Religious Practices on Students' Depression, Anxiety and Stress

Thesis Submitted to the Department of Education

Jadavpur University for Award of the Degree

Doctor of Philosophy (Arts) in Education

Submitted by

Liton Mallick

Under the supervision of

Dr. Muktipada Sinha

Department of Education

Jadavpur University

Kolkata

2022

This thesis is dedicated to the soul of my mother.

For her endless love, dua, support and encouragement

Certificate

Certified that the thesis entitled **"Religious Practices on Students' Depression, Anxiety and Stress"** submitted by me for the award of the Degree of Doctor of Philosophy in Arts at Jadavpur University is based upon my work carried out under the supervision of Dr. Muktipada Sinha, Professor, Department of Education, Jadavpur University and that neither this thesis nor any part of it has been submitted before for any degree or diploma anywhere / elsewhere.

Countersigned by the
Supervisor

Liton Mallick
Date:

Dr. Muktipada Sinha

Acknowledgement

Undertaking this PhD has been a truly life-changing experience for me, and it would not have been possible to do without the grace and blessings of Almighty Allah.

Firstly, I would like to express my sincere gratitude to my advisor Professor Dr Muktipada Sinha, Head, Department of Education, Jadavpur University, for the continuous support of my PhD study and related research and for his patience, motivation, and immense knowledge. His guidance helped me in all the time of research and writing of this thesis. I could not have imagined having a better advisor and mentor for my PhD study.

A special gratitude goes to Bijoy Krishna Panda, Assistant Professor, Department of Education, Jadavpur University, for being very instrumental during the whole study. His active involvement, hands-on sharing, and effective suggestions proved to be particularly helpful.

My heartfelt gratitude also goes to Sarjana Mukhopadhyay, Sharbary Banerjee, Chandika Prasad Ghosal, Arlene Guha Thakurta, Dr Fazle Ramzan Khan and Monojit Pal, who offered me the opportunity to join their team and guided me to write an appropriate thesis.

My gratitude and heartiest thanks to Prof. Sudeshna Lahiri, Professor, Department of Education, University of Calcutta, and Indrajeet Banerjee, Secretary, Faculty Council of Arts, Jadavpur University for their cooperation during this study.

My heartful gratitude to Md. Abu Nayeem, Mouli Saha and Suraj Bhattacharjee for their suggestions and encouragement during the study.

I would like to thank Dr Rakheebrita Biswas, Dr Kishor Kumar Roy, Dr Aparupa Ghosh, Dr Abhijit Sadhukhan, Dr Abhijit Banerjee, Dr Manajat Ali Biswas, Majjafar Ansary, Naznin Firdaus, Khuku Khatun, Sonam Sultana Mebar Hossain, Faruk

Abdulla, Santu Biswas, Bikash Chandra Ghorai, Avijit Pradhan, Mallika Mandal, Puja Roy, Ataur Hossain, Krishna Sarkar, Wasim Akram Khan, Chayan Adak, Chiranjeet Mondal, Omar Farooq, Debjani Ghatak, Partha Das, Rahul Debnath their immense support during the whole data collection process.

Help rendered by his father, Kasem Mallick and his elder sister Poly Mallick, Doli Mallick, and Lamia Aqsa, was a major source of inspiration for the successful accomplishment of this task. He wishes to express his gratitude to all of them for their silent but patient co-operation.

Last but not least, I would like to thank my seniors, juniors and friends for spiritually supporting me throughout this thesis and my life.

Dated, September 1st, 2022 Liton Mallick

Place: Kolkata

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List of Abbreviations

GSS	:	General Social Survey
ADHD	:	Attention Deficit Hyperactivity Disorder
WHO	:	World Health Organization
NMHA	:	National Mental Health Association
GAD	:	Generalized Anxiety Disorder
HIV	:	Human immunodeficiency virus
MH	:	Mental Health
RAS	:	Religious Activity Scales
DASS	:	Depression Anxiety Stress Scales
APA	:	American Psychological Association
SI	:	Spiritual Intelligence
USA	:	United State of America
RW	:	Religious Well-being
RSIPAS	:	Religious/Spiritually Integrated Process Assessment Scale
TPB	:	Theory of Planned Behaviour
TRA	:	Theory of Reasoned Action
SEM	:	Social-Ecological Model
R/S	:	Religion/Spirituality
BDI	:	Beck Depression Inventory
GRAT	:	Gratitude Resentment and Appreciation Test.
ANOVA	:	Analysis of Variance.
4-BDRS	:	Four Basic Dimensions of Religiousness
SWLS	:	Satisfaction with Life Scale
TAGS	:	Attitude toward God Scale
DUREL-M	:	Duke Religious Index Malay Version
Brief RCOPE	:	Brief Religious Coping Scale
HADS-M	:	Malay Version of the Hospital Anxiety and Depressive Scale
FGD	:	Focused group discussions

SBI	:	System of Belief Inventory
SPS-H	:	Spiritual Practices Scale-Hindus
DSES	:	Standard Daily Spiritual Experiences Scale
UR	:	Unreserved
OBC	:	Other Backward Class
SC	:	Schedule Caste
ST	:	Schedule Tribe
B.Ed.	:	Bachelor of Education
H_0	:	Null Hypothesis
RQ	:	Research Question
S	:	Significant
NS	:	Not Significant
SPSS	:	Statistical Package for The Social Sciences
DF	:	Degree of Freedom
N	:	Total Number of Students
M	:	Mean
SD	:	Standard Deviation
MANOVA	:	Multivariate Analysis of Variance
SIG	:	Significance
F	:	F-Test
DSM	:	Diagnostic and Statistical Manual of Mental Disorders
CIDI	:	Composite International Diagnostic Interview

Abstract

Students mental health is an important issue all over the world especially students at the college and university level. World Mental Health Survey among college students across 21 countries reported that 20.3% had experienced psychiatric disorder. Similar findings have also been reported from various states in India. India is in the third position in terms of number of higher education institutions after USA and China. Increase in students enrolment in higher education has associated with increase in mental health problems. On the other hand, religious practices was found to have helped them to cope with their depression, anxiety and stress and improved their mental health as well as well-being as found in many studies. The present study has tried to explore the relationship between religious practices of younger people and their mental health in terms of depression, anxiety and stress in the context of Indian society. It was also meant to find out how religious practices varied across students of college and universities in terms of their different personal and social indicators i.e., gender, age, habitat, family type, marital status and so on. The study also wanted to explore the association between religious practices by students and their levels of depression, anxiety and stress to see the effectiveness of the prior on the latter. In the current cross-sectional study on religious practices, 2210 college and university students from twenty one districts of West Bengal took part. The researcher used Religious Activity Scale (RAS) and DASS-21 as well as its Bengali translation, which were made by the researcher and checked for accuracy. The collected data was put through IBM SPSS software and then shown graphically in Microsoft Excel. The religious practices of students varied by gender, where they lived, their marital status, disability and previous history of mental health issues. The study found religious practices significantly associated with less depression, anxiety and stress and therefore increased mental health and well-being which confirms the existing evidences from previous studies on relationship between religiousness and mental health conducted in last few decades across the world.

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Chapter I

The Context of the Study

Chapter I The Context of the Study

1.1 Introduction

Students mental health is an important issue all over the world especially students at the college and university level. In this critical transition period from adolescents to adulthood they have faced various challenges and pressures across academic, personal and social domains. Therefore, mental health issues are prevalent among college and university students across the globe. The consistent reports from across the world that, students in colleges and universities have higher rate of depression, anxiety, stress, substance usage and other mental health problems. The World Mental Health Survey among college students across 21 countries reported that 20.3% had experienced psychiatric disorder as per DSM IV / CIDI (Auerbach et al., 2016). Similar findings have also been reported from various states in India. Late adolescents and early adulthood i.e., college and university level also had a greater incidents of severe mental illness owing to the neuro-developmental trajectory. It is estimated that 75% of those with severe mental illness would have experienced significant symptoms by the age of 25 years (Kessler et al., 2007).

India is in the third position in terms of number of higher education institutions after USA and China. The increase in students enrolment in higher education has also associated with dramatic increase in the mental health problems across India. The students of higher education represents the world's investment for future and therefore their mental health as well as wellbeing are very essential not only for their own development but also contributing to society's welfare. In this period of tertiary education in India, mental health challenges has still unnoticed and finally some of them developed suicidal thoughts and attempt to commit suicide. Therefore, they are required to adapt to various psychological adjustments as well as coping with social and academic needs. But in India, there is no support services for students' mental health by the trained professionals. Under the circumstances,

religious practices helped them to cope with their depression, anxiety and stress and improved their mental health as well as well-being as religions play an important role in many cultures including India. Various prior research suggests that religiously involved college students have lower level of depression, anxiety, stress and have higher level of psychological wellbeing as well as higher academic performance (Thao, 2020).

How does Dharmacharana or religious practice affect us, especially in the psychological field? We know that stress, depression and anxiety are more common among students now. Depression is a significant cause of suicide. According to WHO, the second leading cause of suicide among children aged between 15-29 years is stress and depression. Studies have shown that anxiety and depression take a toll on students. However, the source of my research to shed light on this matter is religion.

Generally, Indians are religious, and they practice religious activities more than many other countries in the world. Pew Research Centre, along with various other independent studies, shows that about 97% of people in India believe in some creator, God or natural power, and around 85% know or practice their religion. In general, religion is closely intertwined in lives of Indians from birth to death. Therefore, the present study aimed to find out the relationship between students' mental health and their religious practices.

Until the 19th century, mental health and religion had a deep connection. Moreover, in many cases, religious institutions took responsibility for protecting or diagnosing the illness of mental health. The religious places like temple, mosque, church where prayers used to take place on a regular basis, provided moral support to people at personal as well as group level which indirectly helped people maintain their peace of mind. In other words, people used to get moral and ethical support from the fellow religious members, priests, and people full-time involved in religious institutions. Later on, as per Sigmund Freud, there was a

paradigm shift in this regard where he found an association of religion with neurosis and other mental issues.

As a result, the interpretation of religion and human health is divided into two parts, but from the second half of the 20th century, some work has started on this subject. In the 1980s, emotive rational and cognitive behavioural therapy became very popular. They continued to say that religion has a positive effect on human affairs, particularly in the case of depression and anxiety. Some mixed results are found in such cases. There is a strong positive correlation between religion the case of depression. However, anxiety has nothing to do with religion as indicated in many studies.

The present body of research has tried to explore the relationship between religious practices of higher education students and their mental health in terms of depression, anxiety and stress in the context of Indian society.

1.2 Historical background of Religion in India

Religion is the most enigmatic area of human intervention, which is a broad area of research. But, whether and how religion and its wide area of scope and diversity in practice influence mental health is an area of debate. Recent research findings have been able to delve into a certain amount of hope on the positive correlation between them. To trace the impact of religion and religious practice on mental health, it is elementary to address the origin of religion which no doubt has the potential to substantiate interdependence. The advent of religion has a plethora of theories opined by several perspectives. Kant claims that the advent of religion erupts from the human desire to reach something beyond ourselves (Pasternack & Fugate, 2022). The things that remain unexplainable even after using our sense organs have always made human beings curious. Perhaps this search to unravel the unknown has cumulated to shape the idea of Religion amongst people (Carleton, 2016). The objects of fear or respect have been the elements of nature like the Sun, Moon,

Wind, Water, Thunder, and Sea, which have been ascribed with power that has been impossible by human strength to tame. The warmth of the Sun has been the life propagating element, and water sustains life Moon has the light to vanquish the darkness. All these elements have been assorted and idealised throughout all the ancient civilisations ranging from Greek, Mesopotamia, Sumerian, Babylonia and Egypt. This concept has been addressed by Max Muller, who talked of Nature worship, where the earth elements are personified (Girardot, 2002). The civilisations have displayed Rain as God; in India, we worship Indra while Poseidon is the God of Sea; in Babylonia, Marduk became the God of Wind,s and we made Varuna the God of Oceans. This theory of associating inanimate elements of nature with divinity has been regarded as Animism. This theory ushers the thought the character has to spirit. Additionally, animate objects or creatures have also been accepted and respected as objects of spiritual or Devine statute. These plants and animals are referred to as Totems with which a specific social group is shown to be related. The root of this association goes back to the same perspective of fear and aid, the animals that have aided and sufficed human survival along with the angering that have been made into Totems or Symbols which represented a social clan which idealised and worshipped it. This practice or theory of religious advent is called the Totemistic theory (Marshall, 2016). But there is another theory called the Ghost Theory opined by Herbert Spencer, which for cases upon anyone Worship. This theory also claims that Animism is a derivative theory as these spirits chose to dwell upon certain elements that were then ed as God. The journey of Religion is not linear or completely dynamic as the timeline. We can observe people's inclination towards an abstract God, which is one and concrete. The emergence of this trend can be traced back to the unfolding of Judaism. The monotheistic perspective of metaphysics dates back to the ascription of reality as one (Zalta, 2021), which has been personified in several forms where Thales regards it as water, Pythagoras as the Number, and Descartes supports dualism. Religion is an

amalgamation of views and perspectives, and the path to understanding it is never smooth and somewhat inconclusive. But its impact on mental health or wellbeing is more or less positive.

1.3 Major Religious Practices in India

Defining religion in mere words is not an easy feat; many scholars have already tried and failed to explain religion as an entity in a set of words. Wulff (1997) shows that a great definition (of religion) has eluded academicians nowadays as well, and Smith (1963) has tested that the noun 'Religion' isn't always handiest to any proper understanding. While Brown (1987) went on for over a hundred pages while attempting to define, analyse, and measure religion and its related components, Capps (1997) argues that the explanations and definitions of religion given by notable and famous scholars are nothing more than their ideologies and biographies.

It is suggested by English and English (1958) that religion is a system of beliefs, practices, rites, ceremonies and values using which individuals or a community connects with God or to a supernatural entity, and often to each other, to derive a set of values which helps them to interpret better events in the natural world and the life around them.

1.3.1 Hinduism

- **Origin of Hinduism**

Hinduism is one of the oldest religions to be practised within human civilisation. The modern-day religious beliefs and practices grow out of roots established in the pre-Vedic age of the Indus valley civilisation. Briefly, Hinduism is the Hindu religion practised by Hindus and is often recognised as the *Sanatana*. Nowadays, the assumption is established that Hinduism is named such because of the practitioners who are called Hindu. Still, in utmost originality, Hinduism is named such because it originated at the banks of the

river Sindhu, which is the modern-day Indus river- running through India and Pakistan. The exact carbon dating of this religion is nearly impossible because what we know of the religion today is a multi-faceted version of ideas, philosophies and teachings of ancient sages, philosophers and teachers, which have percolated and amalgamated through centuries and generations of believers. The first known religious text associated with Hindu religious beliefs- *Rig Veda*, is estimated to be compiled during the later-Vedic age between 1500-1000 BCE, while some believe the *Rigveda Samhita* to have been compiled between 1900-1200 BCE. Linguistic and other derivative research cantering around this text suggests that before being assembled into its written form, the hymns, prayers and teachings associated with it have been orally transmitted since as late as the 2nd millennium BC.

Today *Rig Veda,* the other three Vedas (*Yajur Veda, Sama Veda and Atharva Veda), Upanishads, Puranas, Ramayana, Mahabharata* and the *Shrimad Bhagavad Gita* are the cannons of the Hindu literary backdrop. Hinduism, as of now, is no longer a universal religious belief. However, it is significantly practised by Asians, especially in India and its neighbouring countries, and is also commonly referred to as the *Sanatana Dharma*, *Arya Dharma* and *Vedic Dharma*.

Hinduism draws from the universal idea of one creator, a supernatural being/power known as *Brahma* or *Parmātmān* in the Sanskrit language, which is believed to be the ultimate and most trustworthy source of all knowledge and creation of the world.

- **Common religious beliefs in Hinduism**

Hinduism believes in the *Brahman* in the *Nirguna* or the *Saguna* form. The term *Brahman* finds its roots in the word *British* which approximately translates into ‘enlarge’ or ‘expand’. Hindu sages believe Brahman to be the ultimate truth, which remains unchanged and indestructible throughout and is the source of all knowledge. In one of the most sacred scriptures of Hinduism- *Shrimad*

Bhagavad Gita (9.23), Lord Krishna addresses the followers of all the other religions that "those who pray with devotion to another god, it is to Me that they pray" (as cited in Kashyap, 2007, p. 496), which proves the universality of the concept of *Brahman*.

According to Kashyap (2007), Hindus consider that God in its final form may be regarded as from aspects: Transcendent (impersonal) and Immanent (personal). The transcendent element is the ideal energy referred to as "Nirguna Brahman", which means one without attributes. The Taittiriya Upanishad (II. 4) states: "Brahman is He whom speech can't express, and whom the thought is not able to attain and comes away baffled" (Kashyap, 2007, p. 496). *Nirguna Brahman* is the ultimate source of meditation and knowledge, not just prayer. It may be stated that *Nirguna Brahman* refers to absolute existence, absolute knowledge and absolute bliss (sat-chit-ananda). Kashyap (2007) says, "It is unborn, self-existent, all peal-pervading the essence of all matters and beings within the universe. It is immeasurable, unapproachable, past conception, past birth, past reasoning and past thought" (p. 497). This factor is likewise stated in the Bhagavad Gita: "Though I manifest myself in all matters, I am recognised without any of them" (Kashyap, 2007, p.497).

Hinduism as religion draws majorly from the people's cultural ethics, beliefs and lifestyle; therefore, the practices associated with this religion might often seem complex and ritualistic. Still, in reality, they are a part of regular life among Hindus. And other than this, not just one but many sacred texts like the *Vedas*, *Puranas*, *Upanishads*, the *Mahabharata*, the *Ramayana* and *Shrimad Bhagavat Gita* are the sources of spiritual knowledge in Hinduism.

Even though Hinduism is widely believed to be a severely complex and ritualistic religion, it has specific singularly distinctive characteristics which set it apart from many other religions (Rao, 2012, p. 3). There exists a wide array of beliefs and doctrines along with spiritual practices and rituals, but all of these can be subsumed under the broader banner of Hinduism. Some of these more comprehensive concepts of Hinduism, which provide the basis for all the

flourishing branches to keep growing, are briefly discussed to maintain a better understanding of the religion for the sake of this study.

1. Dharma

In a layman's understanding, Dharma refers to the righteous way of life as indoctrinated in Hinduism. But Dharma is a much bigger mental and spiritual concept than just an honest way of life. It is commonly believed that Dharma changes with age and a person's social status and is often subjected to society's acceptance. Dharma can be better associated with one's ability to distinguish the right from the wrongdoings not just in action but also in thought and the innate ability to carry these right thoughts and actions in daily life.

Hinduism identifies seven categorisations of Dharma as an abstract to incorporate it better among the followers as duties to be practised (Rao, 2012, p. 35).

I. Nitya Dharma

Nitya Dharma simply refers to the Dharmic activities one must practice with utmost honesty and sincerity daily as a follower of Hinduism.

Manusmriti (6: 92) describes it as the path to practice spirituality. The tenfold law of dharma, true contentment, forgiveness, suppression of unjust desires (Greed, anger etc.), non-stealing, mental and physical purity, self-control (control over senses), straightforwardness, and acquisition of knowledge, truthfulness (in thought, speech and action) and non-anger. Manusmriti (chapter 10, sloka63) (Husain, Beg, & Dwivedi, 2013, p. 146) states that five precise paths of Dharma are to be observed by all human beings irrespective of their gender, social class or caste (varna) and stage of life in their daily life, which is also commonly known as "samanya

dharma" or "sadharana dharma": Ahimsa, Satya, Asteya, Sorcha, Indriya-nigraha (Rao, 2012, p. 36).

i. **Ahimsa**- Ahimsa translates into non-violence and love/compassion for all living beings. The primary belief of Hinduism centres around the idea that every living being is part of the creator or God, and thus, they are all worthy of respect and fair treatment.

ii. **Satya**- Satya as a principle and a word translates to Truth. However, Hinduism also believes that Satya is *Brahman* or *Brahma*, the absolute truth. Practising Hindus must always adhere to the principle of truthfulness in their daily life.

iii. **Asteya**- Asteya, as a word, translates into non-stealing. Hinduism teaches never to steal. Hinduism considers stealing a far greater crime as it runs deeper than pickpocketing or taking things without permission. Killing is stealing life; when one lies, one steals the right of another to truth, corruption is stealing fairness from society, and so on. That is why Asteya holds such a high position in the ideals incorporated by Hinduism.

iv. **Soucha**- Soucha translates into cleanliness or purity. It doesn't only refer to maintaining bodily cleanliness; Hinduism requires its followers to maintain purity at three levels- physical purity: which inscribes hygiene and pure non-contemptuous actions; mental purity: which means purity of the mind through thoughts and words; and spiritual purity: cleanliness of the soul or consciousness by being self-aware (*Atman-Guyana*). Hinduism instils the belief that the purity of the mind and soul can be achieved by practising *Dharma*.

v. **Indriya-nigraha**- *Indriya-Nigraha* means establishing absolute control over the ten human senses, which are the five

sensory organs and the five motor organs. It is a fundamental truth that the cause of all human problems is the inability to control basic human urges and desires. *Indriya-Nigraha* leads to a balanced and controlled lifestyle, where one never loses grip of one's senses and does nothing arrogant or malicious, which might harm the greater good of society. It can be achieved through self-discipline and meditation, where one learns to be in absolute control of one's body, mind and actions.

II. Sva-Dharma

Sva-Dharma refers to the code of conduct as prescribed by Hinduism for every individual. Based on the time, place and situation, every human has a specific prescribed code of conduct and duties which they must fulfil to make the world a better place and follow his or her responsibilities as a human being thoroughly.

In today's context, the concept of Sva-Dharma refers to one's professional or vocational responsibilities, which one must fulfil with the utmost diligence to build a better world.

III. Varna-Dharma

The Hindu society is divided into a *Varna* system which classifies the four different varnas as the four castes: *Brahmans*, *Kshatriyas*, *Vaisyas* and *Shudras*. These four varnas or castes are assigned specific duties and responsibilities within the folds of Hinduism. The concept of *Varna-Dharma* teaches that every caste of society must collectively participate and fulfil their duties and responsibilities towards the community.

IV. Ashrama-Dharma

Hinduism propagates that *Dharma* is not a constant entity because Dharma changes according to an individual's age, class, caste, gender etc. During ancient times, Hinduism followed a specific pattern of the *Ashramas* where it is believed that Hindu sages had divided the life of man into four *Ashramas* comprising of25 years of life each, namely: *Brahmacharya*, *Grihastha*, *Vanaprastha* and *Sannyasa* (Sarma, 1953).

Brahmacharya was the first quarter of life which was to be dedicated to the quest for knowledge, a way to learn and gather knowledge either from the *Gurukuls* or from apprenticeships. *Grihastha* was the next quarter where it was expected of the man to marry and raise a family by fulfilling all his familiar responsibilities as an active part of the stream society. Then followed the *Vanaprastha*, during which a man was required to gradually hand over all his duties to his next generation, move towards a sedentary lifestyle, and prepare to accept his retirement from stream society. And finally, during *Sannyasa*, the man must leave all his worldly attachments and dedicate himself to living as a Sanyasi or mystic in searching for oneness with the ultimate *Brahman*.

V. Nimittya Dharma

The word *Nimittya* directly translates into occasional. Therefore, *Nimittya Dharma* refers to the dharmic actions one must indulge in not on a day-to-day basis but occasionally. These are various ritualistic actions which promote kindness and devotion in the form of *pujas, vratas, Diksha* etc.

VI. Apad Dharma

Apad means emergency; therefore, *Apad Dharma* refers to those emergencies during which one cannot uphold the duties and

teachings of Dharma and must kill, lie or steal for survival or self-defence.

VII. Yuga Dharma

Yuga Dharma means that *Dharma* as a varying entity keeps changing from time to time. *Yuga* means an age. Therefore, depending on societal needs and aspirations, the concept of *Dharma* changes from one *yuga* to another. For instance, with the increasing number of discriminatory models and inequality, modern-day Hindus do not foster the *Varna-based* ideas of profession and vocation, allowing everyone to practice any occupation that suits them.

2. The Kama

The Kama means 'desire' or 'pleasure'. Hinduism propagates that there are human fetal aims which are known as *Purusharthas*, which are *Dharma* (righteousness), *Artha* (wealth and prosperity), *Kama* (pleasure or desire) and *Moksha* (salvation or liberation).

Hinduism believes that the Kama instils the want within humans to pursue betterment and satisfaction in life. The *Kama* can be related to bodily pleasure and professional, personal, mental and lifestyle satisfaction.

3. Samskaras (Sacraments)

Even though Mc Gee (2004) says that *Samskaras* means '*rites to passage*' and '*sacraments'*, these translations do not justify the meaning of *Samskara* as a religious belief in Hinduism.

As a religious belief in Hinduism, *Samskara* places the one practising it on the highest pedestal of perfection because it is not just a few rites to be practised by a Hindu. Still, Samskara constitutes ideals, beliefs and values about human beings and their development in this universe.

Samskara polishes and trains individuals to mark them formally through and into the transition of various phases in their life.

According to Mc Gee (2004), Hindu tradition has more than forty samskaras (approximately forty-eight). Many authorities agreed on a common set of sixteen samskaras of the body, which include: *garbhadhanasamskaras, pumsavana, samskara of simantonnayana, Namakaranasamskara, Niskramanasamskara, Gannaprasanasamskara, Cudakaranasamskara, Karnavedhasamskara, samskara of vidyarambha, upanayana samskara, samskara of veedarambha, kesantasamskara, Samskara of samavartana, vivahasamskara, Antyestisamskara, Śrāddha.*

4. Moksha

Moksha is a Sanskrit word which means *Liberation* or *Salvation* in English. In Hinduism, *Moksha* is considered one of the four aims of human life and the highest of all the three other aims. The attainment of *Moksha* frees one from the cycle of rebirth and attaches their soul to the Brahman, the absolute truth and creator.

It also refers to the union of one's soul with the universal supreme soul (*Parmātmān*) or God. The partnership with God (ultimate soul) can be achieved through way of actual knowledge (*gyana mārga*), a form of work (*karma mārga*) and the practice of devotion (*bhakti mārga*).

5. Guru

The English equivalent for the Sanskrit term '*Guru*' is *Guide*. Hinduism believes that a *Guru* guides an individual towards the path of fulfilment and attainment of the ultimate peace in life. One must devote oneself to one's *Guru* and, in doing so, shall walk the path of enlightenment.

6. Karma

Karma originates in the Sanskrit term 'Karman', which means actions or doings. The Hindu idea of Karma is closely related to the western proverb 'you reap as you sow. Karma doesn't only deal with the present actions of an individual but also the past actions and even the actions of the previous lives. Based on the positivity of these actions, a person is rewarded in the form of attainment of enlightenment and *Moksha*. If the steps are not good, one keeps being stuck in the cycle of death and rebirth; good karma releases one from this cycle of death and resurrection and bestows fulfilment by merging their soul with that of the *Param-atma* upon death, leading to the attainment of *Moksha*.

This concept of *Karma* in Hinduism promotes goodness among the followers and makes one more prone to doing good deeds and thinking good thoughts.

7. Punarjanma

Punarjanma refers to the belief in *rebirth*. Hinduism teaches that the soul (*Atman*) is an immortal entity which lives on even after the death of the mortal human body. The human soul transgresses from one being to another after death and is reborn time and again within the wheel of life and death, which seizes only after the attainment of *Moksha*. This belief among the Hindus inspires the concept of *Karma* and motivates the practice of conscious positive thoughts and actions.

8. Vedanta

Rishis and sages residing on the banks of the Sindhu River recorded the *Vedas*, which comprised the priceless knowledge of the Vedic culture; that is why the literal translation of '*Vedas*' is *Knowledge* (Jitatmananda, 2007, p. 37). The four *Vedas- Rig*, *Yajur*, *Sama* and *Atharva*; majorly focus on the *shlokas* and *mantras* which purify and strengthen the daily existence of man in this world; however, the very end of these *Vedas*

comprises the knowledge that aids in the understanding of the eternal and immortal self within the mortal body of humanity. And these endings of the *Vedas* and the *Upanishads,* which talk about the concept of eternity and achieving salvation, are the main principles behind Vedanta's philosophy.

