model variables.

We thank Dr. Feng Hao, Department of Sociology, for taking a lead role with the data analysis.

Results

Path analysis was used to understand whether frequency of religious service attendance prior to the pandemic relates to enhanced belongingness, diminished perceived impact from COVID-19, and consequently fewer symptoms of depression, anxiety, or stress. The model standardized coefficients are showing in Table 1; the model diagram is shown in Figure 1.

First, when considering religious service alone, people who more often attended services tended to experience *more* depressive, anxious, and stress-related symptoms.

Second, religious service attendance was positively associated with perceived belongingness, and belongingness mediated the religious service attendance and depression, anxiety, and stress link. People who more often attended services *and* felt a sense of belongingness tended to have fewer of these symptoms (**support Hypothesis 1**).

Third, belongingness shielded people from perceiving COVID-19 as having significant impact, and this to related to less severe depressive, anxious, and stress-related symptoms (**support Hypothesis 2**).

Discussion

For many people, the COVID-19 pandemic has brought on increased uncertainty, stress, and psychological distress. **The present study is the first to demonstrate that religious involvement is a protective factor during the ongoing pandemic and relates to diminished psychological depression, anxiety, and distress.**

Importantly, religion's contribution to wellbeing is not direct. Rather, the current study shows that religious involvement amplifies people's sense of belongingness, **and it is through this belongingness that people perceive less impact from the pandemic and experience fewer symptoms related to psychological distress and disorders.**

These results provide new evidence to support key theories in the psychology of religion, to include that religion provides important social benefits linked to enhanced sense of belonging (Crescioni & Baumeister, 2013; Graham & Haidt, 2010), and that religion relates to greater capacity to cope with uncontrollable events and thereby fosters wellbeing (Park, 2013).

Although these results help provide external validity to theoretical ideas by testing how religiosity relates to wellbeing in the context of a real-world stressor, the work has some limitations.

First, the study is correlational and uses cross-sectional data, so cause and effect relations cannot be determined. Second, the DASS measure may not be entirely accurate due to social desirability.

Future studies could focus on using longitudinal designs as well as a sample that includes multiple countries, as this study relied on an American sample.

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This research is part of an ongoing longitudinal study; these results are reported in a manuscript by Michaels, Hao, Ritenour, & Aguilar that is under review.