Three primarily teachings, as recorded by the Vedanta philosophers, are:

a. The ability to attain eternal life, knowledge and bliss (*sat-chit-ananda*) is inherent in every human being. It can be achieved by training the mind, body and soul to manifest spiritual awakening.
b. Every living or non-living being are united and interconnected as long as they are a part of this universe; therefore, every action of every man might seem individual and singular but casts an ever-lasting impact on the world's working. Hence, it impacts the idea of mindfulness and collective consciousness much before the time of modern-day psychotherapy and psychoanalysis.
c. Finally, the rishis imparted that God is not a singular entity; instead, it is an all-pervading consciousness that is a part of every living being and cannot be restricted to any distinct mortal forms. (Jitatmananda, 2007, p. 37).

1.3.2 Islam

The Muslims practice Islam. A Muslim is any male or female who believes in Allah (SAV) and his supremacy. Islam as a religion originated in the middle eastern countries and has spread out to the whole world today. The word '*Islam* 'is Arabic in origin which means 'obedience', 'surrender' or 'submission'; therefore, one who surrenders to Allah is a Muslim.

A Muslim surrenders to not only the will of Allah but also respects and, without any doubt, believes in the teachings of Mohammad (PBUH), who is t, ther of Allah (God).

Islam as a word also signifies peace, which refers to the idea that one who wishes to attain inner peace and self-realisation must follow the Islamic path through the complete surrender of mind, body and soul; and utter submission to the divine will of Allah. Such a path of divine obedience helps one attain a peaceful life and helps society and the nation by establishing a peaceful way of life for everyone in general.

Islam originated in Arabia through the teachings of Prophet Mohammad (PBUH), which says that one who surrenders to Allah's divine will without hesitation is a true Muslim. An ardent follower of Islam abides by the teachings of the Holy Qu'ran. Islam was built on the principles of practicality and humanity; and, thereby, has quickly comprehendible laws, beliefs and religious practices, which maintain a prominent picture of the spiritual teachings of Islam and aid its spread.

The Holy Quran is the most sacred book of Islam and is widely followed by practising Muslims and many outside of Islamic religious practices. The Holy Quran was compiled as the revelations received by Prophet Mohammad from Allah. Prophet Mohammad enlightened the masses about following God's way and establishing Islam's religion. It is a widely accepted premise that Prophet Mohammad worked on the will of Allah and not independently, which further shows the divinity of Islamic religious beliefs and practices.

Common Religious beliefs and practices in Islam

Ibrahim (1997) says that Islam has six cornerstones upon which the faith of Islam as a religion is built, which are: Belief in the omnipresence, omnipotence and omniscience of Allah, who is the creator of the world, belief in the Prophets of Allah who bring His divine knowledge to the realm of men, trust in the power and potential of the Holy Quran which is the one trustworthy source of God's religious knowledge, belief in Angels who protect and guide us and take care of us in the afterlife, trust in the Judgement Day when all our wrongdoings and goodness are measured to decide our afterlife and finally, belief in *Al-Qadar*.

The 'five pillars of Islam are the religious duties a devout Muslim must practice and are the most significant aspect of the Islamic religion. The regular practice and observation of these five duties with utmost devotion and sincerity are what define the character and spirituality of a true Muslim. These are the five 'ibadat' according to Islamic belief, and that is why they are referred to as the 'five pillars of Islam' they are:

1. **Shahadah**

   Shahadah means a declaration of one's faith in Allah. It is the first and foremost important pillar of Islamic religious practices.

"La ilahailla Allah, Muhammadu rrasululah"

This phrase demonstrates one's faith in Allah, which means there is only one true God, and He is Allah, the only true God with the right to be worshipped and without any sons or partners. It is a simple way of declaring one's faith in Allah and becoming a true Muslim.

For the Shahadah to be complete and absolute, a true Muslim must recognise that in the afterlife, then grants entry to only those who work under the will of Allah and follow the path. Every practising Muslim must pronounce the Shahadah at least once in his life after his renunciation into the religion as a *mukallaf*.

2. **Salat**

   After Shahadah, the following duty of a true Muslim is to perform Salat. Salat means offering prayers. Islam propagates offering prayer five times a day during specific times like at dawn, noon, mid-afternoon, evening and night.

   A prayer call is raised during the specific prayer times by the local Mosque, following which Muslims assemble either at the Mosque or their respective homes, schools, offices etc., to offer prayer to Allah. Other than this, Muslims also gather on Fridays for congregations to pray unitedly under the guidance of their local mosques. One must practice cleanliness

and purification by washing themselves before offering prayers. The females are expected to cover themselves completely from head to toe except for their face and hands, and men are to protect themselves at least from navel to knees during prayers. And most importantly, the prayer must be offered to face *Makkah* (the north-eastern direction).

3. **Zakat**

   Zakat is the third pillar of Islamic religious practices, which means the act of charity and supporting the ones who cannot care for themselves, the poor, the needy and the vulnerable.

   The word *'Zakat'* directly means purification because while thinking and acting for the betterment of society and other human beings, one purifies himself from the sin of greed and practices mindful cooperation as an active community member. By performing Zakat, one converts the rest of the wealth as legal and religiously pure. Therefore, Zakat is like an annual form of taxation that aids society's betterment by investing the rich's excess wealth to uplift the poor.

   The amount of Zakat is fixed at 2.5% of an individual's total savings, which is to be given before the start of the month of Muharram, which is noted as the first month of the Islamic calendar.

   Other than Zakat, the Muslims are also required to contribute some amount at the end of the fasting month, called Ramadan, to help the poor celebrate Ramadan (the end of the fasting month), which is called *Sadaqa*.

4. **Sowm**

   Sowm means fasting during the month of Ramadan. It is the fourth pillar of Islamic religious practices. It is a way of showing gratitude to Allah for His benevolence.

   The ninth month of the Islamic calendar is when fasting is observed for the entire month. Depending upon the moon cycle, fasting is observed

for either twenty-nine or thirty days. All practising adult Muslims must fast from dawn to dusk, from sunrise to sunset. Not just food consumption, but it is followed in such a way that they abstain from smoking or tobacco consumption, drinking anything, including water or even swallowing their saliva, using perfumes or scents and being involved in sexual activities.

The fasting begins from sunrise, before which a light meal is shared among family members, and all the abstentions are raised only after sunset. The fast is broken among family members and is a moment of joy and enjoyment.

Fasting during the month of Ramadan is believed to be spiritually enriching and rewarding, teaches one to be humble and grateful to Allah's generosity, and brings one closer to family, friends and neighbours.

However, the Holy Quran does not permit the old or sick, confined or menstruating women and extended journey travellers to keep the fast and asks them to make up for the fasting days by performing fasts later on at their convenience. Mothers with newborns are permitted to not strictly follow the fasting rituals to nursing their children.

Muslims are expected to abstain from wrongdoings during the fast and are even prohibited from thinking anything wrong. This phase is associated with keeping one’s mind, body and soul pure and true by avoiding entering anything into one’s body, mind or consciousness. The Quran is read intensively, and charitable deeds are encouraged. And this form of extreme self-control makes the practising Muslims self-aware and brings them closer to Allah's spirit and divinity.

The fasting ends with the celebration of ‘Eid-ul-Fitr’, where the month of rigorous piousness is celebrated with feasts and festivities.

5. **Hajj**

   Hajj is the pilgrimage to the Holy city of Makkah. It is the fifth and final pillar of Islamic religious beliefs and practices. Every Muslim who is physically and financially capable is expected to take the pilgrimage to the Holy city of Makkah at least once in their lifetime.

   Dul Hejja, which is the twelfth month in the Islamic calendar, is when the Hajj begins annually.

   It is believed that during the Hajj, every Muslim must forget about all their worldly conflicts and problems and focus entirely on spirituality and charity by continually changing the name of Allah and counting on his benevolence.

   Every year around two million people undertake the Hajj, which comprises five days of rituals and praying in and around Makkah.

1.3.3 Christianity

Christianity aims to be relevant and practical to everyday life. Therefore the Christian beliefs and practices are simple and obvious.

1. **Further meditation on the Sunday Sermon**

   Sundays are mass days according to Christian belief, and all practising Christians attend the church for Sunday sermons, during which the pastors talk about Christ and all the sacrifices He went through to save humanity.

   It is expected of everyone to carry forward these lessons and practice them in real life.

2. **Daily prayers**

   Practising Christians must pray to God or Jesus Christ daily and read the Holy Bible regularly.

3. **Family devotion**

   Christians must carry forward their religious beliefs and practices by communicating them to their children. Families must pray together before every meal and thank the Lord for his grace and mercy.

4. **Love thy neighbours**

   Christ teaches one to be loving towards neighbours, which helps in building a sense of brotherhood and universal love.

   Members of the same church are treated as extended family, strengthening community bonding.

Other than these, Christians often indulge in other religious practices like:

1. Meditation
2. Rosary counting
3. Hymn chanting
4. Community Bible reading
5. Confessions
6. Penance
7. Seasonal festivities
8. Charity to church for carrying forward the teachings of Jesus Christ

1.3.4 Jainism

As in Buddhism, Jainism also emerged as an offshoot of Hinduism, and it's the then elaborate ritualistic beliefs and practices. Mahavira was the last Arihant in the Jain's succession, bringing the religion of Jainism into its latest form. Mahavira Jain (599-527 B.C.) was an older contemporary of Goutam Buddha and is believed to be the last in the order of succession of the great Arihants.

The Jains believe in the existence of angels in the human form who emerge as the Prophets to bring them closer to the universal source of life and sustenance. According to them, the entirety of the universe's existence is divided into twenty-

four-time cycles. During each time-cycles, a Prophet has emerged who is referred to as the Arihant or Tirthankara. Mahavira is believed to be the last of these Tirthankaras.

Religious beliefs of Jainism

The religious doctrines of Jainism were fixed and all-encompassing before the Jains were separated into two main sects- Digambaras and Svetambaras (Caillat, 1987). The Digambaras are the extreme sect of Jainism who believes that the sky is the only garment they need to protect themselves and practice nudity. And the Svetambaras are the moderate sect that wears the colour white to represent themselves as followers of universal peace.

1. Nirvana

The religious beliefs of the Jains centre around the core belief that to reach *Nirvana* (salvation in Jainism), man mustn't hurt any living being. This is the core concept of all Jain religious teachings, beliefs and practices. And that is why the Jains practice peace so rigorously. Peaceful co-existence among humans is not the only form of peace; in fact, peaceful co-existence between man and animal, man and trees or plants, the universal consensus in the form of non-violence in any form and figure is the main philosophy of the Jains (Besant, 1966).

2. Jiva

Another critical aspect of the Jain beliefs is the concept of *Jiva*. *Jiva* is the soul that exists within every component of the universe. From a rock lying on the ground to the trees and the animals, everything that is a part of the cosmos is believed to have a soul, which derives its sustenance from the universal source of life and nourishment. This belief differentiates Jainism from the other prevalent religions; Jainism spiritualises even the material forms of the world.

This Jiva within all things have always existed as a form of the eternal cosmic source of life and was not a creation of any single divine powerful force.

Thus Jainism negates the concept of God or *Atman* according to the prevalent Hindu belief. However, other Hindu ideas like Karma and Punarjanma (reincarnation or rebirth) are accepted in Jainism, which teaches one to be conscious because the present actions and thoughts (Karma) of an individual become the basis of the new embodiment of the soul (Punarjanma) in the next life.

3. **Ahimsa**

   Ahimsa is equally as valuable a Jainism philosophy as the Jiva concept. Mahavira widely propagated the belief and practice that all things living, breathing, or non-breathing have the seed of the eternal life source within them and, therefore, shouldn't be slain, hurt or tortured in any way; neither should they be insulted, scared or driven away, nor ever be treated with the slightest form of violence.

   Thus, Ahimsa, a primary religious belief of Jainism, teaches the practice of non-violence and peaceful co-existence.

4. **Jina**

   Even though the Jiva existent in all beings and things of the universe is eternal, through self-mortification and rigorous asceticism, one can become accessible off the endless cycle of life-death-rebirth and achieve liberation or salvation by giving up all earthly ties and passions. When this happens, the Jiva or the soul leaves the perils of the eternal mortal world and becomes one with the source of all universal life and sustenance, unified with the impersonal universal whole, leading to the end of the cycle of rebirth. Not the mortal body, but only the soul or Jiva of the ascetic can achieve this liberation called Nirvana in Jainism.

   This is why Mahavira was given the title of 'Jina', which means conqueror, one who wins over the eternal cycle of life-death-rebirth and becomes part of the universal soul. It refers to winning over feelings,

passions and mere earthly emotions and absolute possession of asceticism.

Religious practices in Jainism

Usually, the Jains should be members of a four-layered social structure called Sangha, which comprises monks, nuns, laymen and laywomen. Jain religious beliefs and practices are built on the absolutism of the Jain Triratna- right faith, knowledge, and conduct. Jains believe that liberation can be achieved by strictly abiding by the Tiratnas.

Temple and idol worship are avoided in Jainism because basic activities such as burning lamps, incense, flower arrangements, making sandal or turmeric paste, offering plucked fruits etc., are seen as a form of violence because these activities affect the natural order of the universe. However, cultic practices and rituals are considered proper because they aid in the progress of the worshipper towards following the order of ascetism.

The monks and nuns who are categorised as the Yati have to adapt to a minimal lifestyle and abide by the following vows:

1. Absolute abstention from harming or injuring life, even as a form of self-defence.
2. Never consume food or drinks after sunset as it might result in unintentionally hurting and injuring insects and smaller beings easy to be ignored in the darkness.

Along with these, the laymen and laywomen who are categorised as the Shravaka are also required to abide by a particular lifestyle and live by some important vows of non-violence, truthfulness, charity etc. Also, the households of the Shravakas are compulsorily needed to perform specific duties to live by the ascetic ways of life mirrored given the monks and nuns (Besant, 1968).

1. Cultivating a right mindset

2. Practicing meditation regularly
3. Fasting on the eighth and the fourteenth day of the moon's waning and waxing period
4. Making confessions about their mistakes and sins.
5. Absolute abstention from intoxication in the form of opium, alcohol, tobacco etc
6. Maintaining strict vegetarian food habits
7. Food products like dairy and honey, obtained from animals and insects, should be strictly avoided.
8. Maintain a rigorous sleep cycle by waking up before sunrise and reciting the Jain mantras by counting fingers.

1.3.5 Buddhism

Buddhism was founded by Buddha in (the 6th Century B.C.). Buddha was born Siddhartha as the prince of a warrior kingdom of Sakyas and Kshatriyas. At the age of twenty-nine, Siddhartha gave up his family life and searched for the absolute truth and the cause of all human suffering.

He practised austerity for six years and followed extreme self-mortification, finally building his path towards spirituality. Buddha created the 'middle course between extreme self-denial and attachment to worldly life, leading him to attain enlightenment under a banyan tree in Bihar. This place in Bihar is now known as Buddha Gaya, where Siddhartha Gautam became the Buddha, which means the enlightened one.

The religious beliefs of Buddhism

Buddhism was built on the principles of the essence of the teachings of Gautam Buddha, which are known as the *Four Noble Truths* of Buddhism: accepting suffering as a part of life, getting to know the cause of suffering, bringing an end to this cycle of suffering, and the observance of the eight-fold path as the way to cease suffering.

1. Human life is fundamentally governed by pain and suffering, referred to as *Dukha.* The recognition of *Dukha* as the source of human pain, suffering and misery is the beginning of Buddhist philosophy.
2. The reason behind the existence of Dukha is the unsolicited desire of human beings for power, pleasure and the fear of death. This idea is the second proposition among the Four Noble Truths of Buddhist teachings. Tanha is called the unquenchable thirst for power, pleasure and immortality, the epicentre of unsatiable greed and avarice for dominance and territory. As a result, one hoards more than one needs while the others starve.
3. Human suffering ends with the ability to stop desiring. When one stops to wish for things to be always pleasureful, wanting more than what one needs and accepts that death is the inevitable end of life, which every living being must experience; human pain, suffering and misery can quickly be brought to an end.
4. The way through which one builds a deeper understanding of the concepts required to cease suffering is the Noble Eight-Fold Path, as suggested by Gautam Buddha himself.

   The Eight-Fold path is that of:

   a) Right view
   b) Right intentions
   c) Right speech
   d) Right conduct
   e) Right livelihood

f) Right effort
g) Right mindfulness
h) Right concentration

Buddhist religious practices

The No Creed ceremony is the first and foremost of all Buddhist practices, which initiates one into the Buddhist social order. During this ceremony, one is required to chant the following:

"I go for refuge to the Buddha

I for refuge to the Law

I go for refuge to the Order."

Buddhism requires its monks to give up the civil order of life and live in monasteries because an ordinary lifestyle hinders the process of following the Eight-Fold path. Some laymen follow Buddhism as disciples of the Buddhist order while being a part of the civil mainstream society.

The monks are required to forsake all familial ties, give up their occupation and other worldly attachments, and lead a solitary lifestyle as members of the monastic community. The monks are further required to show a straightforward and humble life beyond greed and wealth accumulation. They are to wear three pieces of garments consisting of an undergarment, some kind of a coat and an overall cloak. They are also required to shave their heads and beards and maintain a strict vegetarian minimalistic food habit by drawing regular sustenance from begging and the charity of others.

The monks are required to refrain from the following:

1. Killing
2. Stealing
3. Unchastity

4. Lying
5. Intoxication
6. Consumption of solid food after mid-day
7. Music, dance and theatrical representations
8. Using garlands for decoration, salves and perfumes
9. Acceptance of gold and silver
10. Usage of significant and broad couches

Though it is not possible for laypeople to attain Nirvana while being part of the mainstream society, by living by the following principles, laypeople can procure a better and more favourable life for themselves, which will make it possible for them to become an active part of the monastic order (Hackmann, 1988):

1. Non-killing
2. Non-stealing
3. Being chaste
4. Non-singing
5. Abstaining from intoxications

They are advised to lead a moral life by the changing demands of time and situation; they must fulfil their duties and responsibilities towards their parents, teachers, wives, children, subordinates, friends and neighbours.

1.3.6 Sikhism

The Sikh Gurus have laid out the practices required to maintain the Sikh way of life in a straightforward, accurate and practical way.

The primary beliefs upon which the Sikh religious practices are laid are:

1. Naam Surinam

   This means investing oneself in the meditation of God's name and teachings
2. Kirat Karni

   Being honest and methodically leading a good family life

3. Wand kay Shako

   Investing one's excess wealth for the welfare and betterment of the community

4. Simran

   Rigorous meditation

5. Seva

   Selfless service to humanity and other living beings

The Sikh is required to undertake the following observances:

A. Disciplined Life

1. wake up early in the morning.
2. Bath and cleanse the body and mind
3. Engage in family life and address your responsibilities within & outside the family.
4. Earn a living through earnest means.
5. Undertake to help the less well-off with monetary or/and physical help.
6. Exercise your responsibilities to the community and take an active part in the maintenance and safeguarding of the community.

B. Personal Regulations

1. Wear the 5Ks
    1. Kesh – long and uncut hair and a turban to protect the hair on the head.
    2. Kanga – small comb to be used twice daily to keep the hair clean and healthy.
    3. Kacha – underwear in the form of shorts to exercise self-control.

4. Kara – a steel slave bangle on the dominant arm to remind the Sikh to always remember the Guru before undertaking any action.
5. Kirpan – a short dagger to remind the Sikh that he is to defend against the repression of the weak.

2. Meditate by reciting his Gurbani and singing his Kirtan (music-based hymns) and remember Him always.
3. Wash your mind with Sewa, selfless service to the community by doing manual work at the Gurdwara, cleaning the dishes, washing the floors, painting the walls, working in Community Centres, etc.
4. Practice Truth at all times: To live by the Guru's instruction to practice Truth
5. Be kind and merciful to others: Kindness is a virtue that the Sikhs have been asked to exercise at all times. The Gurus have shown how to practise and live a life of kindness and mercy
6. Become a Gurmukhi by doing good deeds: The Sikh Gurus repeatedly ask the dedicated Sikh always to do good deeds

C. Community Practices

1. Organise Gurdwaras: As a community, the Sikhs need to set up a local place of worship called a Gurdwara. Services need to be held in the morning and evening, including:
    1. Asa-di-war kirtan
    2. Sukhmani sahib path
    3. Ardas and Hukamnama
    4. Kirtan programs
    5. Naming Ceremony
    6. Marriage Ceremony
    7. Antim Sanskar
    8. Amrit Ceremony, etc

1.4 Major Religious Practice in West Bengal

West Bengal is a land of many cultures, and at the same time, people from various religious backgrounds reside in West Bengal. Most residents of West Bengal are known to practice Hinduism, but with-it Muslims, Christians, Sikhs, Jains and Buddhists are a part of the diversified population.

1. **Hinduism**

   All the major Hindu sects can be found in West Bengal, and the standard religious practices include regular prayers and temple visits. Durga Puja is the biggest festival in West Bengal, which is a Hindu festival. Still, people, irrespective of any religious biasedness, come forward in celebration of this festival which follows the same time frame as the Nort Indian festival of Navratri. The Durga Puja festival is world-renowned and draws an influx of foreign tourists to the capital city of West Bengal- Kolkata.

   Other Hindu rituals of *Ganga Arti* and *Ganga Snan* are also widely followed. *Kirtans* and *Satsangs* are a common sight. Some practising Hindus even actively indulge in *Gita Path*.

2. **Islam**

   The second most widely practised religion in West Bengal is Islam. Muslims constitute around seventeen per cent of the total population of West Bengal. The celebration of Eid is a common practice among the Muslims of West Bengal. They follow the Ramadan month of fasting along with the festival of Eid. Mosques are frequently visited, and Namaz is also read.

   The various religious practices followed and observed by Muslims are the same in West Bengal, just as in the rest of the world.

3. **Christians**

   Considering how the Britishers declared Kolkata as the capital city of imperialist India, Christianity has always been another popular religion in West Bengal. Many Christians still reside in Kolkata, making festivals like Thanksgiving and Christmas a prevalent custom among the people of West Bengal.

4. **Other religions**

   Along with Hinduism, Islam and Christianity, other religions are Sikhism, Buddhism, and Jainism are practised in moderation in West Bengal. The population of people practising these religions is deficient. However, Gurudwaras, Jain temples, and Buddhist Monasteries are a reasonably common sight in West Bengal.

1.5 Difference between Religiousness and Spirituality

It is a general outlook to analogously address the concepts of religiousness and spirituality. Despite having several affinities in the core area, the images differ in function and scope. Religiousness roughly can be regarded as a narrower and more subjective term, including the beliefs, values, practices, rituals, traditions and customs entangled with a particular religious sect. These develop gradually and in a homogeneous pattern, but their organic shaping occurs with human interaction and its natural tendency towards co-living and sustaining. At the same time, spirituality is a fascinating concept that tries to incorporate a transcendent ideal. The major metaphysical concepts like God, Spirit, nature, life and something traverse beyond our external and sometimes our inner dimensions. Spirituality is a path or moves towards transcendence. Still, no specific or concrete assertion can be made on its nature as the concept remains enigmatic to most because of its far-flowing scope. Koenig et al. describe spirituality as an endeavour to seek meaning and connectedness with the supreme power transcending and providing direction (Koenig et al. 2012). The different definitions have been given by different authors in last few decades but no consensus has been made (Puchalski et al. 2009). But Puchalski et al. gave a broader conception which defines spirituality as the journey of seeking meaning, purpose and relationship with nature, self, others, the Sacred and the moment (Puchalski et al. 2009). Spirituality helps us discover the path of reaching or connecting to the higher being or order. Religiousness is a universal idea as it binds and is followed in a specific way by a community or section of

people. But spirituality is somewhat relative as it is the path to attain meaning and purpose in life which is subject dependent and subject regulated. But it is undeniable that spirituality found its root in religiousness. Therefore, it still shows that there is no consensus on the definition of spirituality but there is a partial consensus on the concept of religiousness.

1.6 Meaning of Religious Practice

Religious practice means people's behaviour towards fulfilling the commitments to certain religious objectives including rituals, sermons, sacrifices, festivals, prayers, public services and so on. The present study operationalized religious practice in terms of three measurable constructs i.e., acceptance belief, moral imperative and religious solidarity. Acceptance belief highlights the beliefs of an individual towards the sovereignty of his or her religion and the acceptance of religious claims to be true. Moral imperative is indicative of the value system which directs the individual towards practising and sustaining religious beliefs as well as stay committed towards the fraternity. Religious solidarity is the social outlook of religiosity which motivate individuals to connect with people of same religions through a participatory and welfare approach. Evidences show that people from different religions across the world have their own way of expressing their religious outlook and adopting means for its sustainability. In the modern societies, where religion is perceived as a force that brings people together for a noble cause, religious practices are rooted so deep in culture that varies with geographical coordinates and people practising religious activities perceive those as part of the culture. Therefore, it is comprehended that religious practice is nothing but a way of living and sustaining our existence within the fraternity.

1.7 Students' Mental Health: Depression, Anxiety and Stress

Generally, students are a group who face various stressful events while spending the critical period of their life in the educational institution. As they move towards a higher level, they face more stressful events like more demanding syllabus, challenging assignments, hostel stay etc., where these challenges need to be coped with effectively. They go through significant life transitions (Chen et al. 2013) as they move from adolescence to adulthood. Their mental health is considered an essential component of their social health (Grinrid and James, 2002). Students at every level of higher education face various challenges and pressures. Because in higher education, many students have to be away from family, besides the new environment, academic demands, peer group pressure, new friends, new subjects, fear of meeting expectations, bad results, worry about a future career, financial stress, loneliness., etc. various problems for them. The pressure is on. That is, it can be said that different types of stressors or triggers are present for students at different levels and institutions of higher education, including colleges and universities. Not only does this affect their academics, but this material situation affects their mental health and well-being. And the mental health and well-being of those vulnerable students who already have problems with family social support and education are more at risk.
So it can be said that students in various institutions of higher learning worldwide have different mental health problems. According to WHO, the experience of psychologists involved in this subject is that at least 10% of students at any institution of learning experience emotional difficulties at some time or several times or consistently during their higher education career. (WHO 2020) Anxiety, stress and depression are some mental health problems they suffer from in their higher education life. It can be said that the mental health of students during this period mainly depends on their level of anxiety, stress and depression. Some of them suffer from one problem, while others suffer from many issues simultaneously (Koenig, 2018).

Depression is one of the most common mental health problems worldwide (Khanam, 2015; Kesler, 2003). Every year, three thousand five hundred million people suffer from this problem (Kaur, 2014). Depression is a mental health problem characterised by psychological distress, despair and unhappiness. Young adult face depression and stress during this transition period from adolescence to adulthood. College and university students are generally more prone to depression along with stress (Kumar Swami 2013) Depression is a multiple problem disorder that imposes a heavy burden on society resulting in impaired personal, social, interpersonal and professional functioning (Husen hosen begas, 2005).

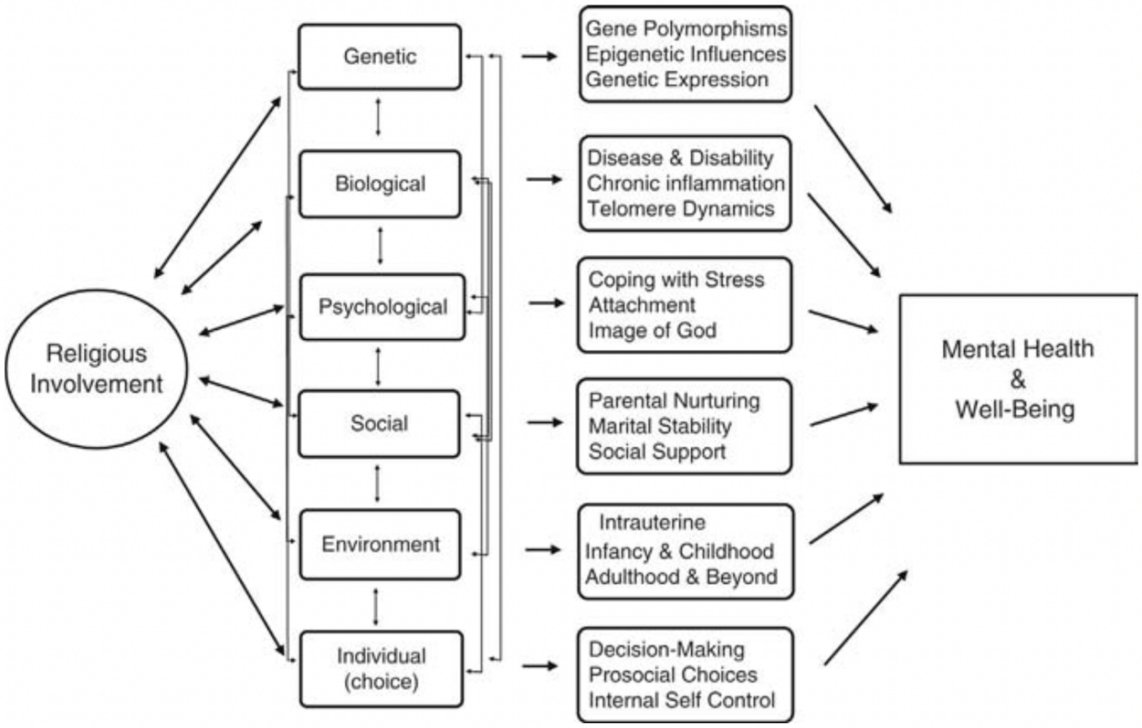
Anxiety refers to fear and apperception about the future unsuddenly. It's a physiological and psychological condition that affects physical cognitive emotional behaviour aspects. But there is a difference between general fear and anxiety. Fear is short-lived and associated with present danger rather than is also associated with escape avoidance. Anxiety, on the other hand, is associated with future dance and long live. It's not under the control of the individual and cannot be avoided. Anxiety is associated with various substance usage including alcohol, tobacco, caffeine etc.

Another important component of mental health is stress. Like anxiety and depression it is also considered as a risk factor for health and wellbeing. Stress is a mental or physical event that is the result of one's involvement with his / her environment and cognitive assessment of the stimulation (Selye, 1956). According to the Chang's dictionary of psychology, "stress is a physical or mental strain that impact on person's distress or even perception of a pain (Chang, 1996).

According to a study published in the Asian Journal of Psychiatry, 37.7%, 13.1% and 2.4% of students were suffering from moderate, severe and extremely severe depression in Indian universities. Many studies reveal high levels of depression and stress among university students worldwide. Busari (2012), Chen et al. (2013), Samsuddin et al. (2013), & Pidgeon et al. (2014) shows that every day,

6.77 students from different age group commit suicide in India. Therefore, it has to be needed to support themselves for coping with these situations. Several studies have shown that college students who are religiously active have less depression, anxiety, and stress. They also have better mental health and do better in academics (Thao, 2020). Religious practice is to prevent the developmental mental disorder and increase mental health resiliency through several pathways beginning before birth and extending across the lifespan which is shown in figure 1.1 (Koenig et al., 2020).

Figure 1.1
Pathways by which religious involvement may affect mental health



(Source: Koenig 2018)

1.8 Religious Practices and Depression, Anxiety, Stress

Recent developments have proven that religiousness has a reverse relationship with mental health, infecting from a very early period; it has been observed that a positive relationship has been maintained amongst the physical, mental and psychological parameters. Religiousness relies on faith, which is an internal motivation generating commitments in people (Gorsuch, 1994). According to a study, research opined that regular religious involvement favours mental health and helps maintain well-being. In contrast to the 28.9% of teenagers who say they are not very happy, 34% of adolescents attend regular church services, according to the GSS (General Social Survey). Children who have ADHD are also seen to be regaining a religious bent (Novis-Deutsch et al., 2022). Learning disabilities also diminish with increased religious practice. Church attendance has been identified as one of the most significant predictors of religiosity, but religious commitment is the most complete. According to the PEW research centre, religious faith aids in developing coping strategies for overcoming difficulties, positive emotions, hope (Sen et al., 2022), and a discernible degree of optimism and self-esteem. People who are active in their communities have better stress management skills and higher levels of life satisfaction.

For people, religious affiliation has been linked to altruistic manners and a more compassionate, empathetic (Ji et al., 2006), and hope-driven society and environment. A prominent indication of the influence of religion on wellness is the significant decline in depressive, anxious, suicidal, drug, alcohol, and violent behaviour. Extraversion, neuroticism, conscientiousness, agreeableness, and openness to experience—the significant components of personality—are all determined and modified according to a person's religion. This is an additional benefit of religiosity on personality development and traits, which is also undeniable. Regular religious activity has miraculously been linked to a sharp decline in delinquency, criminality, and marital instability (Salvatore & Rubin,

2018), as well as improved social capital and family ties. The management of mental health does not limit the advantages of religion.

The majority of mental diseases caused by psychological discomfort and life's bitterness are found in non-religious people. People who practise religion have happier emotions and sentiments, which boost their immune systems and promote physical health. Students make sensitive and significant members of society at a young age. Their way of life is crucial since it improves their health, with religion as a substantial component in fostering their physical and mental well-being.

The National Mental Health Association (NMHA) indicates that 64% of female and 46% of male students suffer from anxiety. In addition to reducing everyday activities, the prevalence of fear and sadness among students is essential since it leads to the development of mental diseases, issues with compliance, and potential criminal activity. Due to the significance of religion for society's mental health, 84 out of 126 medical schools in the United States provide religious courses (Moreira-Almeida et al., 2006). Studies on religious affiliation among students with mental health issues, including anxiety and depression, have shown varying findings for students in various nations.

Papazisis and associates evaluated 123 Greek nursing students and showed that religiosity and spirituality could help lower depression, stress, and anxiety (Papazisis et al., 2014) . Counselling with Buddhist principles may be beneficial to patients with emotional anxiety-based problems and has decreased anxiety levels in pregnant women. It is also observed that when prayer is consistently performed, elderly inmates report feeling better emotionally and having lower levels of anxiety and sadness, more optimism, and more spiritual experience. They also report having lower levels of melancholy and anxiety. Alongside, more optimism and better spiritual experiences have been recognised.

Improvement in handling and coping mechanisms against physical problems and less racial anxiety are also facilitated by religion. Participants in therapy programmes with a strong spiritual component report reduced stress, anxiety, sadness, and intolerance. GAD improvement and improvement of spiritual welfare are the additional advantages of religious practices. It reduces fear of death for oneself and others by creating a sense of meaning in life with added purpose and clarity. For elderly HIV patients, praying has proven to positively affect strength and contentment with life. Surprisingly, the connection between religious affiliation and anxiety in women is more vital than in men. Additionally, non-Muslim students' association was noticeably weaker than Muslim students. Self-control skills get better. The prevention of severe psychoses and other mental illnesses has been seen to have reduced chances. The noticeable decline in depression and the desire to commit suicide makes religion a prized factor for psychological well-being. The remarkable advantages also extend to creating hope, freedom from exhaustion, and attainment of life's purpose, besides an enhanced immune system and happy mood. Perhaps a harmonious and secular society is achievable as a dedication to following social norms increases with incorporating religious practices into daily life.

1.8.1 Religious Practices on Mental Health among Higher Education Students

Religion plays a significant role in human life, but to what extent it affects certain aspects of human life, such as stress and mental health, remains a blurry topic. Buddhism has flourished on the basic developmental concept of mental health and wellbeing as a religious ideology. Therefore, more meditative techniques and breathing exercises instead of idol worshipping are seen in Buddhism as a religious belief and practice. Buddhism as a religion has been able to identify this undeniable connection between religious beliefs/practices and mental health. The relationship between religion, spirituality and mental health has been a matter of

interest for many for a long time, and studies have been conducted to establish a proper estimate of this relationship. People from numerous religious groups are including their voices to the reality that spirituality and religion can contribute to mental fitness and wellbeing, mental illness, and recovery. This has resulted in such popularity of the idea that today research on faith and its courting with happiness and life satisfaction has ended up as first-rate research among various mental health researchers and scholars.

Spiritual and mental well-being can be positively moderated by incorporating religious and spiritual practices. This finds wide recognition among not only spiritual healers of ancient times, but psychotherapists increasingly rely on integrating religious and spiritual practices to bring forth mental health and wellbeing. By inculcating a more comprehensive understanding of the sufferings of life, many world religions point out that religious beliefs and practices help one lead a much healthier, happy and prosperous life (Smith, 2009).

Rangaswami states in his findings that it is indeed a common practice among Indian psychotherapists to depend on religious beliefs and practices to aid individuals in building a good mental state (Rangaswami, 1994). Many religious testaments hold forth the idea that mental well-being and the mental state of peacefulness are better achieved when aided by the guiding light of religious practices. Balodhi and Chowdhary (1986) state in their work that *Atharva Veda*, an ancient religious text associated with Hinduism, has served as an essential aid in achieving mental health and can further be used for rectifying mental afflictions is modified according to the current needs and societal changes. This is not true only for India, but Holdstock (1979) reveals similar findings that when included along with spiritual and emotional aspects, psychotherapy shows better results in the context of the traditional healings associated with the South African culture.

There is much discussion about convergences between religion and otherworldliness, which claim that regularity in religious exercises leads to positive results halfway by assisting individuals with quality inputs that work

towards the betterment of their life in general and mental health in particular (Zinnbauer, & Pargament, 2005).

1.9 Operational Definitions

Depression: Generally, depressions are mental disorders characterised by a profound and persistent feeling of sadness or displeasure and loss of interest in things that were once pleasurable and disturbance in daily activities. In the present study, depression indicates the general meaning of depression as discussed above.

The present study measures depression based on the DASS-21 scale in which depression is operationalised as a score on the DASS-21 assessment consisting of seven items that measure the state of dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia and inertia.

Anxiety: The American Psychological Association (APA) defined anxiety as "an emotion characterized by feeling of tension, worried thought and physical changes like increased blood pressure". It is an excessive, persistent worry and fear about everyday situations. The present study operationalised anxiety as defined by APA and measured using the score on DASS-21 scale under anxiety domain.

Stress: Stress refers to the increased pressure that an individual feel out of everyday activities or towards certain events or phenomena. The present study operationalised stress as a score on DASS-21 consistent with seven items which measure the state of difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable / over-reactive and impatient. The stress scale is sensitive to levels of chronic non-specific arousal.

Religious Practices: The present study operationalized religious practice in terms of three measurable constructs i.e., acceptance belief, moral imperative and religious solidarity. Acceptance belief highlights the beliefs of an individual towards the sovereignty of his or her religion and the acceptance of religious

claims to be true. Moral imperative is indicative of the value system which directs the individual towards practising and sustaining religious beliefs as well as stay committed towards the fraternity. Religious solidarity is the social outlook of religiosity which motivate individuals to connect with people of same religions through a participatory and welfare approach.

Here religious practices is measured as a score on the religious activity scale (RAS) consistent with 15 items that measure three practical aspects of religious activities: acceptance belief, moral imperative and religious solidarity.

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Chapter II

Problem of the Study

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2.1 Literature Review

A literature review is a synopsis of relevant academic works that lay the framework for the evidence needed to proceed with the current inquiry. To objectively examine the rising problem of the effects of religious practices on students' depression, anxiety and stress. It surveyed previous research on the subject, which helped justify the present investigation. To avoid redoing the analysis and finding the problem, you need to think about this part for a better understanding. It helped with both conceptualisation and gaining an in-depth knowledge of the situation. An online journal, a report article, publications, and a thesis were the sources reviewed to provide context for the present discussion. In this vein, we find the following connected studies:

2.1.1 Studies conducted abroad

GALLAGHER et al. (2002) studied the relationship between religion and personality. They claimed that when faith is infused in nature and immersed as one, they emerge as a more expressive force like spirituality. Though the expressions of religion are outward and external and those of spirituality are inward and individual, there lies a connection between religion and spirituality (*Eugene B. Gallagher's Research Works | University of Kentucky, Kentucky (UKY) and Other Places*, n.d.).

Spirituality and mental health are interconnected through multiple dimensions. Spirituality requires connecting at three layers, i.e., the self, the others and the Other, to attain maximum wellbeing. And it is only through spiritual intelligence (SI) that one can develop such connections. Mental health, similarly, is also a state

of well-being that allows the individual to realise his maximum potential and meaningfully contribute toward the more significant benefit of universal creation (Verghese, 2008).

Religion, spirituality and mental health and their importance in treating various disorders have long been of interest among researchers (George, Larson, Koenig, & McCullough, 2000; Koenig, 2001; O'Conner, Pronk, Tand, & Whitebird, 2005; Pargament, 1997). Keshavarzi & Haque (2013) explored the religion of Islam regarding human health, behaviour and spirituality and offered a therapeutic guideline of psychological mediation within the Islamic context (Keshavarzi & Haque, 2013).

Pelechova et al. (2012) investigated how professionals conceptualise the relationship between beliefs and work from diverse faiths and occupations. Focusing on threefold aims, i.e., to study the relationship between religious trust and clinical practice among mental health professionals, to investigate the ongoing debate between science and religion, and to bring forth a practical understanding of such conflicts, they conducted a semi-structured interview with 10 participants to categorise their beliefs regarding the similar/different aspects and the pros/cons of religion and spirituality upon mental health profession. Findings showed that participants value spirituality for its internal and external significance and benefits (Pelechova et al., 2012)

Reavley et al. (2012) investigated the acknowledgement of depression, help-seeking intentions, and beliefs regarding interventions and stigmatising attitudes in an Australian university. Findings showed that most participants recognised depression and said they would ask for help if needed. However, factors like tender age, male gender, being born outside of Australia, lower level of education, lack of

recognition of depression etc., have been associated with stigmatising attitudes. Mental health complications were found to affect exam performance, dropout rates in the tertiary levels, inability to work/study for days, et. c (*Mental Health Literacy in Higher Education Students - Reavley - 2012 - Early Intervention in Psychiatry - Wiley Online Library*, n.d.).

Dein et al. (2010) identified positive associations between wellbeing and religiosity, with religious faith and spirituality as established strategies among suffering individuals in coping with the adversities in life. Findings showed that knowledge of the effect of religious fabeliefnd and spirituality on mental health is essential in good clinical practice (*(34) Religion, Spirituality and Mental Health | Halina Grzymała-Moszczyńska - Academia.Edu*, n.d.).

Koenig (2009) reviewed studies on the relationship between religion, spirituality, and mental health, mainly focusing on anxiety, depression, psychosis, substance abuse, and suicide. Findings showed that religious beliefs and practices are related to effective coping with anxiety, depression, psychosis, substance abuse, and suicide; religi us delusions are associated with psychotic disorders – making it difficult to conclude whether religious beliefs and practices are a liability or a liability resource (Koenig, 2009).

Moreira-Almeida et al. (2006) reviewed 850 studies published throughout the 20th Century to investigate the relationship between religion and mental health. Findings showed that most studies identified a positive correlation between higher levels of religious involvement and lesser levels of depression, substance abuse and suicidal thoughts and behaviour, as well as psychological wellbeing (higher morale, positive affect, happiness, and overall life satisfaction). Findings also showed that such a positive correlation is more evident among the elderly,

those with disability and medical issues, and those under various types of stress (Moreira-Almeida et al., 2006).

Koenig et al. (2012) reviewed various research items on the relationship between religion and mental health published from 1872 to 2010 to explore the values, beliefs, and practices of two religious faiths - the Christians and the Muslims. Findings suggested a similarity between Christians and Muslims regarding religious involvement and mental health outcomes (*Crossroads…exploring Research on Religion, Spirituality and Health – Center for Spirituality, Theology and Health*, n.d.).

Hill & Pargament (2003) explored various concepts and measures related to physical and mental health in religion and spirituality. Findings highlight the scope for further investigation in measuring and conceptualising religious and spiritual factors regarding physical and psychological health (Hill & Pargament, 2003).

Rippentropa et al. (2005) investigated the effect of religion/spirituality on health issues among 157 patients in the USA. Using hierarchical multiple regression analyses, they found a substantial relationship - having both costs and benefits - between religion/spirituality and physical and mental health conditions. Private religious practice was more frequent among severely suffering patients and was more inversely related to physical health outcomes. Factors like forgiveness, spiritual experience, religious affairs etc., were identified as predictors of mental health conditions (Rippentrop et al., 2005).

Brown et al. (2013) explored the correlation between spirituality (religious coping and spiritual wellbeing) and psychological (depression and anxiety) variables. Their findings reported a positive correlation between higher levels of

religiosity and spiritual well-being. They decreased mental and emotional illness, higher levels of existential wellbeing, and lower levels of depression and anxiety. Moreover, existing existential well corresponded to spirituality and mental health. Findings also claimed that religiously active individuals report lesser traits of depressive symptoms (Brown et al., 2013).

King et al. (2013) investigated the relationship between a spiritual/religious appreciation of life and psychiatric indicators and analyses. Collecting data from interviews with 7403 participants, their study reported a vulnerability to mental disorders among people who claim to have spiritual beliefs without any religious framework. They also mentioned a need for further research (King et al., 2013).

Allen et al. (2008) explored the relationship between levels of religiousness/spirituality, depression and anxiety, and a desire for quick death among 81 male inmates in Alabama, USA, in terms of their age, ethnicity, and nature of the crime. Data was collected through an oral interview of 30 to 60 minutes. Findings showed that an increasing number of regular spiritual experiences and not feeling rejected by God were related to better emotional health (Allen et al., 2008).

Vitorino et al. (2018) studied how various levels of religiousness and spirituality are associated with anxiety, depressive symptoms, optimism, happiness, and quality of life among 1046 adults in Brazil. Findings of this cross-sectional study revealed that having higher levels of spirituality and religiousness was related to better outcomes than having just one/none. Similarly, higher levels of religiousness without spirituality also corresponded to better results (Vitorino et al., 2018).

Bensaid (2021) explored the basic tenets of spiritual parenting, mainly focusing on the features, values and methods followed by Muslim parents in raising spirituality among children. Findings identify that combining deep faith in religion and theoretical approaches to comprehensive spiritual parenting intertwined with modernity allows parents scope for creativity, intercultural experience, and adaptation in their spiritual parenting and raising spirituality among children (Bensaid, 2021).

Miryazi et al. (2017) studied how people's religious attitudes can influence their health. One of the main ways to prevent and treat mental disorders is by emphasising spiritual, divine and monotheistic perspectives. Still, in this study, a significant relationship wasn't observed between religious attitudes and mental health. It is realised that stronger religious beliefs promote students' mental health. In this regard, more attention must be paid to teaching theoretical and practical issues of religion, and creating profound ideas in students is essential (Mirzayi et al., 2017).

H.F. Unterrainer et al., in their paper, have provided a background to the development of the Multidimensional Inventory for Religious/Spiritual Wellbeing and then summarised the findings derived from its use with other health measures and personality. The results have established substantial evidence to prove that religiosity/spirituality positively relates to various mental health indicators, including subjective well-being and well-being dimensions. Furthermore, religiosity/spirituality has been regarded as essential in recovering from mental illness and providing a protective function against addictive or suicidal behaviours (Unterrainer et al., 2014).

Johnson Olusegun Ajayi et al. (2014) have studied to investigate religious practices in Nigeria and the effect on the development of the society using the experimental method. Though religion could be a source of social unity and cohesion in a social

setting, it was discovered that over the years in Nigeria, religion has merely led to persecution, torture, wanton bloodbath and destruction of social and economical materials (Dike et al., 2020).

Carl E. Thoresen et al . (Jan 2005) asserted in this paper that religion continues to be vital since it combines both personal and public character. It regards that religious beliefs and practices significantly impact individual lives and influence public life daily. Therefore, Sufism as a spiritual doctrine and practice has attracted many Muslims in the modern world as an alternative to political and puritan Islam. Also, Sufism has the prowess of acting as a critical reminder of its deep commitment to helping Muslim consciousness against the ever-growing materialism and consumerism plaguing the modern world. Thus, it concluded that Sufism has a significant role in understanding modernity and enjoying the fruits of modernism (Thoresen et al., 2005).

In this study, Holly K. Oxhandler (2016) has described validating the Religious/Spiritually Integrated Process Assessment Scale (RSIPAS) across five helping professions. The RSIPAS was initially developed to measure clinical social workers' self-efficacy, attitudes, perceived feasibility, behaviours, and overall orientation toward integrating clients' religion and spirituality in practice. The current study examines this instrument's internal consistency and criterion, discriminant, convergent, and factorial validity with a sample of clinical social workers, psychologists, nurses, counsellors, and marriage and family therapists in Texas (N ¼ 550). The findings support the reliability (a ¼ .95) and various forms of validity, with an improved fit in the factor structure among this more diverse sample. Therefore, this article asserts that RSIPAS may be used among these five helping professions to identify training needs or evaluate training efforts related to integrating clients' religious or spiritual beliefs in mental and behavioural health treatment (Oxhandler, 2016).

Through the current article, Christian K, ner, and David Parker (2016) have explored the complex intersections of religiosity, power and inequality in an inner-city district of Birmingham, England. They drew on data from over 100 qualitative interviews with residents and religious actors to reveal the manifold, at times contradictory local manifestations of religiosity: variously reproducing traditional expectations and behaviours and contesting prevailing patterns of stratification; as capable of both entrenching social boundaries and of fostering 'friendly', pluralistic co-existence. In broader conceptual terms, through this paper, they have argued for a 'locality approach', which acknowledges the importance of religiosity in the area without reducing all significant social relationships and interactions with it. In particular, they drew on mediated discourse analysis. They argued that its distinction between a 'nexus-' and a 'community of practice (Scollon 2001) offers much to the sociology of religion in helping to illuminate intra-, inter-, and non-religious discourses and techniques, as well as their inter-relationships, unfolding in a locality (Karner & Parker, 2014).

Christopher Alan Lewis and Kate M. Loewenthal (2018), in the Special Issue of Mental Health, Religion & Culture, have illustrated some of the diversity and richness of contemporary research examining the relationship between religion and obsessional neurosis, with particular reference to culture. One area of specific prominence has been exploring the links between religion and mental health, particularly religion and obsessional neurosis (Freud, 1907). This collection of studies on obsessive acts and religious practices may be considered part of a much broader initiative that has sought to examine the scientific credibility of Freudian theory (e.g., Fisher & Greenberg, 1978, 1985, 1996; Kline, 1972, 1981). However, as is common in this general area, hypotheses are difficult to conceptualise, operationalise, and test. Those derived explicitly from the writings of Freud (1907) are no different (Lewis & Loewenthal, 2018).

Jonas Kolb and Erol Yildiz (2019). Their study is based on a change in perspective, shifting front and centre the religious orientation of the Muslim population as seen from their perspective and experiences. The study's findings on Muslim diversity in Austria show how differentiated, complex, ambivalent, and hybrid the everyday religious practice of individuals directly on the ground is or can be. The article focuses on a form of open religiosity practised above all by members of the successor generations. The study's findings prove that the dominant proportion of Muslims in Austria do not define themselves using conventional and classic theological contents of faith but rather approach this from the matrix of their lived realities. The article asserts the requirement of theology that recognises and takes seriously the changed realities of life of the persons practising Islam and, on that basis, projects a theology in keeping with the times—a theology that, in this manner, creates a different consciousness in respect to religious diversity and furnishes new perspectives and horizons for religious education (Kolb & Yildiz, 2019).

Nazrul Mubin bin Ahad through the study, has explored the development of religious life among the Muslim Cham in Cambodia in several aspects in terms of their practices of the pillars of *Islam, Īman* (faith), and Islamic events in Cambodia, as well as the challenges and unity among them in the country. This paper focuses on the premises of practice in religious life among the Muslim Sunni Cham while mentioning others in some parts if needed. Mixed methods were used to obtain the data and information; first, in documents such as books, articles, and journals. Secondly, interviews and surveys have also been conducted to support the arguments. However, it is found that according to the observations, the Muslim community is not 100% doing all the practices due to factors such as lack of understanding and knowledge leading to lack of implementation (*(34) A STUDY*

ON THE RELIGIOUS PRACTICES OF MUSLIM MINORITY: MUSLIM CHAM IN CAMBODIA AS A CASE STUDY | Nazirul Mubin Ahad - Academia.Edu, n.d.).

Rizky Adi Sudrajad & Bambang Hari Wibisono (2021). This study identifies the relationship between activity patterns and the built environment in Krapyak District. The harmony between activity patterns, the built environment, and the meaning of a complex philosophical axis of Krapyak District was fascinating for the authors to investigate, especially in light of the district's environmental issues. This study used a deductive approach with a descriptive-qualitative method based on the behavioural space system model of place-centred mapping. It is concluded that there are three layers of activity and space, namely the religious layer, the socio-cultural layer, and the philosophical axis layer, that interact with one another with specific spatial patterns(*(PDF) SPATIAL PATTERNS OF ISLAMIC RELIGIOUS ACTIVITIES IN KRAPYAK DISTRICT, YOGYAKARTA*, n.d.).

In this study, Georgios A. Tzeferakos & Athanasios I. Douzenisin (2017) have tried to give a general overview of the interconnection between Islamic faith, mental health, and law, focusing on specific key concepts and practices. In a rapidly changing world and large numbers of people move from one country to another, leading to cultural admixture, the need to familiarise with different cultures has become imperative. This study shows that despite significant differences between western and Muslim societies, many common historical points could and should be the basis for sincere and constructive dialogue. This necessity is of great importance in the field of Psychiatry and Forensic Psychiatry, where every person's subjective reality and identity lies in a dynamic balance with the social, historical, and cultural ambit in which he lives (Tzeferakos & Douzenis, 2017).

In their study, Ahmet Tanhan & J. Scott Young (2021) have provided the proposed concept map and framework to explain a range of intrapsychic and social barriers Muslims face as they consider using mental health services. Collaborating with Muslims through mental health services to address their issues and enhance well is more likely to contribute to the well-being of other non-Muslims, considering the global conditions we live in. In the current study, the authors have (a) reviewed 300 peer-reviewed manuscripts on Muslim mental health to understand how researchers have used concept maps or theoretical frameworks to design their empirical research and (b) prepared a comprehensive concept map based on the literature review to determine the central concepts affecting Muslims' approach to the use of mental health services, and (c) proposed a contextual theoretical (conceptual) framework. They titled the framework as Muslims' approach to using mental health services based on the Theory of Planned Behavior and the Theory of Reasoned Action (TPB/TRA) in the context of a Social-Ecological Model (SEM). They even drew the framework based on TPB/TRA, SEM, and the review of Muslim mental health literature (the concept map). The concept map and the framework provide the essential constructs about the challenges Muslims face when attempting to utilise mental health services. It is to be considered that future researchers can use the concept map and the framework to conduct theoretically and evidence-based grounded empirical research (Tanhan & Young, 2022).

The researchers expanded previous studies on family conflict and preteens' depression and anxiety. The researcher evaluated whether private religipracticesises mediated family conflict and depression and anxiety symptoms.Seventy-five5 boys and 85 girls aged 11-12 participated. According to Steensland and colleagues (2000), 52.5% of preadolescents were Evangelical Protestants, 18.8% were Mainline Protestants, 16.3% were Catholic, 1.3% were Jewish, 3.1% were unconventional conservative, 0.6% were nontraditional liberal, and 7.5% indicated no religion. 35.6% of mothers were Evangelical Protestants,

38.8% were Mainline Protestants, 18.8% were Catholic, 1.3% were Jewish, 3.1% were unconventional conservative, 0.6% were nontraditional liberal, and 1.9% had no religion. Private and structured religious practises of preteens were not awithociated with depression and anxiety. These results show that preadolescents who executnormalar personal religious behaviours may be more robust to familial conflict (Davis & Epkins, 2009).

This study summarises quantitative studies on religious depression, including randomised clinical trials on spiritual therapies for depression. This research will assist clinicians in evaluating if patients' religious views are a benefit or a liability. Religion and spirituality were used interchangeably (R/S) because of thdiscusseding research. First, both involve the transcendent. Second, when religion questions were used when spirituality was measured without mental health elements (wellbeing, tranquilly, meaning and purporeligiousectivity to others, etc.), tic, developmental, and environmental variables increase depression risk besides R/S. In most research, R/S involvement reduces depression, especially in the setting of life stress. The systematic review shows that more studies suggest R/S advantages than hamper per cent versus 6 per cent of studies). Several high-quality research demonstrates that R/S engagement may raise depression risk in particular populations (those with family problems) or impair depression prognosis (a single study on substance abusers). In randomised clinical studies, interventions that use patients' R/S beliefs reduced depression symptoms. Clinical trials are currently comparing religious psychotherapy to mainstream therapies [62]. Depression is linked to R/S participation. Given the widespread frequency of R/S and depression, its usage as a coping activity and reported effectiveness, and the substantial handicap depression causes, researchers and doctors need to understand better how R/S affects mental health and vice versa (Bonelli et al., 2012).

The current study surveys Christian denominations, religious beliefs, and mental health of college students. Depression, anxiety, and religiosity were measured. A sample of 430 students from a Midwestern institution participated. Participants completed demographic, religious beliefs and influence, Beck Anxiety Inventory (BAI; Beck, 1990), and Beck Depression Inventory questionnaires (BDI; Beck, 1987). The religious beliefs and influence questionnaire asked participants about their religious affiliation, level of religiosity, and church attendance. Religious influence and religiosity were graded from "not at all" to "extremely." Never, once or twice a year, once every two to three months, once a month, two or three times a month, and once a week or more. The sample size limits the generalizability of the current study's results. The convenience sample was predominantly young college students. As students adjust to independent living, their religious ideas may change, leading to sadness. The model was primarily Anglo-American females, which may limit generalizability. Only Catholic and Protestant Christians participated, limiting the study's generalizability. This study could impact anxiety and depression treatment. The current study complements rising evidence linking religion and mental health (Jansen et al., 2010).

IN THE STUDY, Duet al.M. Areba et.al (2017) examined the associations between positive and negative religious coping, symptoms of depression and anxiety, and physical and emotional well-being among Somali college students in Minnesota. It was an online cross-sectional survey of 156 participants (ages 18-21, M=21, SD=2.3). The results of the current exploratory study provided empirical evidence that a relationship exists between coping and physical and psychological health indicators among young adults of Somali origin (Areba et al., 2018).

In their study, Sasan Vasegh and Mohammad-Reza Mohammadi (2007) assessed the associations between religious variables, anxiety and depression in a sample of Muslim students (N=285) from Roozbeh Psychiatric Hospital of Tehran

University of Medical Sciences. Subjects were given a religiosity questionnaire and the Beck anxiety and depression inventories. The findings of this study support the hypothesis that religion plays a protective role against depression (Vasegh & Mohammadi, 2007).

Andrea Ferenczi et al. (2022) conducted online quantitative research for Gratitude, Religiousness and Well-being based on a sample of 54 men and 169 women participants (mean age = 39.13, SD = 15.90). The Gratitude Resentment and Appreciation Test (GRAT) was initially developed by Watkins et al. (2003) to measure dispositional gratitude. This study showed that religiousness is linked to higher gratitude, and an increase in appreciation may increase subjective well-being (Ferenczi et al., 2021).

Zahra Taheri-Kharameh (2016), in her article The Relationship between religious-spiritual well-being and stress conducted a cross-sectional study in 2015. The population of this study included 150 students using the random sampling method at Qom University of Medical Sciences. The instruments used in this research included the Multidimensional Inventory for Religious Spiritual Wellbeing-48. The findings of this study showed a significant relationship between the component of immanent hope and stress, anxiety, and depression (Taheri-Kharameh, 2016).

Yonathan Aditya et al.(2021), in their research on 'Does Anger Toward God Moderate the Relationship Between Religiousness and Well-Being?' derived data from 228 respondents (55 male) from a Christian university, Bintan, Indonesia, using the Four Basic Dimensions of Religiousness (4-BDRS), the Attitude toward God Scale (TAGS-9), and the Satisfaction with Life Scale (SWLS). The results demonstrated that anger reduced the effect of religiousness on well-being. It

revealed a complicated dynamic of having a relationship with God (Aditya et al., 2021).

Benedict Francis et al. (2019), in their study on Religious Coping, Religiosity, Depression and Anxiety among Medical Students in a Multi-Religious Setting, used a cross-sectional study done among Year one to Year five undergraduate medical students at the Faculty of Medicine, University of Malaya. Six hundred twenty-two medical students were participants. Duke Religious Index Malay Version (DUREL-M), Malay Version of the Brief Religious Coping Scale (Brief RCOPE-M) and Malay Version of the Hospital Anxiety and Depressive Scale (HADS-M)were used for this purpose. The outcome concluded that negative religious coping had more robust mental health outcomes than positive religious coping (Francis et al., 2019).

Timothy B. Smith et al. (2003) reviewed the literature using meta-analytic methods to determine the potential utility of religiousness as a predictor of depressive symptoms. This association was examined with data from 147 independent investigations (total N = 98,975). Evidence was found that religiousness is modestly but reliably associated with depressive symptoms at the bivariate level. This appears to apply across different gender, ethnic, and age groups (Smith et al., 2003).

2.1.2 Studies conducted in India

Babu and Nithya (2020) explored the relationship between spirituality and religion and to what degree mental health professionals identify as spiritual or religious. Forty mental health professionals participated in this quantitative study. This used two questionnaires, i.e. the religious attitude scale (Rajamanickam, 1988) and the spirituality scale (Pradhan, 2015). Findings showed no significant

relationship between spirituality and religion among mental health professionals (Nc, 2020).

The function of religion and spirituality in developing virtues and well-being was explored in a qualitative study. The sample included 30 adults (M = 40.97, SD = 9.61) from Delhi–NCR. Six Indian religions were represented (5 per religion, namely, Hinduism, Islam, Christianity, Sikhism, Buddhism and Jainism). Focused group discussions collected data (FGDs). Participants were briefed on the study and participated voluntarily. FGD with five same-religion participants. Six FGDs were held at six different sites, a community centre or a church (or equivalent). After establishing rapport, participants answered three FGD questions. Prosocial behaviour, appreciation, and forgiveness were found to be fostered by different religions. Participants cited the three virtues and spirituality as key contributors to their mental wellness. This research integrates mental health approaches with conventional research (Sharma & Singh, 2019).

This study addresses spirituality and depression in multireligious India. Cross-sectional description. In 2012, 120 depressed patients in Kolar, Karnataka, India, sought outpatient psychiatric care. Psychotic, life-threatening, or drug- or alcohol-related conditions removed subjects. Participants had mild, moderate, or severe depression. Outpatients got tricyclic or serotonin reuptake inhibitors and psychoeducation on depression, medication side effects, medication compliance, and follow-up. Consent was freely given. The researcher used sociodemographic proforma, Beck Depression Inventory-II, and Body Mind-Spirit Wellbeing spirituality scale. The current study examined the link between spirituality and depression among depressive disorder patients in India. This study found a negative link between depression and spirituality in India using an ecumenical paradigm of spirituality. Spirituality should be discussed with depressed individuals to help them find meaning in life and cope with the disease. Spirituality

and depression remain vital areas of research that may lead to novel treatments for depressed individuals (Rentala et al., 2017).

This study aimed to determine the relationship between spirituality and depression among patients with cancer visiting a tertiary care institute in Uttarakhand State in northern India. All India Institute of Medical Sciences, Rishikesh, one of the major healthcare facilities of the Indian government, was studied using cross-sectional descriptive methods. Cancer patients 18 to 65 years old, undergoing radiation, chemotherapy, or surgery, and speaking Hindi or English were eligible. Participants completed a socio-demographic survey, PHQ-9, and System of Belief Inventory (SBI15R). Five multilingual experts validated the English (Socio-Demographic Proforma) and Hindi versions of the study's tools (SBI-15R). The translated tools were split-half evaluated for reliability. Many cancer patients in India suffer from depression, typically undetected or untreated. This study examines Indian cancer patients' spiritual beliefs and activities. Most participants (59%) strongly (18%) believed in God. Spirituality and depression in cancer patients were inversely related in this study. (r=0.209, p0.05). Depression and therapy type were linked by researchers (inpatient and outpatient treatment). 69% of cancer patients were outpatients, whereas 31% were hospitalised (Haokip et al., 2022).

Ahmed Hankir et al. (2015). This paper broadly answered two related questions. Firstly, 'What is the relationship between Islam and the West?' and secondly, 'What is the relationship between Islam and mental health?' About the latter, for many people, religion and mental health are deeply and intimately intertwined. For example, faith can enable a person to develop mental health resilience, and Islam has been reported to be a protective factor against suicidal behaviour. The paper was concluded by illustrating how the two questions are interrelated. The authors have also provided data from a short survey conducted on Muslims

residing in Britain about identity. They have asserted that a holistic approach considering a person's religious beliefs is the best and most effective way of addressing mental health. Islam, as a way of life, has conferred protection against developing mental illness for a countless number of Muslims by offering them a community that they can integrate with (which is crucial since social exclusion is a significant issue for people who have mental health problems (Evans Lacko 2014)) and can also give them structure and purpose for living (Hankir et al., 2015).

Hossein Yousofi (2011) this paper deals with the relationship between human bodily-mental health and religious involvement. The author gives an argument and detailed explanation of why and how religious involvement by a committed person will warrant human mental and bodily health. This paper presumes that all world religions are in common in this regard but have been limited to the Islamic perspective only. The article articulates that Islamic teachings are the first value advice in Quranic verses, and other religious practices play an influential role in warranting human health (Yousofi, 2011).

Suraiya IT et al. (2019) aimed their research to show how the phenomenon of the spiritual movement in the dimension of Sufism has a real power to improve the social problems of the modern world. It has been asserted that as a holistic and transcendence philosophy, Sufism provides Muslims greater latitude to engage in debates about increasingly divisive politics shaping their societies while confronting the stringent and narrowing ideologies of fundamentalists. Sufism also can serve as a critical reminder of its deep commitment to helping Muslim consciousness against the ever-growing materialism and consumerism plaguing the modern world (Uin et al., 2019).

Singh and Husain (2015) studied the difference in spiritual beliefs between 160 adult Muslim male and female devotees in U.P., India. Data was collected using the Spiritual Belief Scale (Schaler, 1996) and analysed through an independent sample t-test. Findings show that females have firmer spiritual beliefs in religion than their male counterparts (Husain**, 2015).

Singh (2015) investigated the relationship between psychological well-being and spiritual practices among 130/204 Hindus in U.P. Data was collected using the Spiritual Practices Scale-Hindus (SPS-H) (Singh and Husain, 2014) and the Psychological Well-being Scale (Prakash and Bhogle, 1995). Findings show a significant positive correlation between the Hindus' psychological well-being and spiritual practices (*Relationship between Spiritual Practices and Psychological Well-Being among Hindus, » The International Journal of Indian Psychology*, n.d.).

Udhayakumar and Ilango explored the relationship between mental health and spirituality among older adults practising spiritual meditation. Data was collected using the Dass scale (Lovibond & S. H. Lovibond, 1995) and the Spiritual wellbeing scale (Paloutzian and Ellison 1982) in that descriptive research among 30 elders from Tamilnadu, India. Their results identified a strong positive correlation between higher levels of spiritual beliefs and better quality of mental health among those practising spirituality (*(PDF) Spirituality and Mental Health among the Elderly Practising Spirituality*, n.d.).

Ajit Singh Negi et al. (2019), in the study on 'Spirituality as a predictor of depression, anxiety and stress among engineering students', collected data from 914 engineering students of IIT Roorkee, India. A self-administered questionnaire and DASS-21 scale were used in the current study. It was found that symptoms of stress, anxiety and depression are more in male students than in female students

and the sense of spirituality for female students is more vital than that in male students (Negi et al., 2021).

Bhola Nath et al. (2018) conducted a cross-sectional study among 91 MBBS first-year students from the government medical college of North India using a purposive sampling method. Daily spiritual experiences were measured using Standard Daily Spiritual Experiences Scale (DSES). The significant finding was that although daily spiritual experiences vary among participants, spiritual orientation and everyday spiritual experience exist among medical students (Nath & Yadav, 2020).

Behere et al. (2013) studied the relationship between religion and mental health. This study aimed to determine how diverse religious belief systems and rituals affect people's mental health. After analysing multiple studies, researchers found a favourable correlation between religious involvement and mental health and illness. (Behere et al., 2013)

In his article, Agarwal (1989) described a positive correlation between religion and mental health. He argued that religious activity could have positive and negative outcomes, such as contributing to developing psychiatric disorders and fostering a favourable mental attitude among the populace. Faith and belief systems are optimal mental health's most essential and practical components. (Agarwal, 1989)

A study was conducted to determine the relationships between religious beliefs and distress and well-being among Hindu college students. Researchers investigated the relationship between religious belief and psychological well-being and discomfort. Using a questionnaire relating to pain and psychological

well-being, he analysed 178 samples and discovered that their relationship was moderate. Therefore, religious belief or action cannot be considered a fundamental source of psychological well-being (Park & Kamble, 2020).

A correlation was discovered between religiosity and anxiety among Kargil's Muslim students by Shekar and Hussain (2017). A researcher gathered information from 120 undergraduate students at a government degree college. The data was collected using the Psychological Measure of Islamic Religiousness developed by Hisham Abu Raiya (2005, 2008) and The State-Trait Anxiety Inventory developed by Spielberger et al. (1983). According to the study, there is neither a positive nor a negative association between these characteristics.

Mutalik et al. (2016) examined a study to assess psychological distress such as anxiety, depression, and stress among Bagalkot government degree college undergraduates. A sample of 133 students was selected for the study, and the DASS-21 scale and general health questionnaire were utilised to collect pertinent information regarding the psychological condition of the students. The findings revealed a high level of anxiety among the students, with females being more distressed than their male counterparts (Mutalik et al., 2016).

2.2 Synthesis of Reviewed Studies

The researcher analyzed 55 studies concerning religion and mental health, of which 17 were Indian, and 38 were foreign—most studies employed survey methodology. In most researches, random sampling procedures were devised to choose the samples. The results of these studies are contradictory and inconsistent. The studies also found that religious practices had sound as well as adverse effects on psychological well-being. There are few studies on this topic in West Bengal, and researchers discovered a significant knowledge gap

regarding the listed background variables. Therefore, the researcher chose this area as his research topic and analysed it based on predetermined objectives.

2.3 Research Questions

The researcher has identified the following research questions that he believes should guide the current study: -

- How far are religious activities practised by young adults studying at colleges and universities in West Bengal?
- How do different social and demographic factors contribute to various religious practices?
- Does religious practice reduce anxiety, depression and stress?
- Is religious practice associated with good mental health?

2.4 Statement of the Problem:

It was seen that studies on religious practices exist in the literature on personality, morality, physical health, society and other domains of human interactions. Very few studies were found relating to the impact of religious practices on mental health and other related areas. Considering the importance of mental health and its probable root in peoples' daily practices, including religious practice, the researcher felt inquisitive about how religiosity and religious practices affect mental health. Based on the theoretical knowledge of religiosity and participatory idea about religious practices in West Bengal, the researcher put forward the above research questions to see through whether the multi-dimensional nature of religious practices has benefitted the mental health of people. Hence, the problem for the present study has been identified and specified as ***Religious Practices on***

Students' Depression, Anxiety and Stress.

2.5 Delimitation

- The study covered 2210 students from 21 out of 23 districts in West Bengal.
- Only the following indicators have been considered – gender, habitat, type of institution, education level, religion, social category, family type, and marital status.
- Major three religions in West Bengal, i.e., Hinduism, Islam and Christianity, were considered.
- Students studying at 22 govt. Aided colleges and nine state universities were included as participants in the study.
- Religious activity was measured in terms of acceptance belief, moral imperative and religious solidarity.
- Good mental health was addressed regarding lower depression, anxiety and stress levels.

2.6 Objectives

In light of the fundamental research concerns and study restrictions, the following objectives were determined:

- To know the degree of religious activity practised by higher education students in West Bengal.
- To relate the magnitude of religious activity of students with their social and demographic factors.
- To determine the extent of depression, anxiety and stress among students at the higher education levels.

- To relate the level of depression, anxiety and stress of students with their social and demographic factors.
- To know whether the practice of religious activity is related to depression, anxiety and stress among higher education students.
- To find out whether religious activity contributes to good mental health.

2.7 Hypotheses

- **H_01**: No significant relationship exists between students' depression and their religious activities measured in terms of acceptance belief.
- **H_0**2: No significant relationship exists between students' depression and their religious activities measured in terms of moral imperative.
- **H_{03}**: There is no significant relationship between students' depression and their religious activities measured in terms of spiritual solidarity.
- **H_{04}**: No significant relationship exists between students' anxiety and religious activities measured regarding acceptance belief.
- **H_{05}**: No significant relationship exists between students' anxiety and their religious activities measured in terms of moral imperative.
- **H_{06}**: No significant relationship exists between students' anxiety and their religious activities measured in terms of spiritual solidarity.
- **H_{07}**: No significant relationship exists between students' stress and religious activities measured regarding acceptance belief.
- **H_{08}**: No significant relationship exists between students' stress and their religious activities measured in terms of moral imperative.
- **H_{09}**: No significant relationship exists between students' stress and their religious activities measured in terms of spiritual solidarity.

- **H_{010}**: Religious activities performed by the students do not significantly affect their depression, anxiety and stress altogether.

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Chapter III

Methods and Procedures

Chapter III Methods and Procedures

Research methodology describes the comprehensive processes of collection and analysis of data and the systematic solution of the research problem. This chapter is divided into two parts: Methods and Procedure. The methods part is further divided into design of the study, population and sample, description of variables, and instruments. The procedure part, on the other hand, is divided into collection, quality, and analysis of data.

3.1 Methods

The main purpose of this study is to measure religious activity and mental health of higher education students in West Bengal. The researcher conducted a survey in twenty one districts out of twenty three districts in West Bengal. Samples were chosen using purposive sampling method to ensure they resemble a good representation of the whole.

3.1.1 Design of the Study

Research designs are "plans and the procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis" (Creswell, 2009). A Cross-sectional survey design provides a quantitative description of beliefs, trends, attitudes, opinion or values of a population by studying a sample pooled from that population. Religious activity and mental health are such types of constructs which are better comprehended by self-reporting using valid and reliable instruments at a given time framework. This study follows the steps of a cross-sectional survey design that quantitatively measures the religious activity in relation to mental health of higher education students, as well as provides a quantitative analysis and interpretation of the same.

3.1.2 Population

Students who were studying at colleges and state universities in West Bengal were considered the target population of the study. At the time of the present study, the total number of students studying at higher education level in West Bengal is 19.58 lacs (AISHE, 2019-20), which was considered the population of this study.

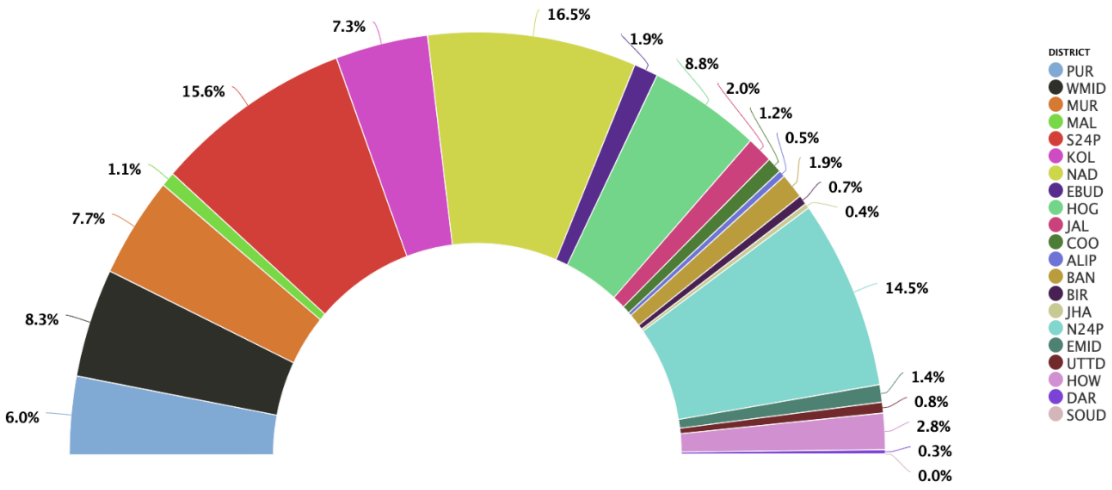
3.1.3 Sample

A representative sample size of the population is required for conducting any quantitative. Using the sampling error formula, taking confidence level = 95% and confidence interval = 5, the required sample size for 19.58 lacs students is 385. However, the sample of the present study consisted of 2210 (nearly sixfold the required sample size) learners from the twenty-one districts in West Bengal, namely Alipurduar, Bankura, Birbhum, Coochbehar, Darjeeling, East Burdwan, East Midnapore, Hoogly, Howrah, Jalpaiguri, Jhargram, Kolkata, Malda, Murshidabad, Nadia, North 24 Parganas, Purulia, South 24 Parganas, South Dinajpur, Uttar Dinajpur, West Midnapore. Therefore, it is assumed to be a good representation of the entire population of students studying different subjects at higher education levels in the aforementioned districts of West Bengal. The purposive method was opted to select districts, and students were selected using a random sampling method. The following table represents the sample distribution by district:

Table 3.1
Sample Distribution by divisions

Districts	No. of Sample	Percentage of Total
Purulia	132	5.97
West Midnapore	184	8.33
Murshidabad	171	7.74
Malda	25	1.13
South 24 Parganas	345	15.61
Kolkata	162	7.33
Nadia	365	16.52
East Burdwan	42	1.90
Hoogly	195	8.82
Jalpaiguri	45	2.04
Coochbehar	27	1.22
Alipurduar	11	0.50
Bankura	43	1.95
Birbhum	16	0.72
Jhargram	9	0.41
North 24 Parganas	321	14.52
East Midnapore	30	1.36
Uttar Dinajpur	18	0.81
Howrah	61	2.76
Darjeeling	7	0.32
South Dinajpur	1	0.05
Total	2210	100%

Figure 3.1
Showing sample distribution by districts



3.1.4 Description of variables

The following independent and dependent variables were taken into consideration in this study:

- Independent variables –

  1) Gender – *Two categories were considered, i.e., male and female;*

  2) Age*;*

  3) Habitat - *Two types of locality were considered, i.e., village and rural;*

  4) Institution type – *Two categories were considered, i.e., college and university;*

  5) Religion - *Three categories were considered, i.e., Hinduism, Islam and Christianity;*

  6) Family structure - *Two levels were considered, viz. joint family and nuclear family;*

7) Marital status - Two levels were considered, viz. single and married

8) Education level – four levels were considered, viz. undergraduate, postgraduate, B.Ed., and research

9) Social category – four levels were considered, viz. unreserved, scheduled caste, scheduled tribe, and other backward class;

10) Presence of disability – two levels were considered, viz. yes and no

- Dependent variables –
  - Religious activity; and
  - Mental health – *depression, anxiety and stress level were considered (description given in instrument details).*

Figure 3.2
Thematic diagram of variables

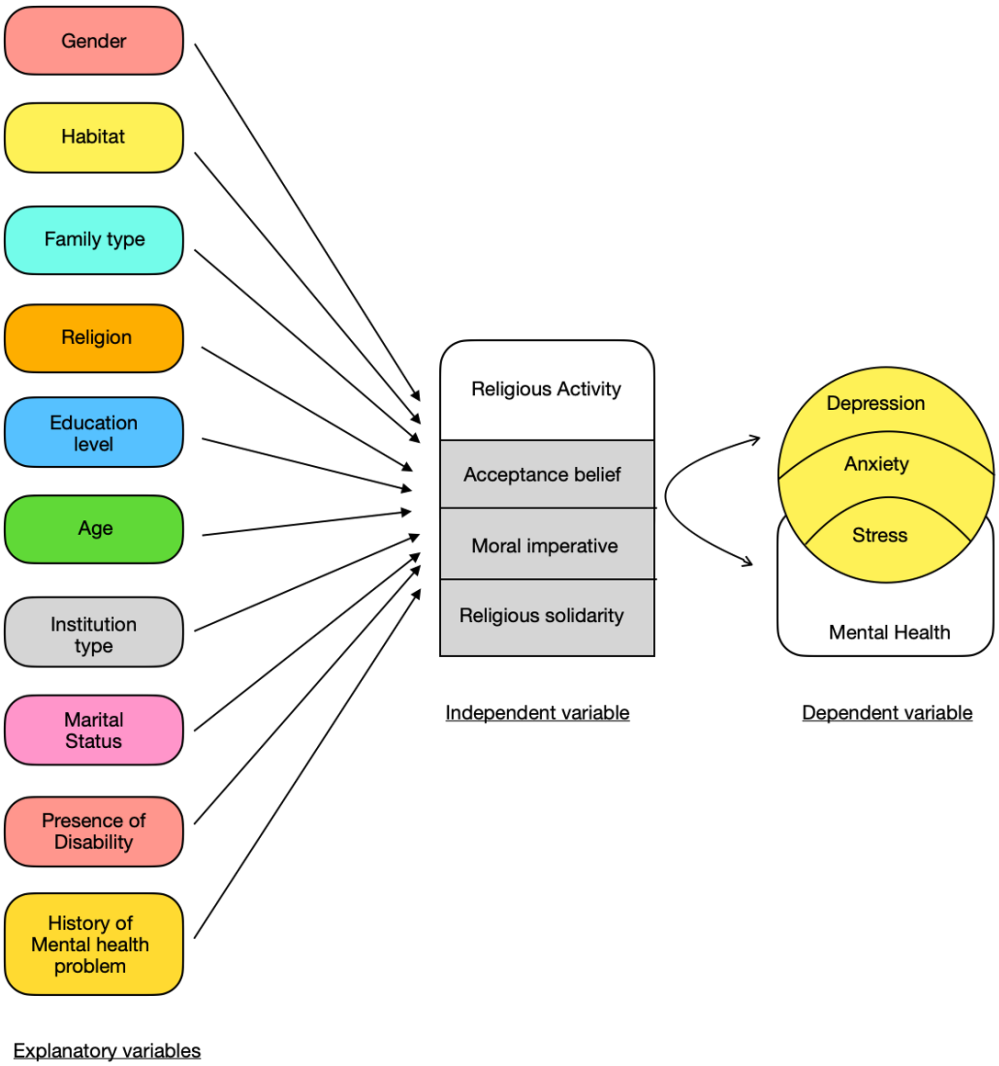


Table 3.2
Sample distribution by Levels of Independent Variables

Sl. No.	Variable	Levels	N	Percentage
1.	Gender	Male	577	26.11
		Female	1633	73.89
2.	Habitat	Rural	1550	70.14
		Urban	660	29.87
3.	Institution type	College	1735	78.51
		University	475	21.49
4.	Religion	Hinduism	1703	77.06
		Islam	411	18.60
		Christianity	96	4.34
5.	Family structure	Nuclear	1391	62.94
		Joint	818	37.01
6.	Marital status	Unmarried	2083	94.25
		Married	127	5.75
7.	Education level	Undergraduate	1558	70.50
		Postgraduate	308	13.94
		B.Ed.	270	12.22
		Research	74	3.35
8.	Social category	Unreserved	1076	48.69
		Scheduled caste	509	23.03
		Scheduled tribe	66	2.99
		Other backward class	559	25.29
9.	Presence of disability	No	1898	85.88
		Yes	312	14.12

Figure 3.3
Showing sample distribution by gender

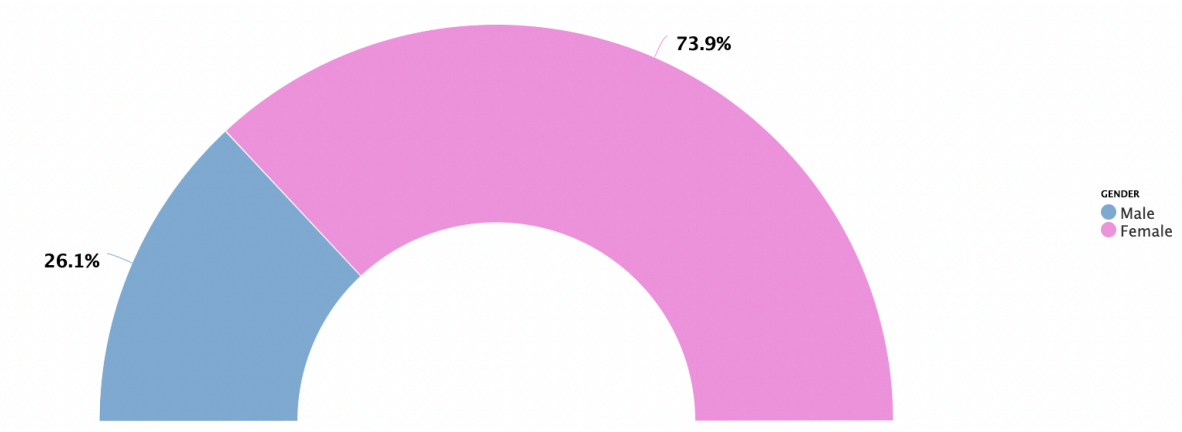


Figure 3.4
Showing sample distribution by habitat

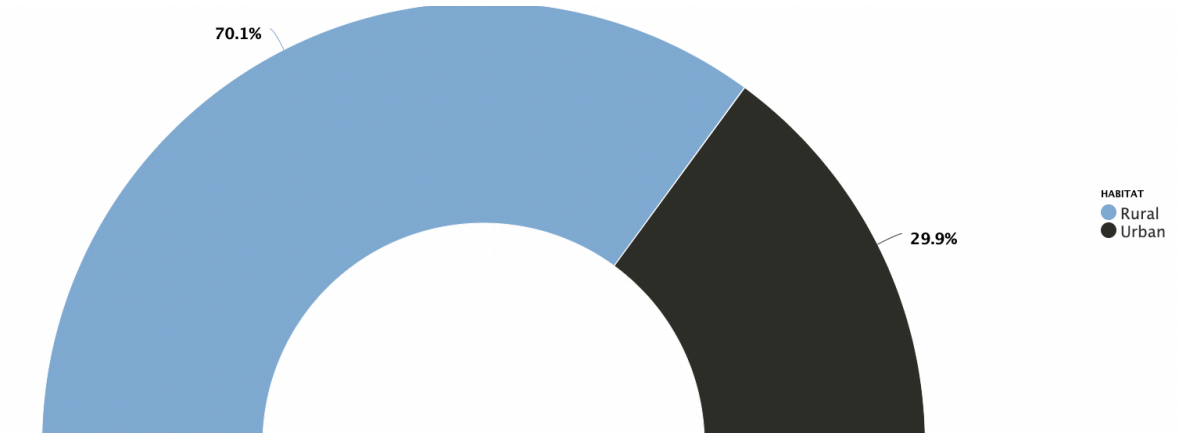


Figure 3.5
Showing sample distribution by family structure

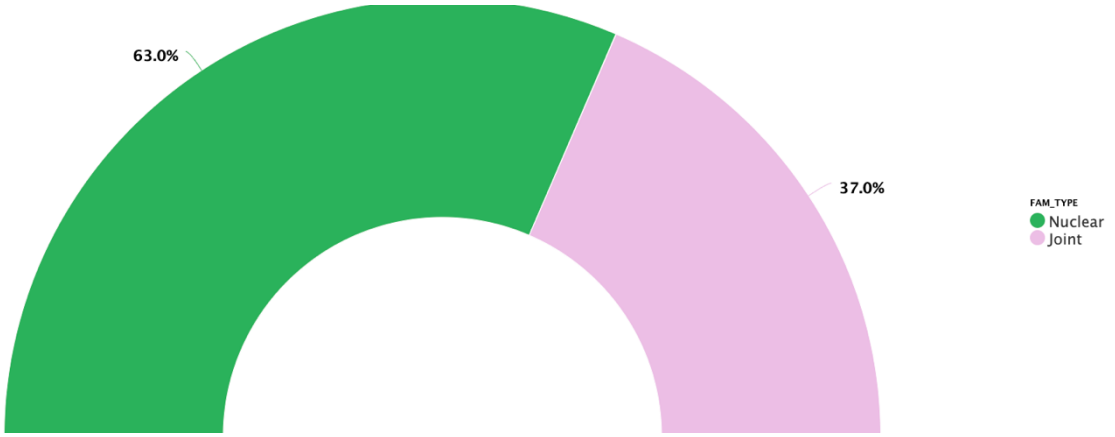


Figure 3.6
Showing sample distribution by institution type

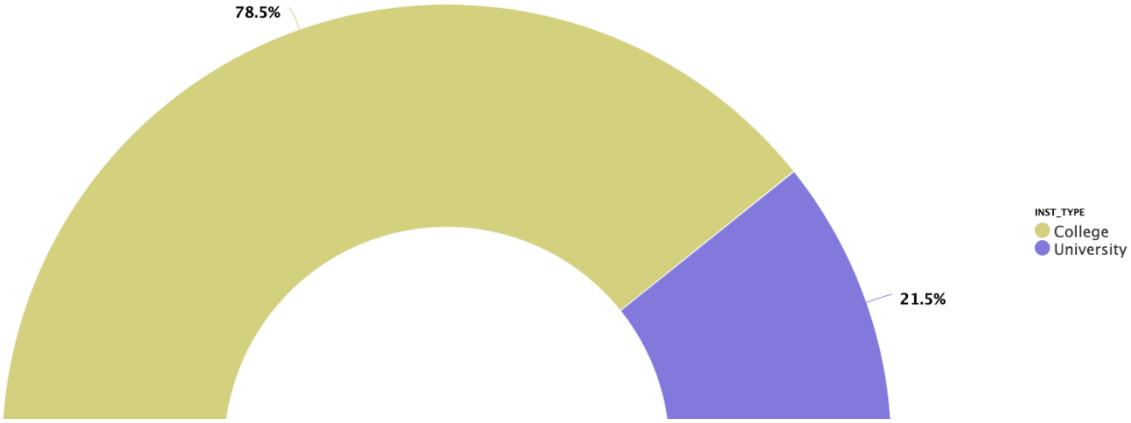


Figure 3.7
Showing sample distribution by religion

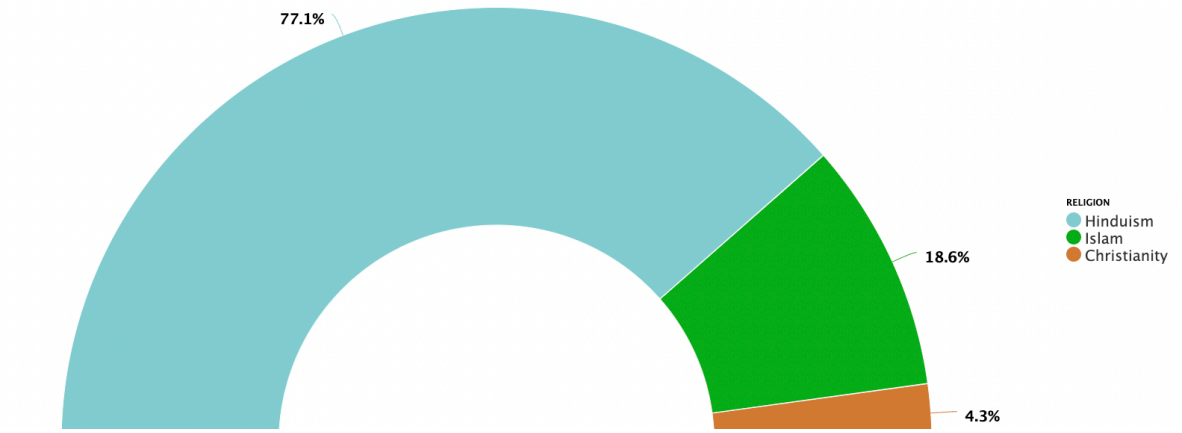


Figure 3.8
Showing sample distribution by social category

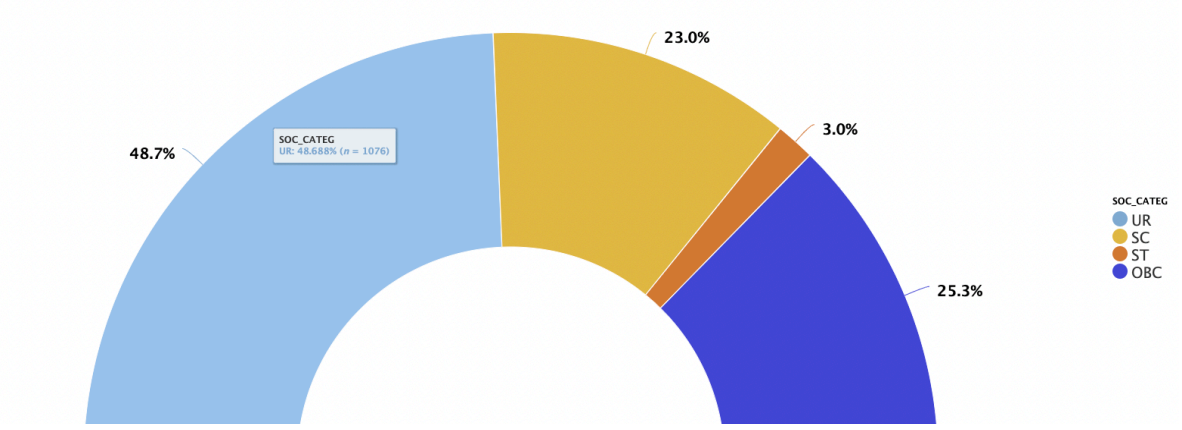


Figure 3.9
Showing sample distribution by education level

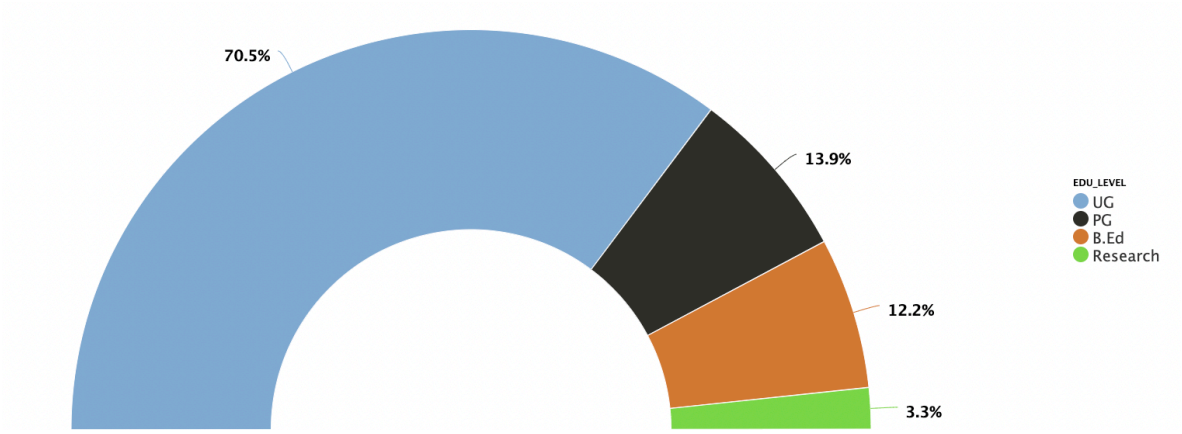


Figure 3.10
Showing sample distribution by presence of marital status

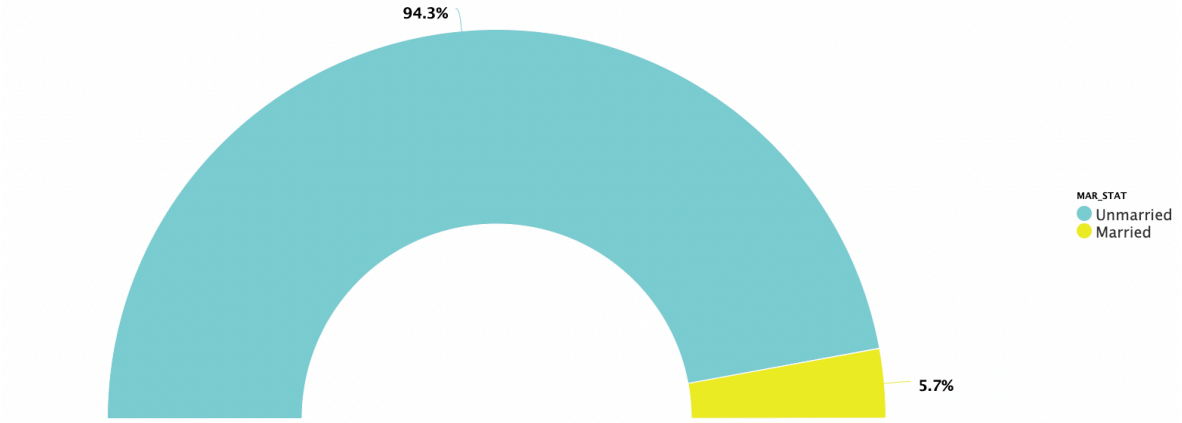


Figure 3.11
Showing sample distribution by presence of disability

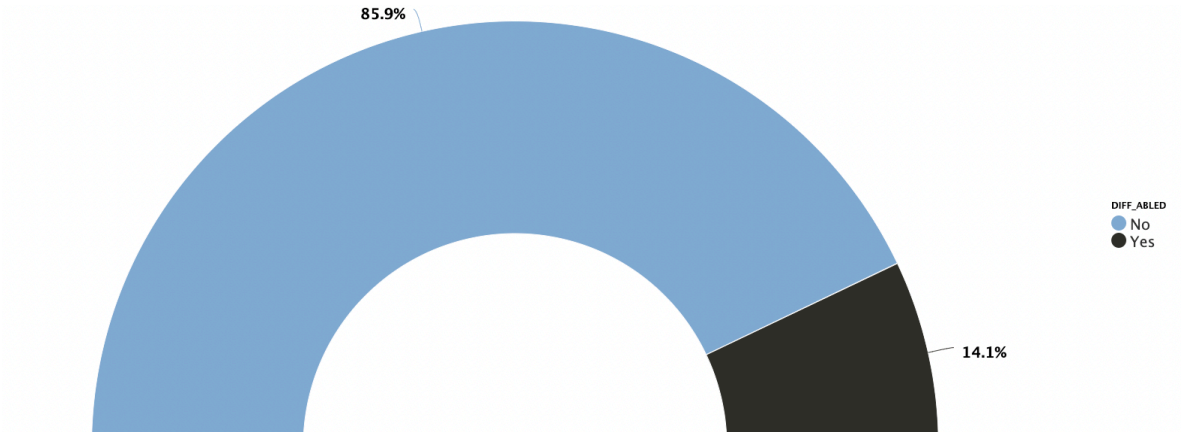


Figure 3.12
Showing sample distribution by presence of mental health problem

3.1.5 Instruments for data collection

The present study used two main instruments for collecting data:

- **Demographic Datasheet**

The researcher has formed a basic information sheet for collecting demographic and academic information from the students. The form included information regarding name, gender, age, habitat, institution type, religion, social category, family structure, marital status, education level.

- **Religious Activity Scale**

Religious Activity Scale (RAS) is a self-report questionnaire in Bengali that examines three aspects of religious activity. It was developed in 2022 by the researcher (Liton Mallick), Bijoy Krishna Panda and Muktipada Sinha of Jadavpur University. The religious Activity Scale is a set of religious practice-related orientations that has three subscales, namely, acceptance belief, moral imperative, and religious solidarity. RAS consists of 15 items under these three subscales

measured on a five-point Likert scale. The Cronbach's alpha of the scale is 0.82, which is very satisfying for application.

Table 3.3
Dimensions of Religious Activities Scale

Sl.	Dimensions	High scorers perceive themselves as…
1	acceptance belief	আমার ধর্মের প্রতি পূর্ণ বিশ্বাস আছে।
2	acceptance belief	আমি ধর্মীয় শৃঙ্খলা (Religious Discipline) গুলো মেনে চলি।
3	acceptance belief	আমি আমার ধর্মের বিধান অনুয়ায়ি পবিত্র থাকার চেষ্টা করি।
4	moral imperative	আমি ধর্মীয় সাহিত্য বা ধর্মগ্রন্থ পড়ি।
5	religious solidarity	আমি আমার ধর্মীয় স্থানে যাই।
6	religious solidarity	আমি একাগ্র চিত্তে ধর্মীয় সাধনা করি।
7	acceptance belief	আমি দৈনন্দিন জীবনের সকল ক্ষেত্রে আমার ধর্মের আদর্শ মেনে চলি।
8	moral imperative	ধর্মীয় কারণে উপবাস পালন করি।
9	religious solidarity	আমি ধর্মীয় স্থানে প্রার্থনা করি।
10	religious solidarity	আমি ধর্মীয় উপদেশমূলক সমাবেশে (Satsang / Ijtema / Prayer Service) অংশগ্রহণ করি।
11	religious solidarity	আমি ধর্মীয় স্থান (তীর্থ যাত্রা) দর্শন করেছি।
12	religious solidarity	আমি ধর্মীয় আচার, শোভাযাত্রা, জনসমাবেশে অংশগ্রহণ করি।
13	moral imperative	আমি খাবার পূর্বে বা পরে আমার সৃষ্টিকর্তার নাম স্মরণ করি।
14	religious solidarity	আমি ধর্মীয় কাজে আর্থিক সাহায্য করি।
15	moral imperative	আমি সাক্ষাতের সময় ধর্মের বিশেষ সম্বোধনমূলক শব্দ ব্যবহার করে থাকি।

Scoring

The RAS was administered in 5 points Likert scale where 0 = never, 1 = most of the times, 2 = prefer not to mention, 3 = sometimes, 4 = never. There was not a single

item on the scale negatively phrased or reverse scored. The sum of all the scores represents the total score of religious activity with minimum = of 0 and maximum = of 60.

- **Depression, Anxiety and Stress Scale – 21 Items (DASS-21)**

The Depression, Anxiety and Stress Scale - 21 Items (DASS-21) is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress. Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest / involvement,

anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic nonspecific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset / agitated, irritable /

over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items. The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The

assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by normal subjects and clinical populations are essentially differences of degree. The DASS-21 therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD.

Scoring

The score of the responses ranged from 0 to 3, with a format of 0 being *Did not apply to me at all, 1* being *Applied to me to some degree, or some of the time, 2* being

Applied to me to a considerable degree, or a good part of time, and 3 being *Applied to me very much, or most of the time.*

The categorization of level of mental health problem are as follows:

Level	Depression	Anxiety	Stress
Normal	0 – 4	0 – 3	0 – 7
Mild	5 – 6	4 – 5	8 – 9
Moderate	7 – 10	6 – 7	10 – 12
Severe	11 – 13	8 – 9	13 – 16
Extremely Severe	14 +	10 +	17 +

3.2 Procedures

This section describes the details of the test instruments' administration to collect data, followed by filtering, tabulation, and analysis.

3.2.1 Collection of Data

The data collection process was administered weekly from 15th March 2022 to 27th May 2022. On the days of visits to the university and college campuses, the Heads of the Departments/Institutes were approached by the researcher to explain the study's purpose and process. The researcher also clarified the confidentiality clauses of the shared information and data and submitted an authorisation letter for obtaining data issued by the supervisor on behalf of the Department of Education, Jadavpur University. After being forwarded by the competent authority, the researcher received permission from the head of those universities

and colleges. Then the researcher proceeded to the collection of data. A total of 16 universities & 30 colleges were approached by the researcher across all the twenty-one districts, among which 9 universities and 22 colleges gave consent to obtaining data from their students, totalling 1240 respondents. Due to the remoteness of some areas, data from 1067 students across all the districts were collected online using Google Forms. Students were also informed of the purpose of the study and the requirement for their cooperation. After getting their informal consent, the researcher provided them with all three instruments. There was no time limit ascribed to the participants for completing the questionnaires in physical paper 'n' pencil mode. However, about 95% of the participants completed their tasks in about 25 minutes.

3.2.2 Quality of Data

A total of 2307 participants responded to the questionnaires. However, 97 did not complete the questionnaires or provide multiple pieces of information and therefore were excluded from the dataset. Data from the rest of the 2210 participants were then adopted and considered sample units in this study.

3.2.3 Analysis of Data

The researcher used Microsoft Excel 2019 for tabulation and Jamovi (open source) version 2.3.11 to analyse data about variables. Descriptive statistics indicating Percentage analysis and Mean and Standard deviation was used to comprehend the characteristics of the sample. Graphical representation was illustrated through Bar, Stacked, and Line diagrams to represent students' religious activity and mental health in terms of different independent variables. Moreover, two-tailed Independent sample t-test, two-tailed Mann Whitney Rank Sum test, One-way ANOVA with interaction effect, Pearson's product-moment correlation, Spearman Rank Difference correlation and Chi-Square Test of Independence were employed for analysis.

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Chapter IV

Result and Interpretation

Chapter IV Result and Interpretation

This chapter is divided into three parts. The first part of this chapter has represented *descriptive statistics,* i.e. mean, standard deviation, percentage analysis and correlation coefficient which was calculated to find out variations in religious activities construct, depression, anxiety and stress measured in terms of self-described response to religious activities scale and DASS scale respectively. Some form of graphical representation i.e. bar diagram was made in this part for better understanding of the descriptive nature of current data.

The second part deals with *inferential statistics computer* to draw out the population of students in higher education in West Bengal. The analyses include the –Chi-square test of independence- one way ANOVA and MANOVA. All the analyses and graphical representations have been made using IBM PSS 20 software.

The third part deals with testing hypotheses in light of inferential statistics pooled from the descriptive statistical data**.**

4.1 Descriptive Statistics

The study covered 2210 students at various higher education levels, i.e., undergraduate, postgraduate, B.Ed. and research in West Bengal. The descriptive analyses were made with the different explanatory variables of the students and presented in the following sections.

4.1.1 Central tendency of religious activities score by different variables

Religious activities and Gender

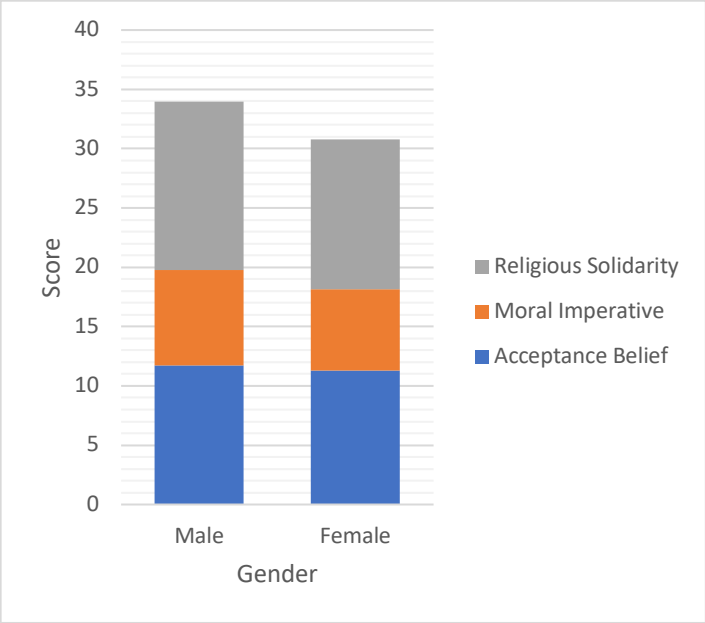
It was found that male students were more engaged in religious practices (m=33.55) than female students (m=30.70), but the consistency of practices was higher in females (sd=10.835) than their male counterparts (sd=12.923). Also, the

male participants were in a remarkably better position than female students in terms of religious solidarity (mean difference = 1.55).

Table 4.1
Comparing levels of gender in terms of their religious activities

Dimensions of RA	**Male** Mean (SD)	**Female** Mean (SD)
Acceptance Belief	11.75 (4.025)	11.32(3.847)
Moral Imperative	8 (4.22)	6.81 (3.88)
Religious Solidarity	14.20 (6.02)	12.65(4.049)
Overall	33.55 (12.923)	30.70(10.835)

Figure 4.1
Bar diagram comparing religious activities by gender



Religious activities and Habitat

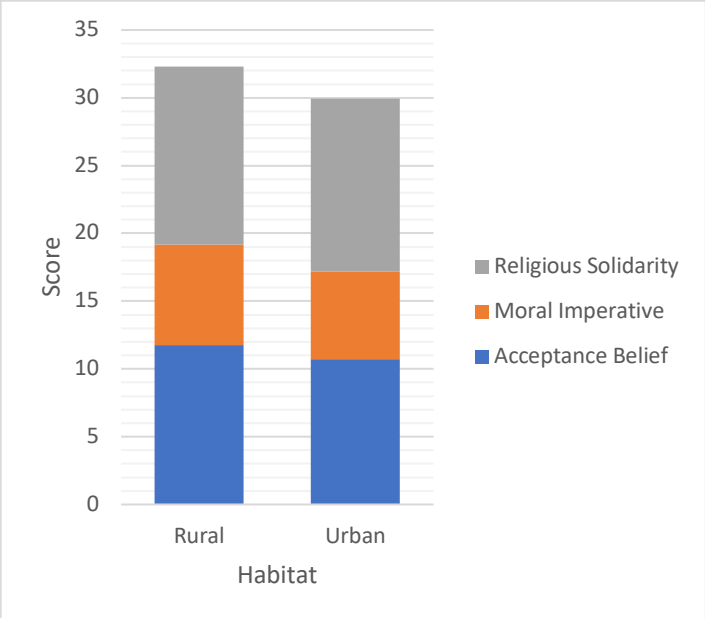
It was found that students in rural areas were more engaged in religious practices (m=32.13) than in urban regions =29.81). They have shown higher religio-spiritual traditions in three dimensions of the religious activities scale. Urban

students were also found to have practised religious activities to a reasonable extent.

Table 4.2
Comparing levels of gender in terms of their religious activities

Dimensions of RA	**Rural** Mean (SD)	**Urban** Mean (SD)
Acceptance Belief	11.75 (3.667)	10.70 (4.306)
Moral Imperative	7.40 (3.909)	6.47 (4.154)
Religious Solidarity	13.17(5.202)	12.77 (5.717)
Overall	32.13 (10.937)	29.81(12.530)

Figure 4.2
Bar diagram comparing religious activities by habitat



Religious activities and Education Level

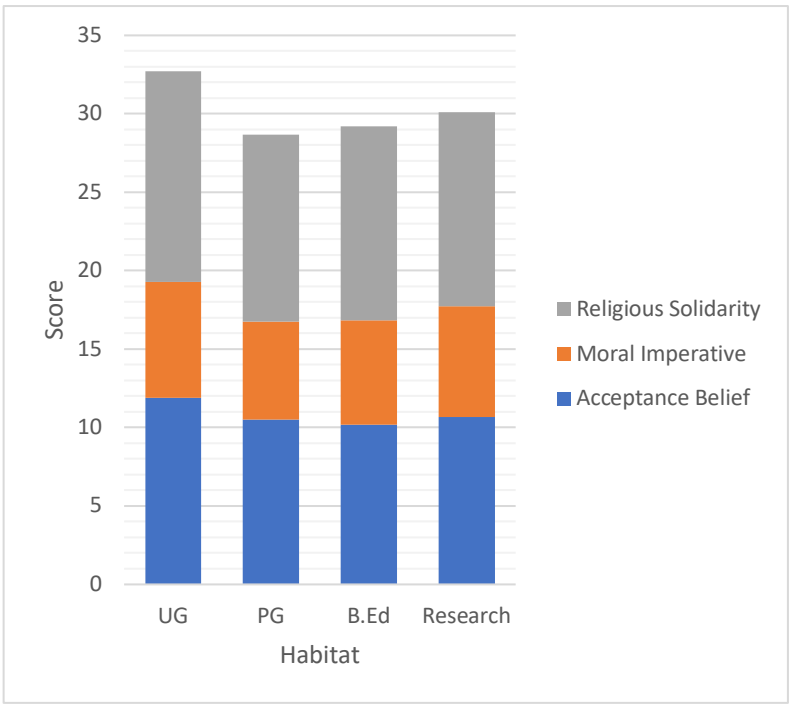
The results found undergraduate students as the most practitioner of religious activities (m=32.47) compared to the other levels of education from which students participated in this study. It was also seen that the degree of religious practices was high at a younger age (undergraduate level) but noticeably low among the postgraduate students (m=28.67) and at the same time slightly high

among the B.Ed. (m=29.01) and research students (m=30.90). The trend of differences in religious activities among students at four educational levels was also similar when each dimension of the religious activities measure was considered.

Table 4.3
Comparing students of different education levels in terms of their religious activities

Dimensions of RA	**UG** Mean (SD)	**PG** Mean (SD)	**B.Ed.** Mean (SD)	**Research** Mean (SD)
Acceptance Belief	11.90 (3.645)	10.50 (3.934)	110.20 (4.598)	10.69 (4.111)
Moral Imperative	7.38 (3.885)	6.25 (4.009)	6.65 (4.474)	7.04 (4.090)
Religious Solidarity	13.43 (5.123)	11.92 (5.227)	12.34 (6.431)	12.36 (5.697)
Overall	32.47 (10.855)	28.67 (11.360)	29.01 (13.872)	30.90 (12.082)

Figure 4.3
Bar diagram comparing religious activities by education level



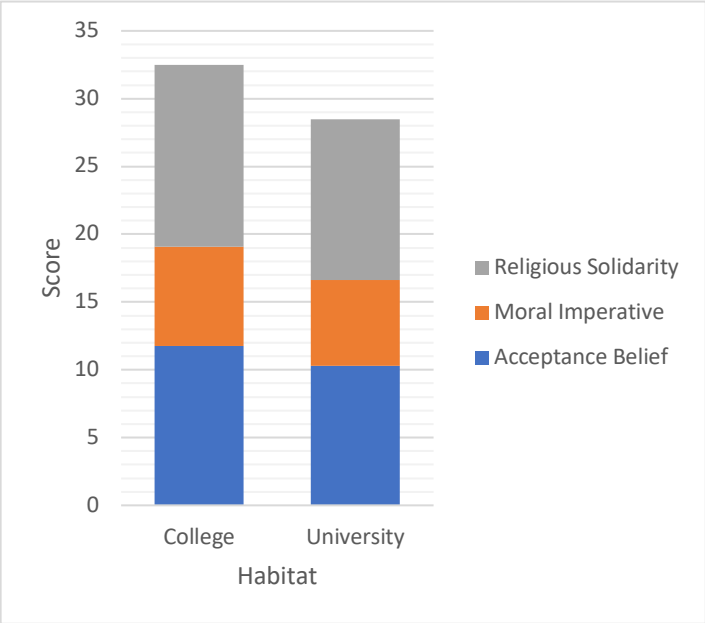
Religious activities and Institution type

It was found that college students did practice more religious activities (m=32.25) compared to those studying at universities (m=28.47). The difference was persistent across all three dimensions of the measure. Even the consistency of religious practices among college students (sd=11.182) was higher than that if university students (sd=12.075).

Table 4.4
Comparing students of different types of institutions in terms of their religious activities

Dimensions of RAS	**College** Mean (SD)	**University** Mean (SD)
Acceptance Belief	11.75 (3.788)	10.29 (4.078)
Moral Imperative	7.34 (3.944)	6.31 (4.124)
Religious Solidarity	13.38 (5.239)	11.87 (5.643)
Overall	32.25 (11.182)	28.47 (12.075)

Figure 4.4
Bar diagram comparing religious activities by institution type



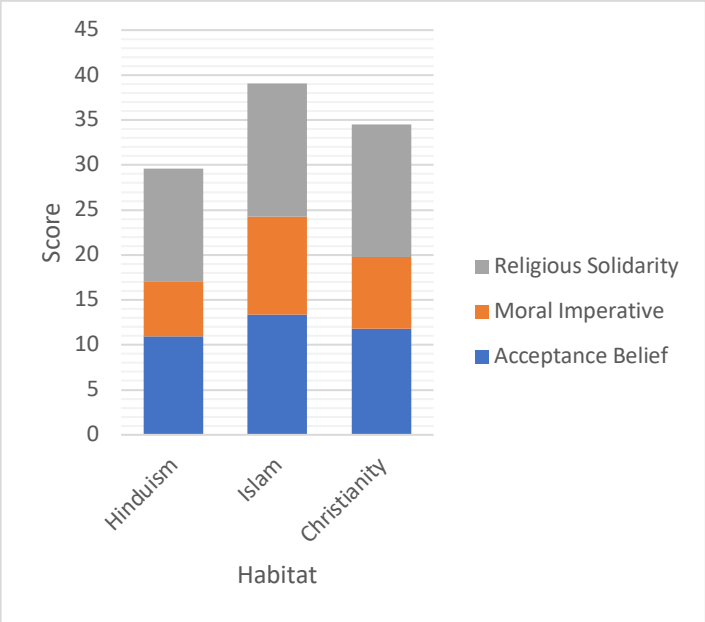
Religious activities and Religion

It was found that the Islamic students (m=38.95) consistently practised religious activities much more than those of other religions i.e. Hinduism and Christianity. Hindu students were found to have least the acceptance belief (m=10.95), moral imperative (m=6.15) as well as religious solidarity (m=12.53). The results showed that the Christian students were too close (mean difference = 4.45) to Islamic students in regarding spiritual solidarity.

Table 4.5
Comparing students of different religions in terms of their religious activities

Dimensions of RAS	**Hinduism** Mean (SD)	**Islam** Mean (SD)	**Christianity** Mean (SD)
Acceptance Belief	10.95 (4.008)	13.35 (2.704)	11.78 (3.705)
Moral Imperative	6.15 (3.622)	10.92 (3.037)	7.99 (4.25)
Religious Solidarity	12.53 (5.187)	14.81 (5.513)	14.73 (5.89)
Overall	29.46 (11.093)	38.95 (9.537)	34.50 (12.019)

Figure 4.5
Bar diagram comparing religious activities by religion



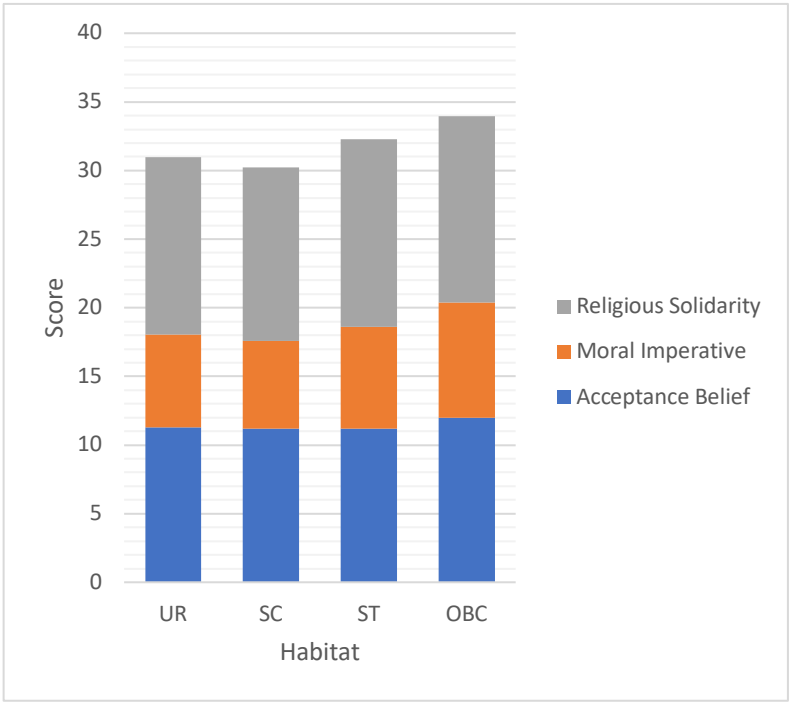
Religious activities and Social category

The results found that Other Backward Class (OBC) students as the most practitioner of religious activities (m=33.89) compared to the other social categories from which students participated in this study. It was also seen that the degree of acceptance belief was lowest among scheduled tribe (ST) students (m=11.17), moral imperative (m=6.40) and religious solidarity (m=12.64) was lowest among scheduled caste (SC) student the s at higher education level.

Table 4.6
Comparing students of different social categories in terms of their religious activities

Dimensions of RA	**Unreserved** Mean (SD)	**SC** Mean (SD)	**ST** Mean (SD)	**OBC** Mean (SD)
Acceptance Belief	11.27 (3.981)	11.19 (3.979)	11.17 (3.877)	12.00 (3.606)
Moral Imperative	6.79 (4.007)	6.40 (3.648)	7.42 (3.803)	8.37 (4.065)
Religious Solidarity	12.92 (5.423)	12.64 (5.326)	13.67 (5.620)	13.61 (5.211)
Overall	30.78 (11.734)	30.02 (11.182)	32.39 (11.457)	33.89 (10.901)

Figure 4.6
Bar diagram comparing religious activities by social category



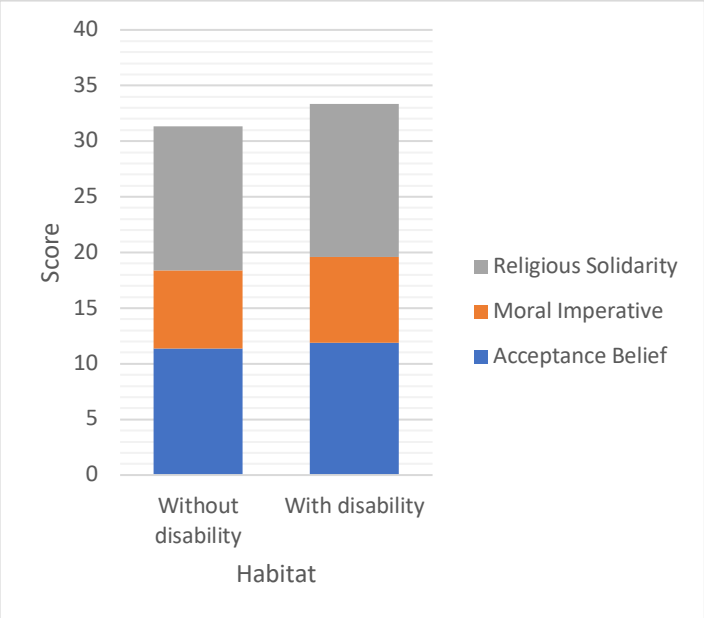
Religious activities and Disability

It was found that the students with some kind of disability practised more religious activities (m=33.35) than those without disabilities (m=31type. The disability was persistent across all three dimensions of the measure.

Table 4.7
Comparing students with and without disabilities in terms of their religious activities

Dimensions of RAS	**Without disability** Mean (SD)	**With disability** Mean (SD)
Acceptance Belief	11.36 (3.918)	11.88 (3.747)
Moral Imperative	7.02 (3.995)	7.71 (4.028)
Religious Solidarity	12.94 (5.359)	13.76 (5.341)
Overall	31.13 (11.516)	33.35 (11.107)

Figure 4.7
Bar diagram comparing religious activities by disability



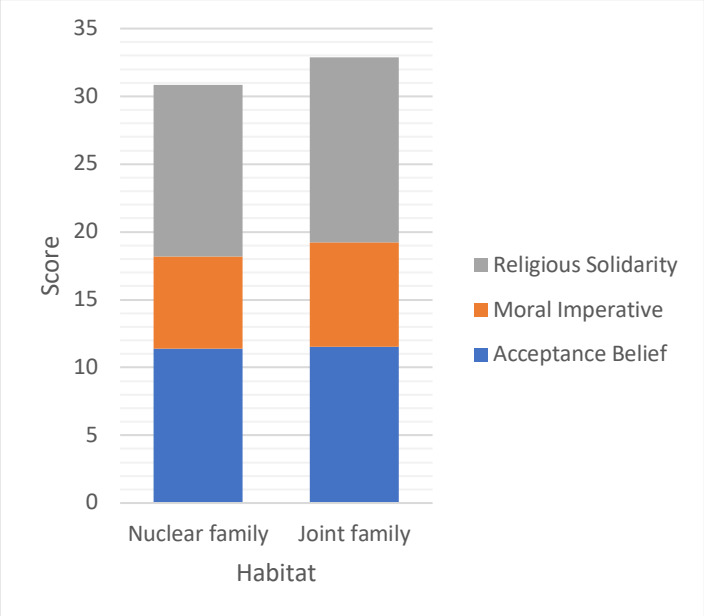
Religious activities and Family type

It was found that the students from joint families performed more religious activities (m=32.90) than those from nuclear families (m=30.59). The mean difference was persistent across all three dimensions of the measure but the consistency of practice was lower among students from joint families.

Table 4.8
Comparing students from different family types in terms of their religious activities

Dimensions of RAS	**Nuclear family** Mean (SD)	**Joint family** Mean (SD)
Acceptance Belief	11.39 (3.964)	11. 52 (3.783)
Moral Imperative	6.79 (3.933)	7.70 (4.064)
Religious Solidarity	12.69 (5.153)	13.68 (5.653)
Overall	30.59 (11.330)	32.90 (11.603)

Figure 4.8
Bar diagram comparing religious activities by family type



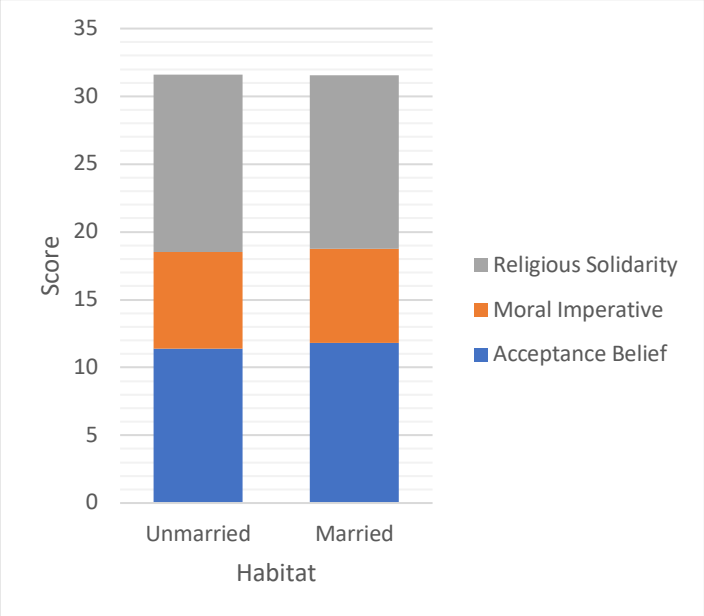
Religious activities and Marital status

It was found that although the married students performed a little more religious activities (m=31.58 overall, moral imperative and religious solidarity were higher among unmarried students (m=7.13, m=13.07 respectively). Acceptance belief was found to be mine for married students (m=11.80) than unmarried students.

Table 4.9
Comparing unmarried and married students in terms of their religious activities

Dimensions of RAS	**Unmarried** Mean (SD)	**Married** Mean (SD)
Acceptance Belief	11.41 (3.922)	11.80 (3.573)
Moral Imperative	7.13 (3.984)	6.94 (4.349)
Religious Solidarity	13.07 (5.350)	12.83 (5.583)
Overall	31.43 (11.494)	31.58 (11.339)

Figure 4.9
Bar diagram comparing religious activities by family type



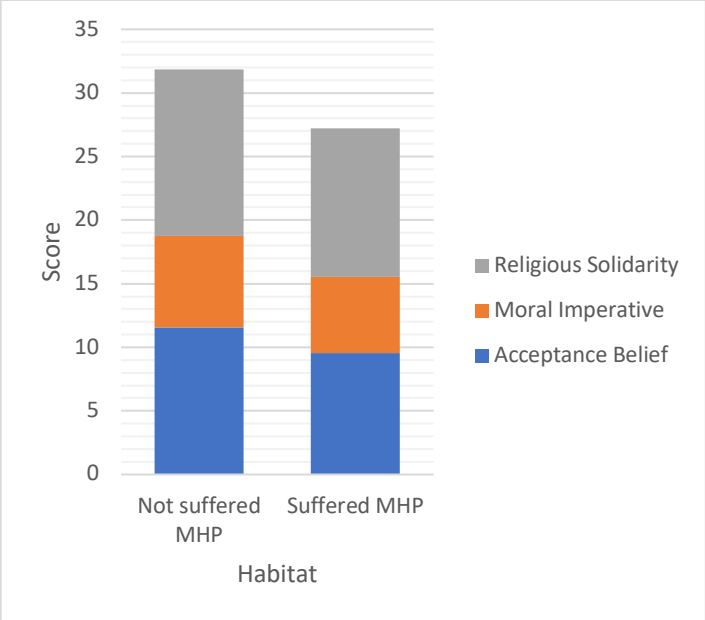
Religious activities and History of mental health problem

It was found that the students who have suffered from mental health problem in past, practiced noticeably less religious activities (m=27.71) than students who have not suffered from mental health problems (m=31.69). The mean difference was persistent across all three dimensions of the measure.

Table 4.10
Comparing religious activities by students with and without history of mental health problem

Dimensions of RAS	**Not suffered MHP** Mean (SD)	**Suffered MHP** Mean (SD)
Acceptance Belief	11.55 (3.818)	9.56 (4.684)
Moral Imperative	7.19 (3.992)	5.96 (4.069)
Religious Solidarity	13.13 (5.347)	11.69 (5.472)
Overall	31.69 (11.389)	27.71 (12.248)

Figure 4.10
Bar diagram comparing religious activities by history of mental health problem



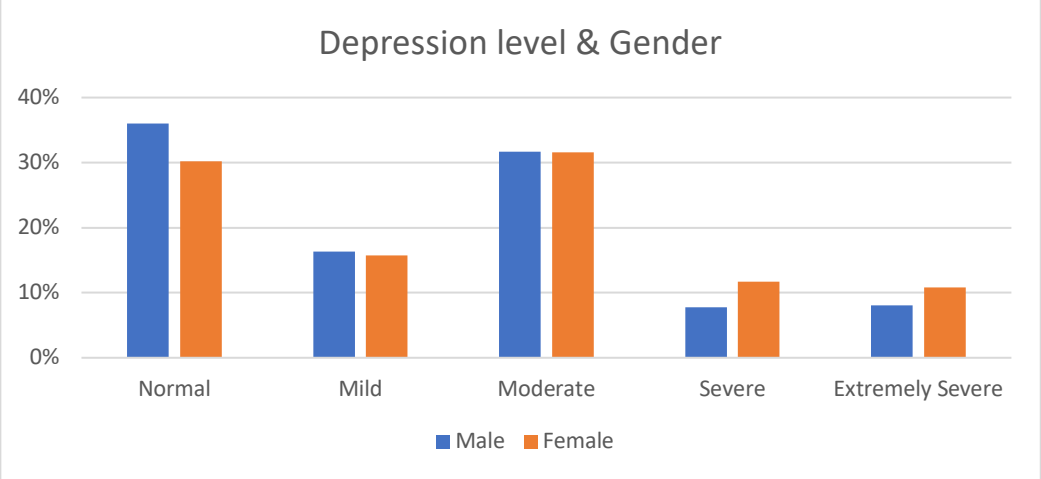
4.1.2 Levels of depression, anxiety and stress by different variables

Gender and Depression, Anxiety, Stress

Table 4.11
Comparing levels of depression, anxiety and stress by gender

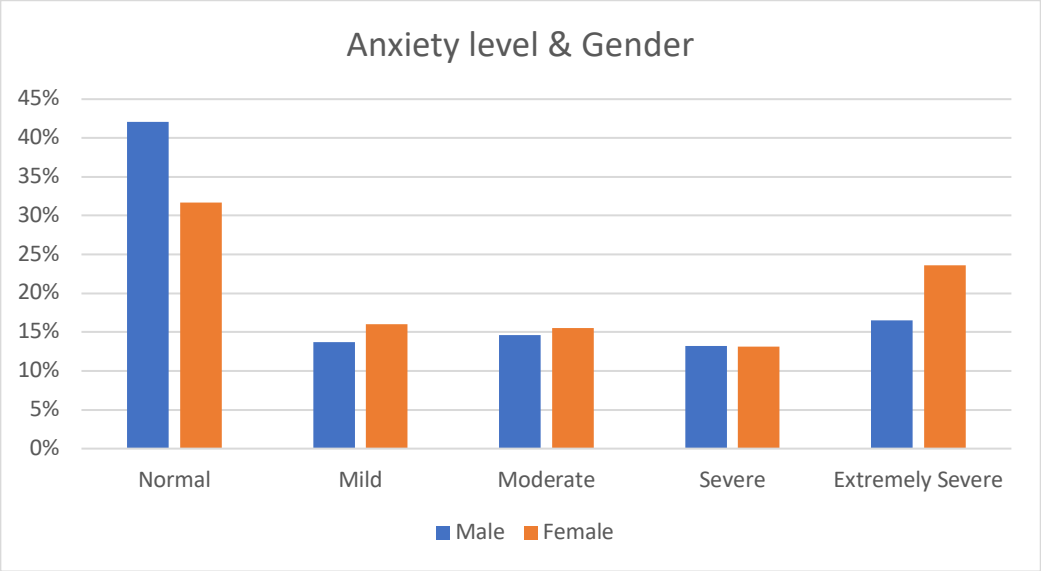
Levels	Dimensions	Gender	
		Male	Female
Normal	*Depression*	208 (36%)	493 (30.2%)
	Anxiety	243 (42.1%)	518 (31.7%)
	Stress	331 (57.4%)	804 (49.2%)
Mild	*Depression*	94 (16.3%)	257 (15.7%)
	Anxiety	79 (13.7%)	262 (16%)
	Stress	86 (14.9%)	256 (15.7%)
Moderate	*Depression*	183 (31.7%)	515 (31.6%)
	Anxiety	84 (14.6%)	253 (15.5%)
	Stress	93 (16.1%)	332 (20.3%)
Severe	*Depression*	45 (7.8%)	191 (11.7%)
	Anxiety	76 (13.2%)	214 (13.1%)
	Stress	50 (8.7%)	179 (11%)
Extremely Severe	*Depression*	47 (8.1%)	176 (10.8%)
	Anxiety	95 (16.5%)	386 (23.6%)
	Stress	17 (2.9%)	62 (3.8%)

Figure 4.11
Bar diagram comparing depression level by gender



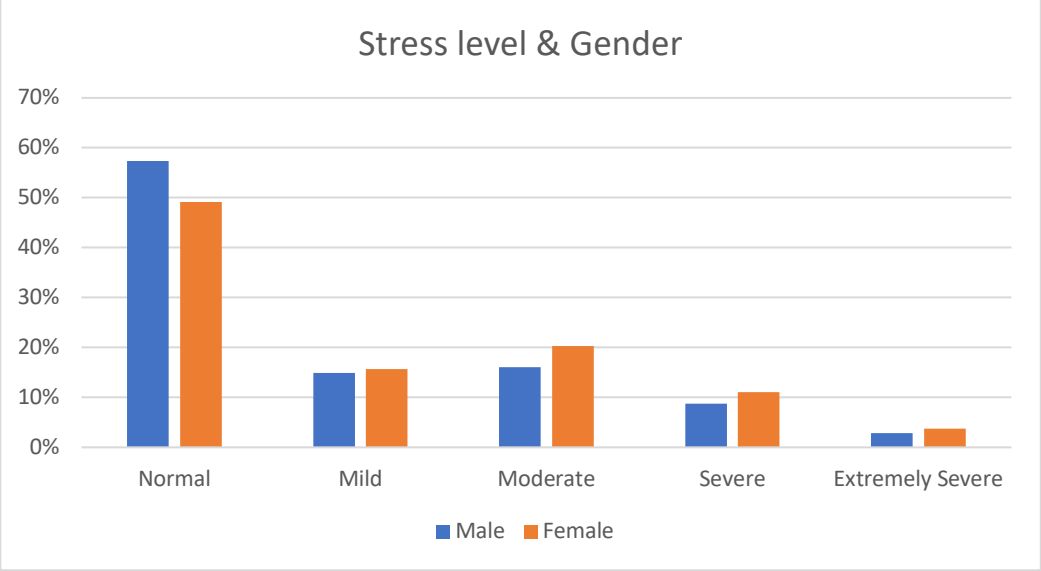
It was found that female students were more depressed than male students as the percentage of female students with severe and extremely severe depression was higher than that of male students at higher education level in West Bengal.

Figure 4.12
Bar diagram comparing anxiety level by gender



It was found that female students were suffering from anxiety more than male students as the percentage of female students with extremely severe anxiety was higher than that of their male counterpart.

Figure 4.13
Bar diagram comparing stress level by gender



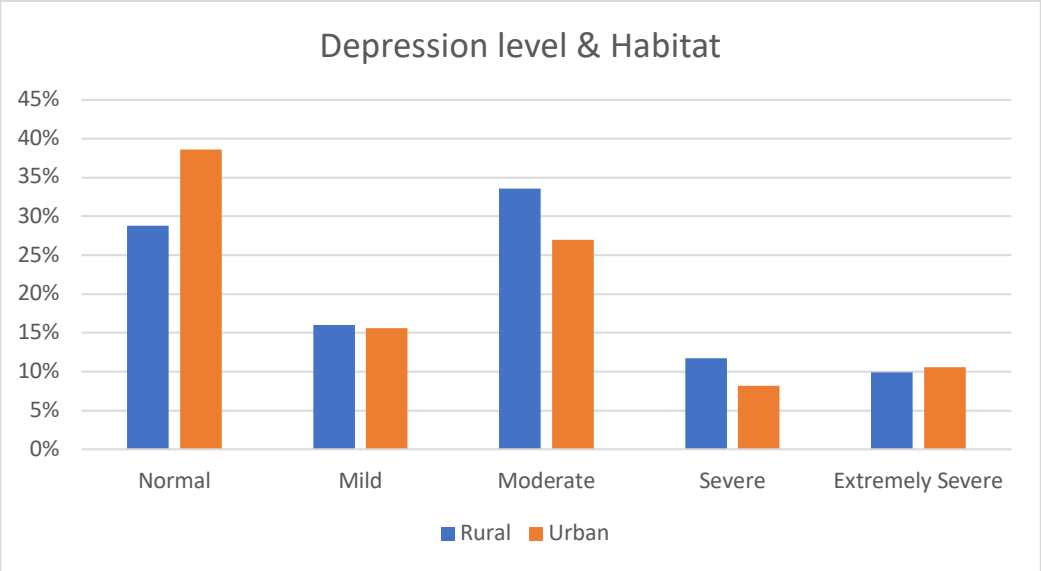
It was also found that female students were more stressed than male students as the percentage of female students with moderate, severe and extremely severe stress level was higher than that of their male counterpart.

Habitat and Depression, Anxiety, Stress

Table 4.12
Comparing levels of depression, anxiety and stress by habitat

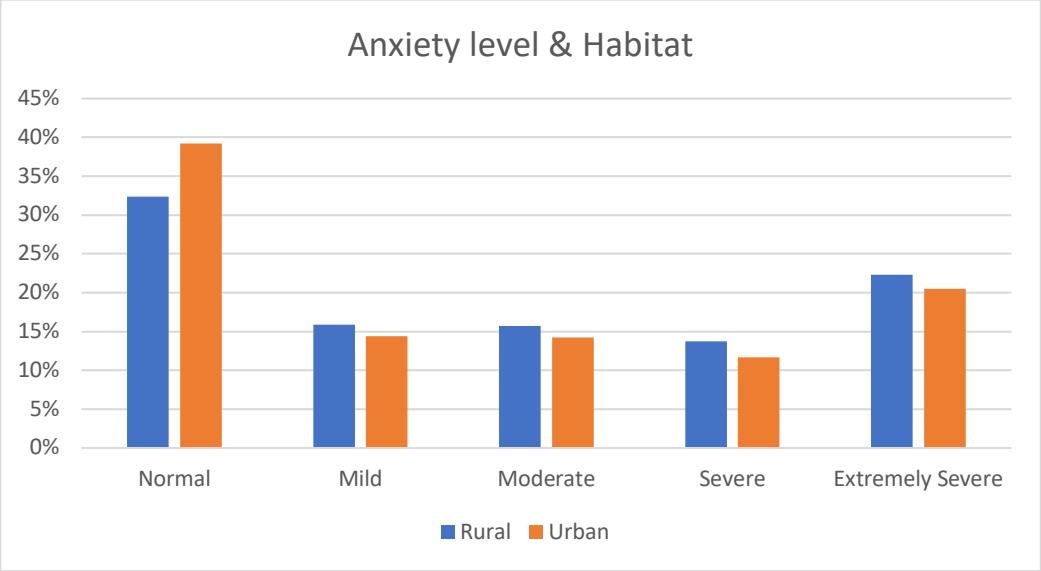
Levels	Dimensions	Habitat	
		Rural	Urban
Normal	*Depression*	446 (28.8%)	255 (38.6%)
	Anxiety	502 (32.4%)	259 (39.2%)
	Stress	773 (49.9%)	362 (54.8%)
Mild	*Depression*	258(16%)	103 (15.6%)
	Anxiety	246 (15.9%)	95 (14.4%)
	Stress	246 (15.9%)	96 (14.5%)
Moderate	*Depression*	520 (33.6%)	178 (27%)
	Anxiety	243 (15.7%)	94 (14.2%)
	Stress	317 (20.5%)	108 (16.4%)
Severe	*Depression*	182(11.7%)	54 (8.2%)
	Anxiety	213 (13.7%)	77 (11.7%)
	Stress	164 (10.6%)	65 (9.8%)
Extremely Severe	*Depression*	153 (9.9%)	70 (10.6%)
	Anxiety	346 (22.3%)	135 (20.5%)
	Stress	50 (3.2%)	29 (4.4%)

Figure 4.14
Bar diagram comparing depression level by habitat



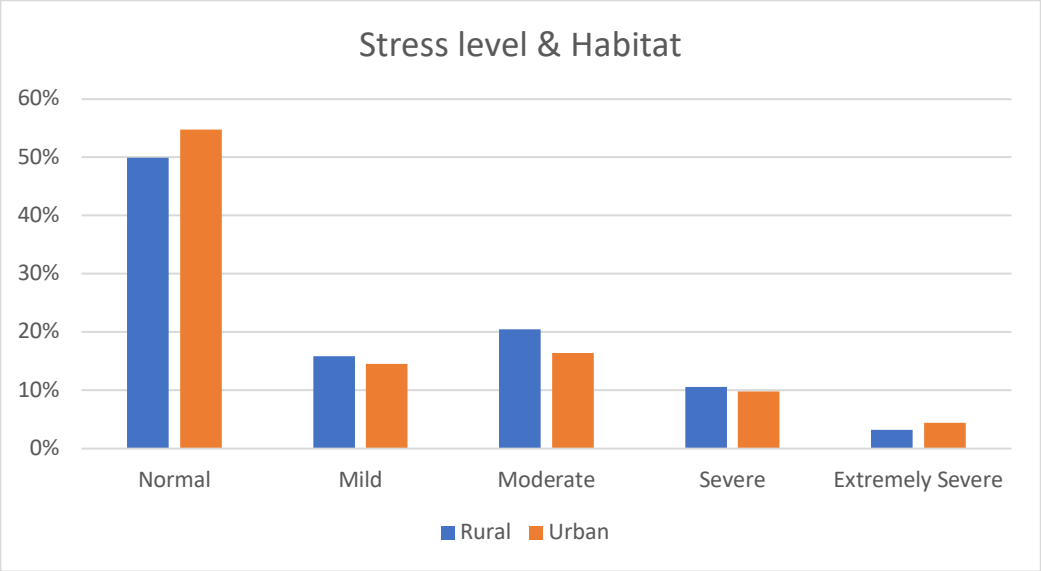
It was found that students from rural areas were overall more depressed than urban areas' students as the percentage of rural students with moderate and severe depression was higher than that of urban areas' students. Students from urban areas comparatively more suffered from extremely severe depression than that of rural areas.

Figure 4.15
Bar diagram comparing anxiety level by habitat



It was found that students from rural areas suffered from more anxiety than urban areas' students as the percentage of rural students with severe and extremely severe level of anxiety was higher than their urban counterparts.

Figure 4.16
Bar diagram comparing stress level by habitat



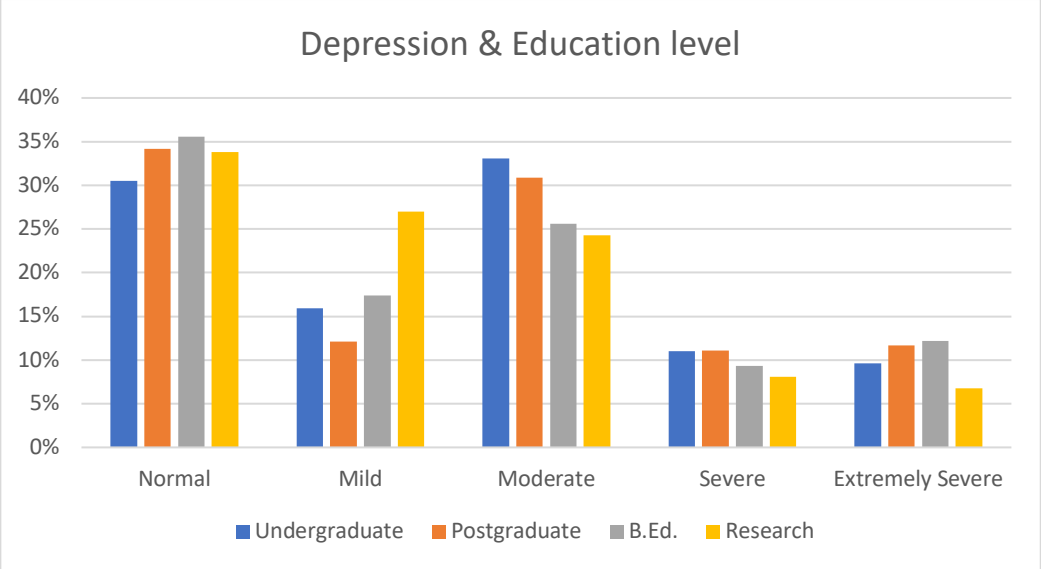
Although, it was found that urban areas' students were suffering from extremely severe stress more than students from rural areas, but the overall stress was higher among rural areas' students.

Education level and Depression, Anxiety, Stress

Table 4.13
Comparing levels of depression, anxiety and stress by education level

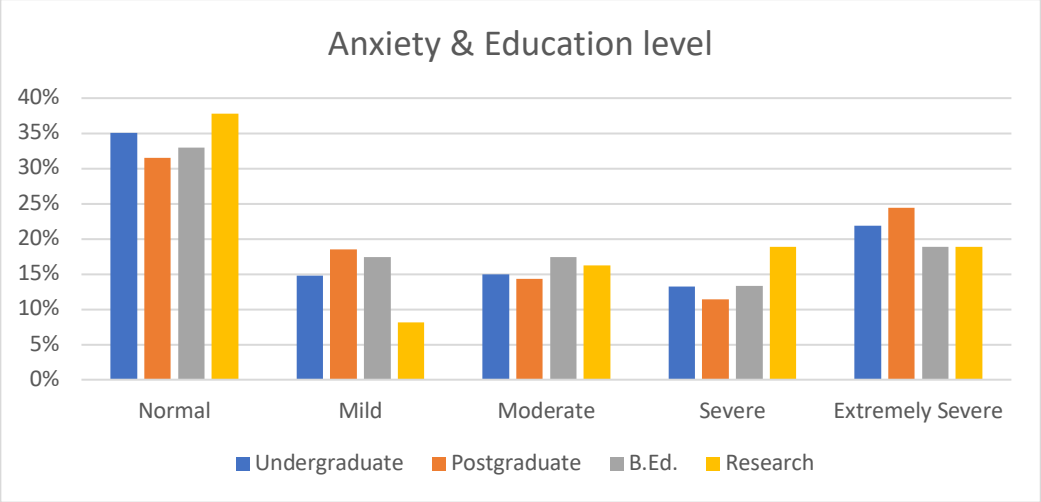
Levels	Dimensions	Education level			
		Undergraduate	**Postgraduate**	**B.Ed.**	**Research**
Normal	*Depression*	475 (30.5%)	105 (34.2%)	96 (35.6%)	25 (33.8%)
	Anxiety	547 (35.1%)	97 (31.5%)	89 (33%)	28 (37.8%)
	Stress	815 (52.3%)	146 (47.4%)	139 (51.5%)	35 (47.3%)
Mild	*Depression*	247 (15.9%)	37 (12.1%)	47 (17.4%)	20 (27%)
	Anxiety	231 (14.8%)	57 (18.5%)	47 (17.4%)	6 (8.1%)
	Stress	230 (14.8%)	50 (16.2%)	49 (18.1%)	13 (17.6%)
Moderate	*Depression*	516 (33.1%)	95 (30.9%)	69 (25.6%)	18 (24.3%)
	Anxiety	234 (15%)	44 (14.3%)	47 (17.4%)	12 (16.2%)
	Stress	300 (19.3%)	65 (21.1%)	44 (16.3%)	16 (21.6%)
Severe	*Depression*	171 (11%)	34 (11.1%)	25 (9.3%)	6 (8.1%)
	Anxiety	205 (13.2%)	35 (11.4%)	36 (13.3%)	14 (18.9%)
	Stress	159 (10.2%)	34 (11%)	29 (10.7%)	7 (9.5%)
Extremely Severe	*Depression*	149 (9.6%)	36 (11.7%)	33 (12.2%)	5 (6.8%)
	Anxiety	341 (21.9%)	75 (24.4%)	51 (18.9%)	14 (18.9%)
	Stress	54 (3.5%)	13 (4.2%)	9 (3.3%)	3 (4.1%)

Figure 4.17
Bar diagram comparing depression by education level



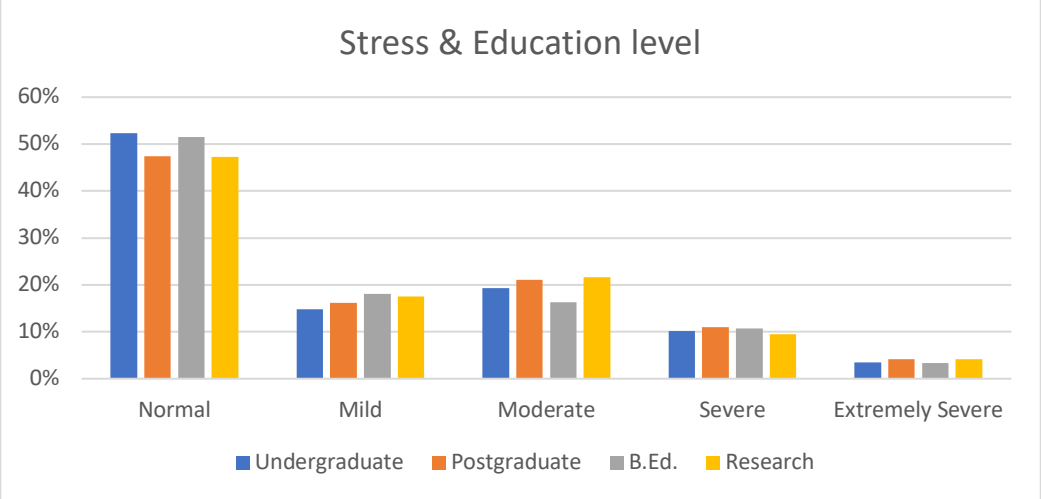
It was found that the B.Ed. students were suffering from extremely severe depression more than students pursuing other education levels. Undergraduate students were also reported to have moderate level of depression which is comparatively higher than others students.

Figure 4.18
Bar diagram comparing anxiety by education level



It was found that the postgraduate students were suffering from extremely severe anxiety more than students pursuing other education levels. Research students were also reported to have severe level of anxiety which is comparatively higher than others students.

Figure 4.19
Bar diagram comparing stress by education level



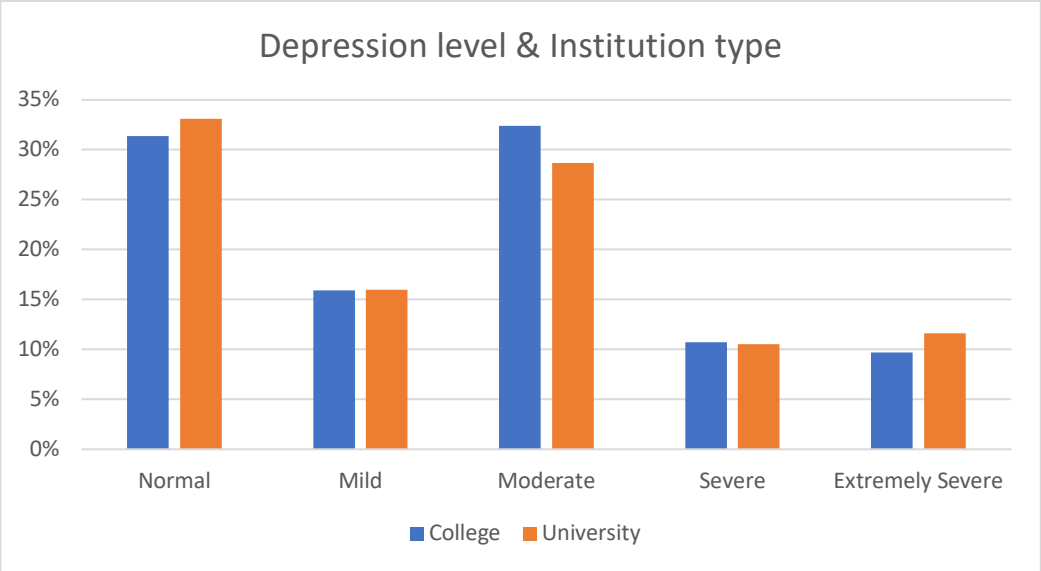
It was found that majority of the students at higher education in West Bengal possessed normal level of stress. Some variation of stress was found in severe and extremely severe level but that is not a matter of worry.

Institution type and Depression, Anxiety, Stress

Table 4.14
Comparing levels of depression, anxiety and stress by institution type

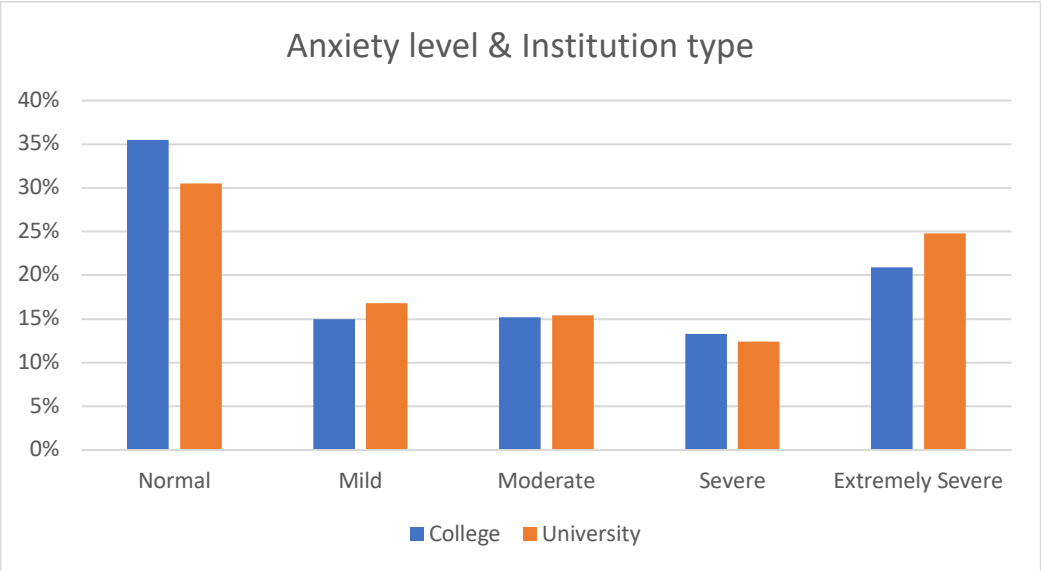
Levels	**Dimensions**	**Institution type**	
		College	**University**
Normal	*Depression*	544 (31.4%)	157 (33.1%)
	Anxiety	616 (35.5%)	145 (30.5%)
	Stress	918 (52.9%)	217 (45.7%)
Mild	*Depression*	275 (15.9%)	76 (16%)
	Anxiety	261 (15%)	80 (16.8%)
	Stress	259 (14.9%)	83 (17.5%)
Moderate	*Depression*	562 (32.4%)	136 (28.7%)
	Anxiety	264 (15.2%)	73 (15.4%)
	Stress	330 (19%)	95 (20%)
Severe	*Depression*	186 (10.7%)	50 (10.5%)
	Anxiety	231 (13.3%)	59 (12.4%)
	Stress	171 (9.9%)	58 (12.2%)
Extremely Severe	*Depression*	168 (9.7%)	55 (11.6%)
	Anxiety	363 (20.9%)	118 (24.8%)
	Stress	57 (3.3%)	22 (4.6%)

Figure 4.20
Bar diagram comparing depression level by institution type



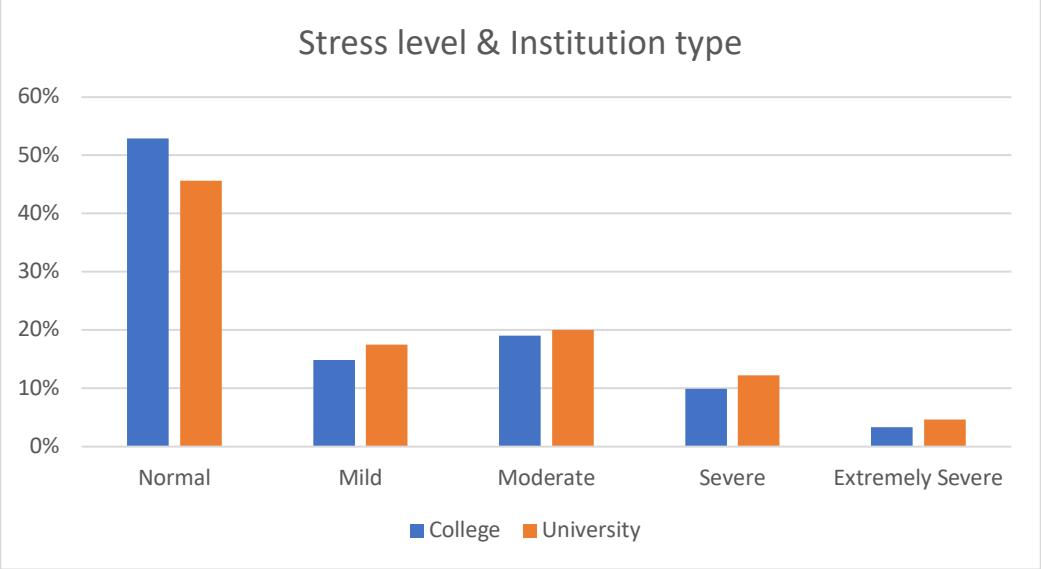
It was found that university students were more depressed than college students as the percentage of university students with extremely severe depression was higher than that of college students. Students from colleges comparatively more suffered from moderate depression than that of university students.

Figure 4.21
Bar diagram comparing anxiety level by institution type



It was found that university students were more anxious than college students as the percentage of university students with extremely severe anxiety was higher than that of college students.

Figure 4.22
Bar diagram comparing stress level by institution type



It was found that university students were more stressed than college students as the percentage of university students with mild, moderate, severe and extremely severe stress was higher than that of college students.

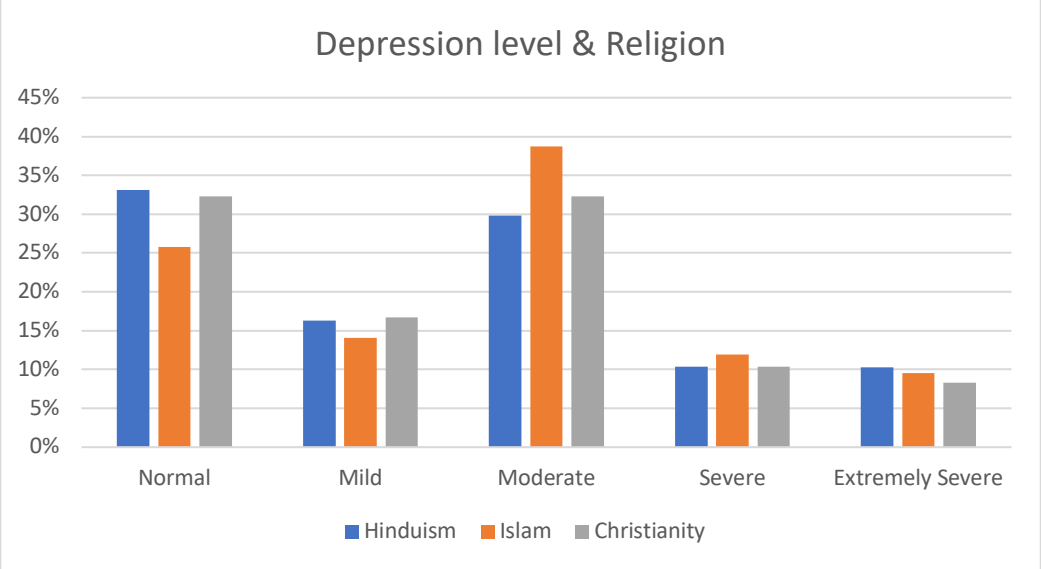
Religion and Depression, Anxiety, Stress

Table 4.15
Comparing levels of depression, anxiety and stress by religion

Levels	Dimensions	Religion		
		Hinduism	Islam	Christianity
Normal	*Depression*	564 (33.1%)	106 (25.8%)	31 (32.3%)
	Anxiety	586 (34.4%)	150 (36.5%)	25 (26%)
	Stress	873 (51.3%)	214 (52.1%)	48 (50%)
Mild	*Depression*	277 (16.3%)	58 (14.1%)	16 (16.7%)
	Anxiety	277 (16.3%)	42 (10.2%)	22 (22.9%)
	Stress	270 (15.9%)	54 (13.1%)	18 (18.8%)

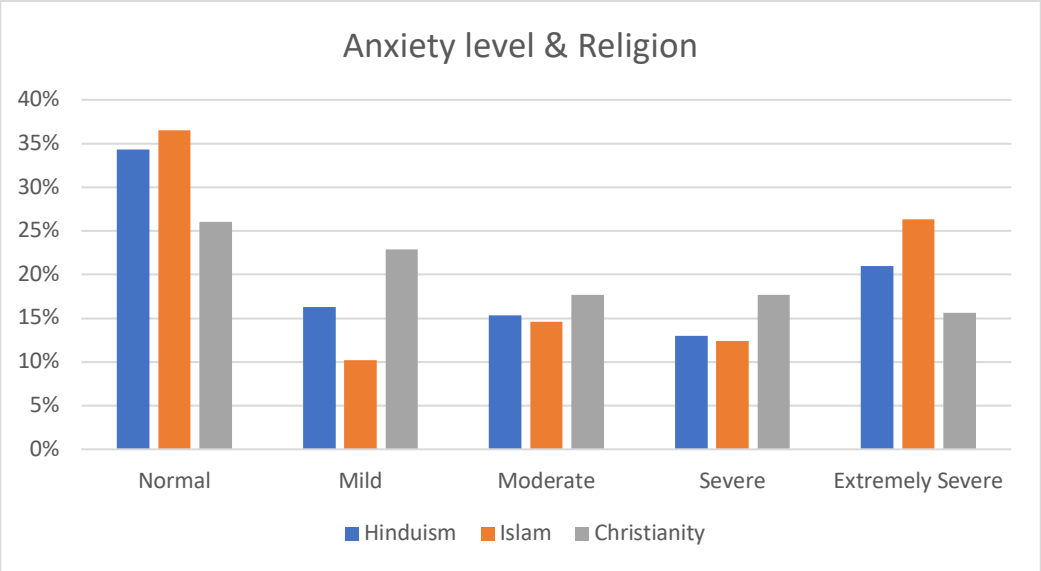
Moderate	*Depression*	508 (29.8%)	159 (38.7%)	31 (32.3%)
	Anxiety	260 (15.3%)	60 (14.6%)	17 (17.7%)
	Stress	318 (18.7%)	86 (20.9%)	21 (21.9%)
Severe	*Depression*	177 (10.4%)	49 (11.9%)	10 (10.4%)
	Anxiety	222 (13%)	51 (12.4%)	17 (17.7%)
	Stress	175 (10.3%)	47 (11.4%)	7 (7.3%)
Extremely Severe	*Depression*	176 (10.3%)	39 (9.5%)	8 (8.3%)
	Anxiety	358 (21%)	108 (26.3%)	15 (15.6%)
	Stress	67 (3.9%)	10 (2.4%)	2 (2.1%)

Figure 4.23
Bar diagram comparing depression level by religion



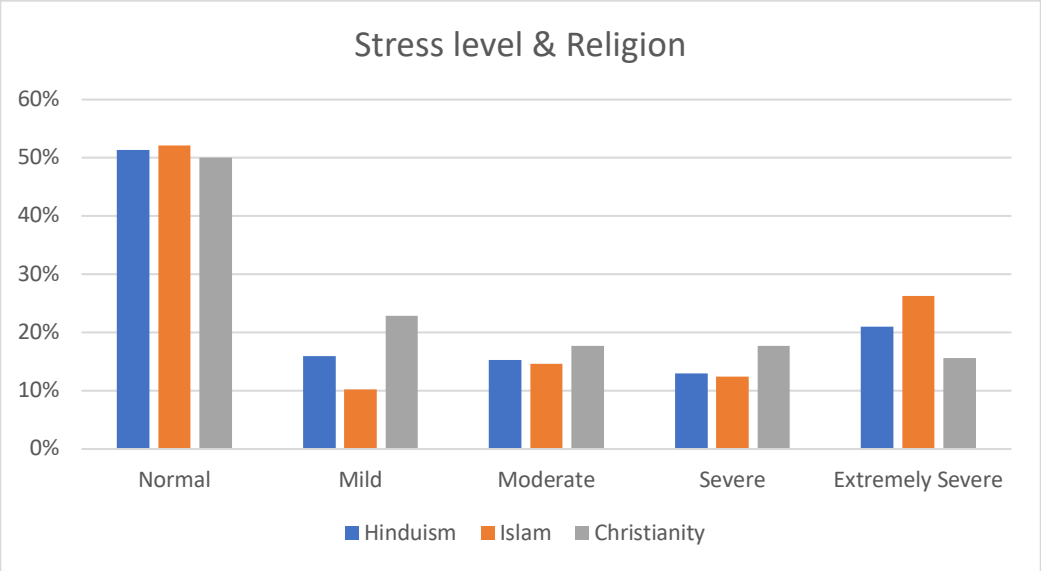
It was found that Islamic students were more depressed on average than Hindu and Christian students as the percentage of Islamic students with moderate and severe level of depression was higher than that of other students. Hindu students were most suffering from normal depression and a very small percentage of them are suffering from extremely severe depression.

Figure 4.24
Bar diagram comparing anxiety level by religion



It was found that students of Islam religion were more anxious than other students as the percentage of Islamic students with extremely severe anxiety was higher than that of students affiliating to other religions.

Figure 4.25
Bar diagram comparing stress level by religion



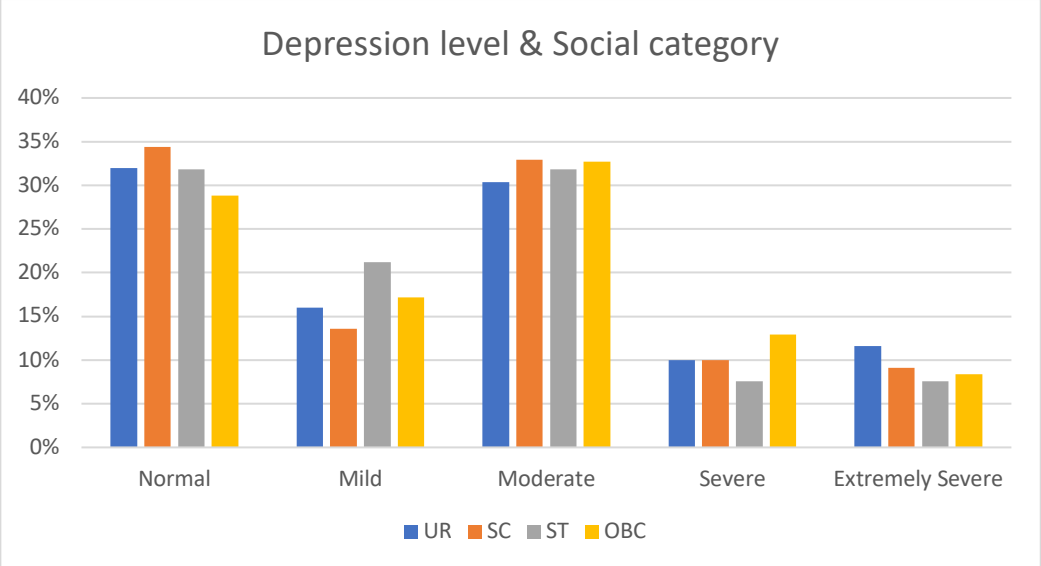
It was found that students of Islam religion were more stressed than other students as the percentage of Islamic students with extremely severe stress was higher than that of students affiliating to other religions.

Social category and Depression, Anxiety, Stress

Table 4.16
Comparing levels of depression, anxiety and stress by social category

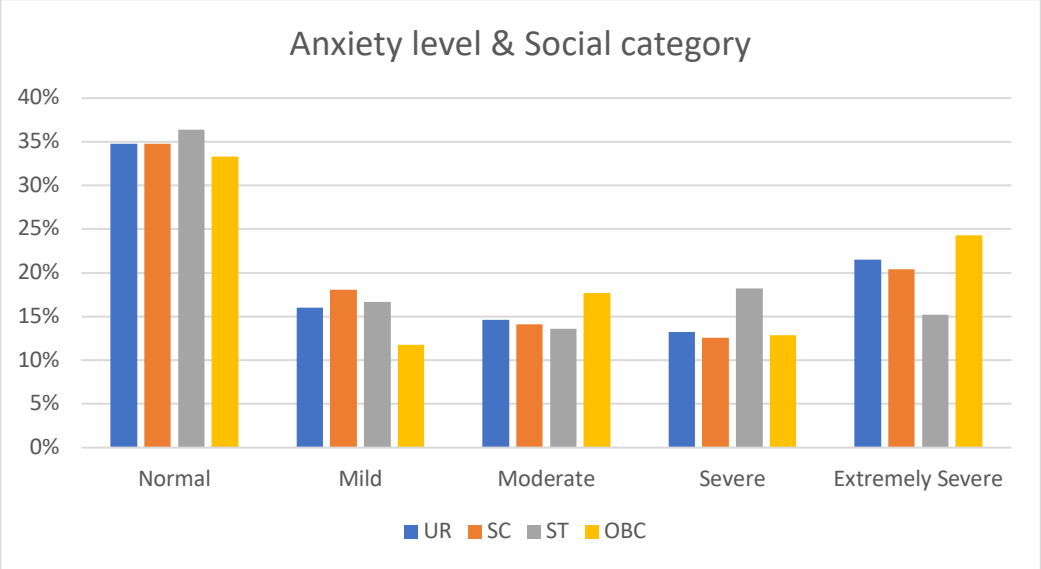
Levels	Dimensions	Social category			
		UR	SC	ST	OBC
Normal	*Depression*	344 (32%)	175 (34.4%)	21 (31.8%)	161 (28.8%)
	Anxiety	374 (34.8%)	177 (34.8%)	24 (36.4%)	186 (33.3%)
	Stress	547 (50.8%)	271 (53.2%)	37 (56.1%)	280 (50.1%)
Mild	*Depression*	172 (16%)	69 (13.6%)	14 (21.2%)	96 (17.2%)
	Anxiety	172 (16%)	92 (18.1%)	11 (16.7%)	66 (11.8%)
	Stress	161 (15%)	84 (16.5%)	12 (18.2%)	85 (15.2%)
Moderate	*Depression*	327 (30.4%)	167 (32.9%)	21 (31.8%)	183 (32.7%)
	Anxiety	157 (14.6%)	72 (14.1%)	9 (13.6%)	99 (17.7%)
	Stress	212 (19.7%)	89 (17.5%)	9 (13.6%)	115 (20.6%)
Severe	*Depression*	108 (10%)	51 (10%)	5 (7.6%)	72 (12.9%)
	Anxiety	142 (13.2%)	64 (12.6%)	12 (18.2%)	72 (12.9%)
	Stress	115 (10.7%)	47 (9.2%)	5 (7.6%)	62 (11.1%)
Extremely Severe	*Depression*	125 (11.6%)	46 (9.1%)	5 (7.6%)	47 (8.4%)
	Anxiety	231 (21.5%)	104 (20.4%)	10 (15.2%)	136 (24.3%)
	Stress	41 (3.8%)	18 (3.5%)	3 (4..5%)	17 (3%)

Figure 4.26
Bar diagram comparing depression level by social category



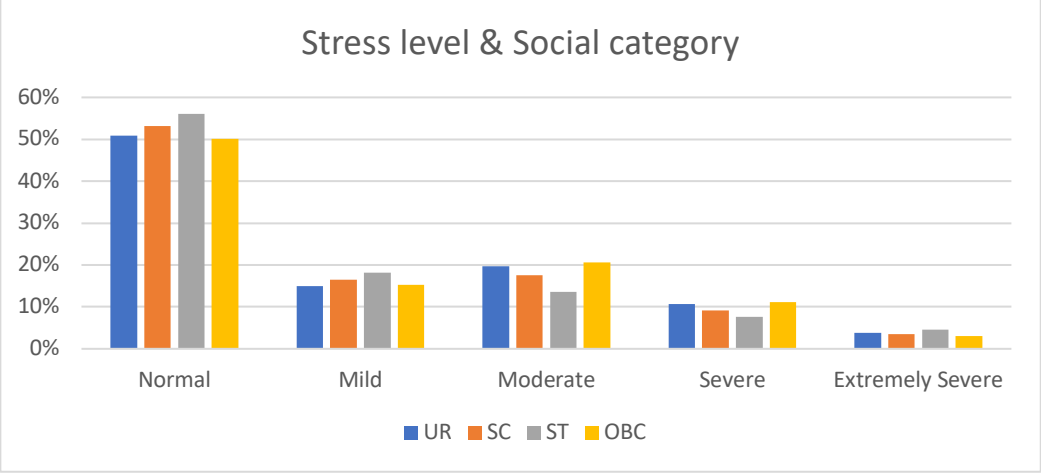
The analysis found that the depression was highest among the unreserved (UR) category students followed by scheduled caste (SC), other backward class (OBC) students. Comparatively, depression was lowest among the scheduled tribe (ST) or tribal students at higher education level in West Bengal.

Figure 4.27
Bar diagram comparing anxiety level by social category



OBC students were found to have extremely severe anxiety more than the other category students. Unlike depression level, anxiety was persistent at severe level among the scheduled tribe students.

Figure 4.28
Bar diagram comparing stress level by social category



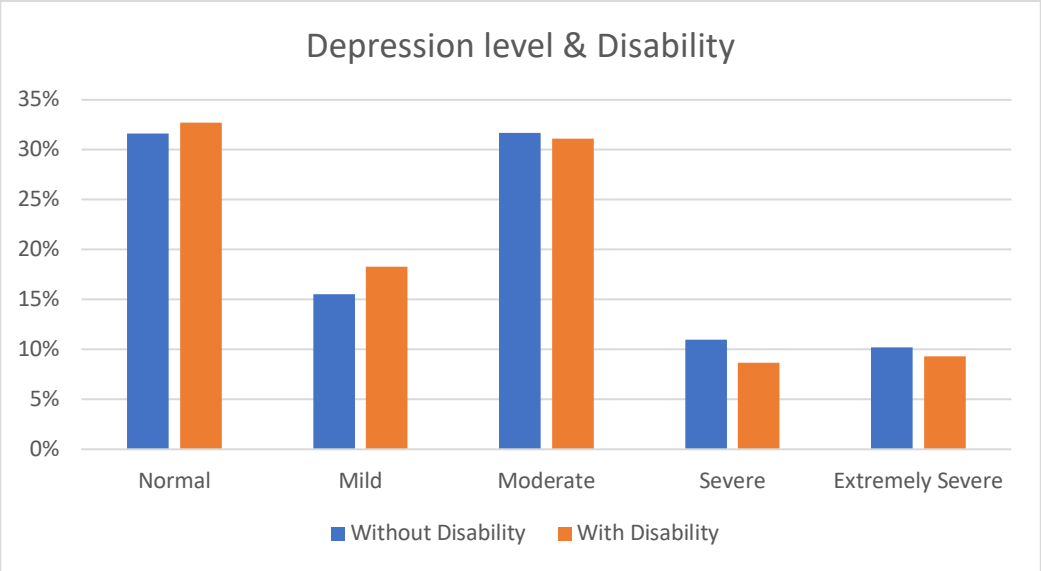
It was found that stress was not so high among the higher education students based on their social category. Although, other backward class students were reported to have some degree of severe stress, but the percentage is very little.

Disability and Depression, Anxiety, Stress

Table 4.17
Comparing levels of depression, anxiety and stress by disability

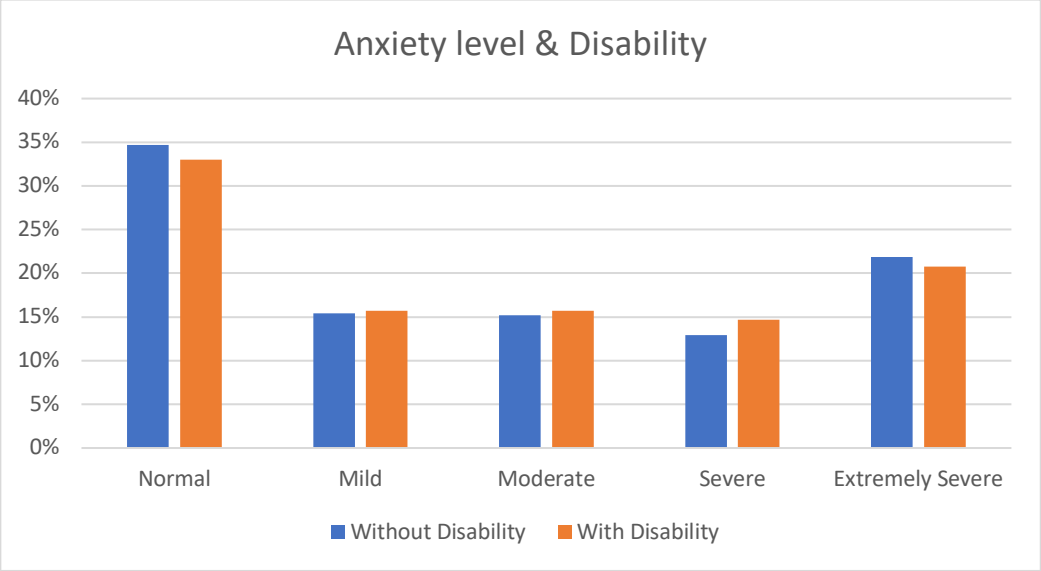
Levels	**Dimensions**	**Disability**	
		Without	**With**
Normal	*Depression*	599 (31.6%)	102 (32.7%)
	Anxiety	658 (34.7%)	103 (33%)
	Stress	973 (51.3%)	162 (51.9%)
Mild	*Depression*	294 (15.5%)	57 (18.3%)
	Anxiety	292 (15.4%)	49 (15.7%)
	Stress	291 (15.3%)	51 (16.3%)
Moderate	*Depression*	601 (31.7%)	97 (31.1%)
	Anxiety	288 (15.2%)	49 (15.7%)
	Stress	371 (19.5%)	54 (17.3%)
Severe	*Depression*	209 (11%)	27 (8.7%)
	Anxiety	244 (12.9%)	46 (14.7%)
	Stress	197 (10.4%)	32 (10.3%)
Extremely Severe	*Depression*	194 (10.2%)	29 (9.3%)
	Anxiety	416 (21.9%)	65 (20.8%)
	Stress	66 (3.5%)	13 (4.2%)

Figure 4.29
Bar diagram comparing depression level by disability



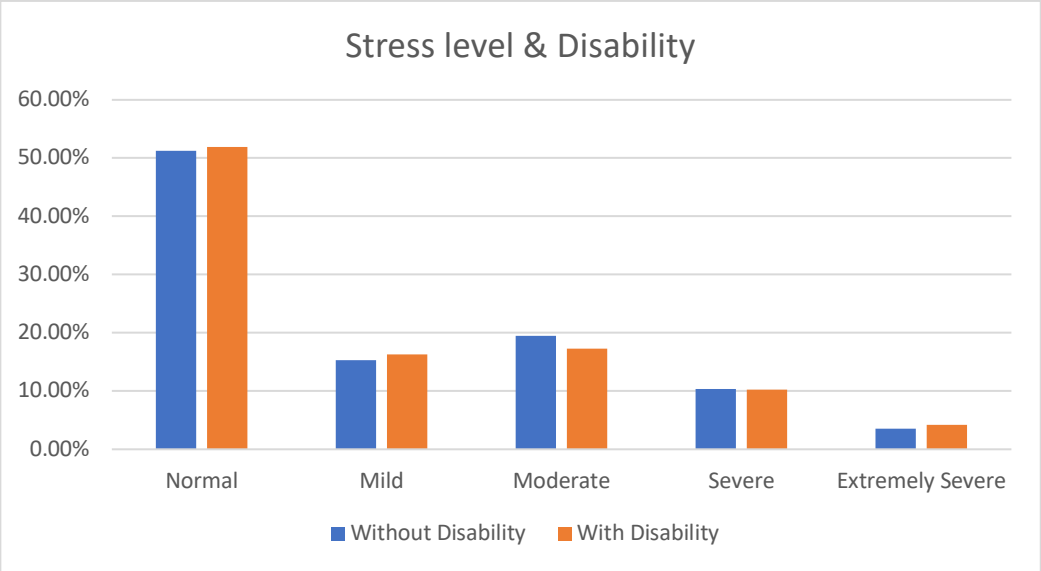
It was found that students with some kind of disability were less depressed than students without any form of disability. Although, in terms of mild level depression, disabled students reported to have it more than students without disability

Figure 4.30
Bar diagram comparing anxiety level by disability



There exists almost negligible differences in terms of anxiety level between students with and without disability at higher education in West Bengal.

Figure 4.31
Bar diagram comparing stress level by disability



It was found that in higher education, students who have some kind of disability, faced more stress compared to the students without any kind of disability.

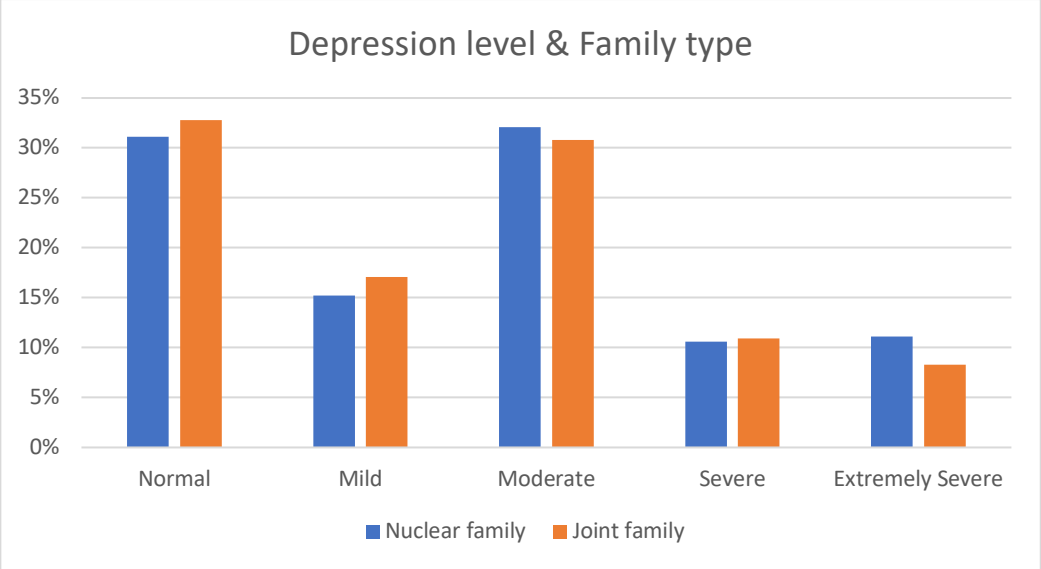
Family type and Depression, Anxiety, Stress

Table 4.18
Comparing levels of depression, anxiety and stress by family type

Levels	**Dimensions**	**Family type**	
		Nuclear family	**Joint family**
Normal	*Depression*	433 (31.1%)	268 (32.8%)
	Anxiety	476 (34.2%)	285 (34.8%)
	Stress	721 (51.8%)	414 (50.6%)
Mild	*Depression*	211 (15.2%)	140 (17.1%)
	Anxiety	215 (15.5%)	126 (15.4%)
	Stress	209 (15%)	133 (16.3%)
Moderate	*Depression*	446 (32.1%)	252 (30.8%)
	Anxiety	212 (15.2%)	125 (15.3%)
	Stress	259 (18.6%)	166 (20.3%)
Severe	*Depression*	147 (10.6%)	89 (10.9%)
	Anxiety	191 (13.7%)	99 (12.1%)

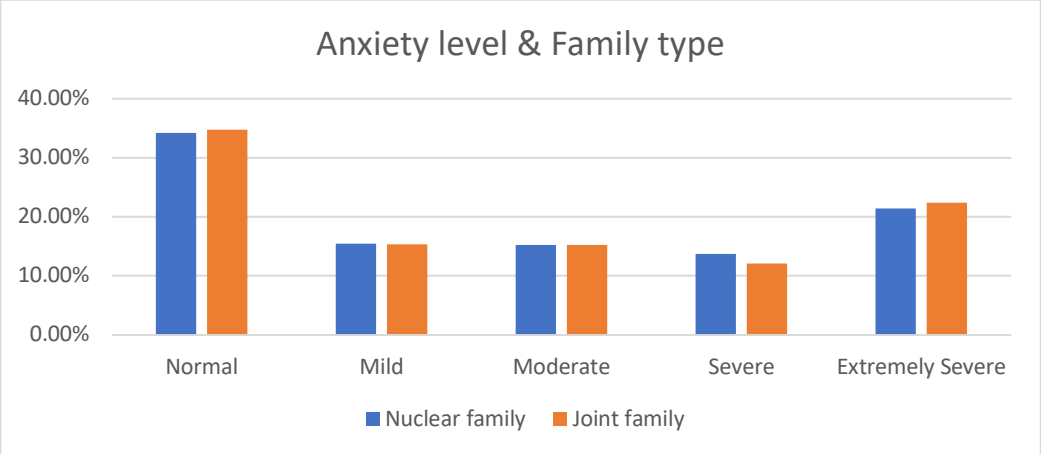
	Stress	146 (10.5%)	83 (10.1%)
Extremely Severe	*Depression*	154 (11.1%)	68 (8.3%)
	Anxiety	297 (21.4%)	183 (22.4%)
	Stress	56 (4%)	22 (2.7%)

Figure 4.32
Bar diagram comparing depression level by family type



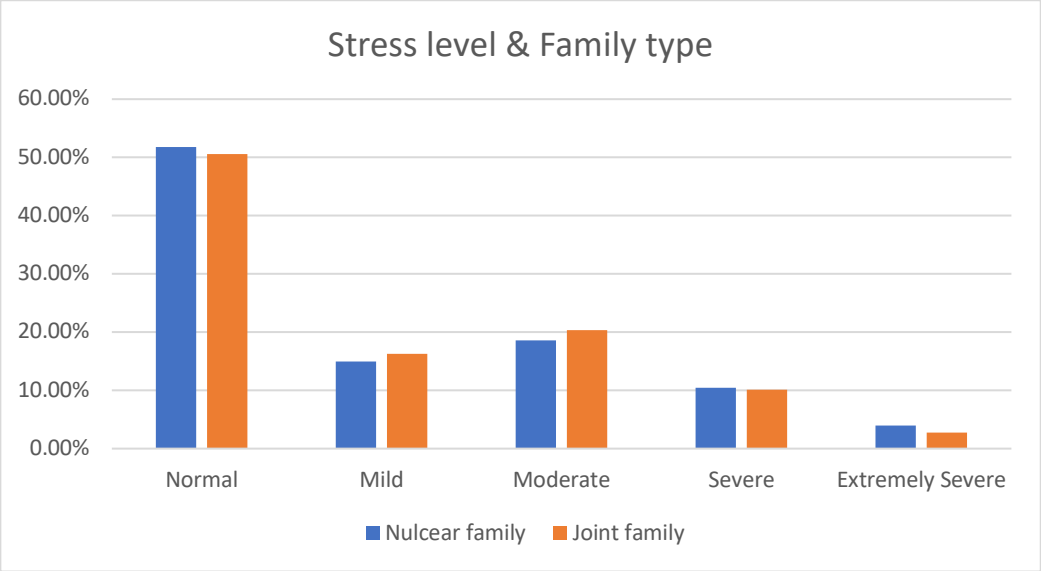
There exists moderate, severe and extremely severe level of stress among students in higher education, but when comparing them by family type they belonged to, it was found that students from nuclear families experience more depression than student from joint families.

Figure 4.33
Bar diagram comparing anxiety level by family type



There exists almost negligible differences in terms of anxiety level between students from nuclear families and students from joint families.

Figure 4.34
Bar diagram comparing stress level by family type



Although, there exists almost negligible differences in terms of stress level between students from nuclear families and students from joint families but nuclear family structure imparts comparatively more stress on students.

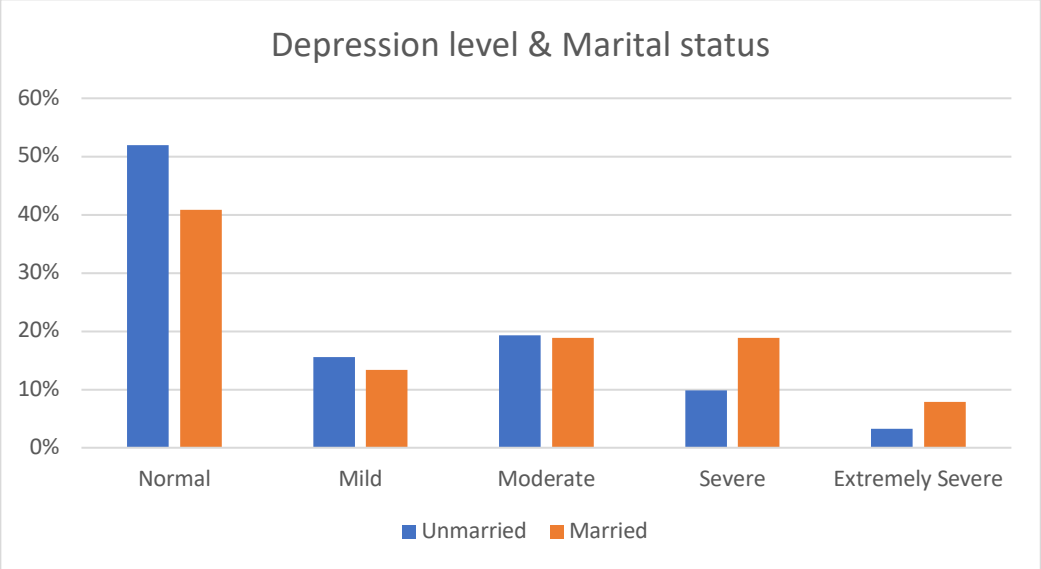
Marital status and Depression, Anxiety, Stress

Table 4.19
Comparing levels of depression, anxiety and stress by marital status

Levels	**Dimensions**	**Marital status**	
		Unmarried	**Married**
Normal	*Depression*	668 (32.1%)	33 (26%)
	Anxiety	725 (34.8%)	36 (28.3%)
	Stress	1083 (52%)	52 (40.9%)
Mild	*Depression*	326 (15.7%)	25 (19.7%)
	Anxiety	321 (15.4%)	20 (15.7%)
	Stress	325 (15.6%)	17 (13.4%)
Moderate	*Depression*	667 (32%)	31 (24.4%)

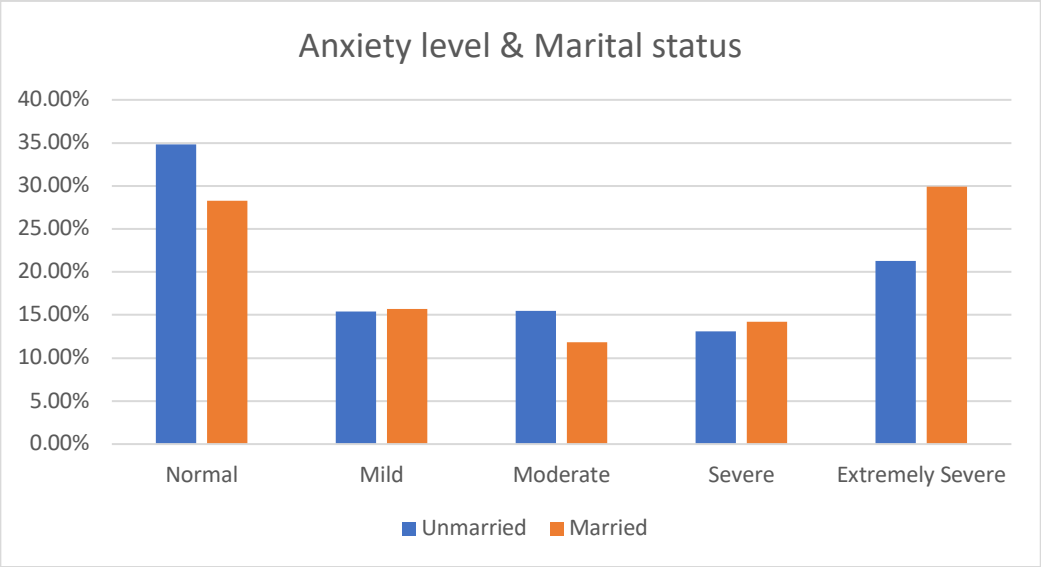
	Anxiety	322 (15.5%)	15 (11.8%)
	Stress	401 (19.3%)	24 (18.9%)
Severe	*Depression*	222 (10.7%)	14 (11%)
	Anxiety	272 (13.1%)	18 (14.2%)
	Stress	205 (9.8%)	24 (18.9%)
Extremely Severe	*Depression*	199 (9.6%)	24 (18.9%)
	Anxiety	443 (21.3%)	38 (29.9%)
	Stress	69 (3.3%)	10 (7.9%)

Figure 4.35
Bar diagram comparing depression level by marital status



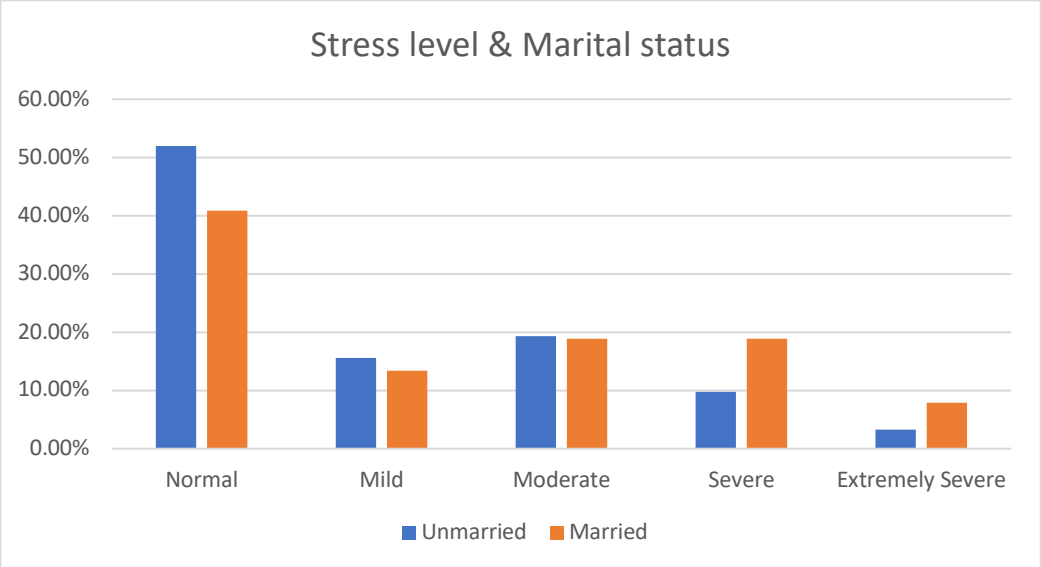
Married students were found to have more depression compared to unmarried students at higher education level in West Bengal as there exists noticeable differences in severe and extremely severe depression level.

Figure 4.36
Bar diagram comparing anxiety level by marital status



Married students were found to have more anxiety compared to unmarried students at higher education level in West Bengal as there exists noticeable differences in severe and extremely severe anxiety level.

Figure 4.37
Bar diagram comparing stress level by marital status



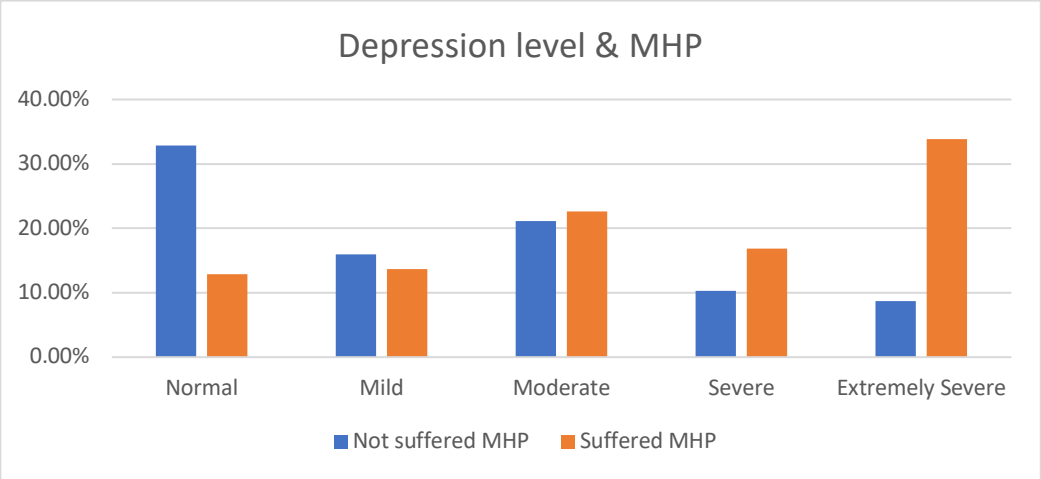
Stress was also higher among married students compared to unmarried students at higher education level in West Bengal.

History of Mental Health Problem and Depression, Anxiety, Stress

Table 4.20
Comparing levels of depression, anxiety and stress by history of mental health problem

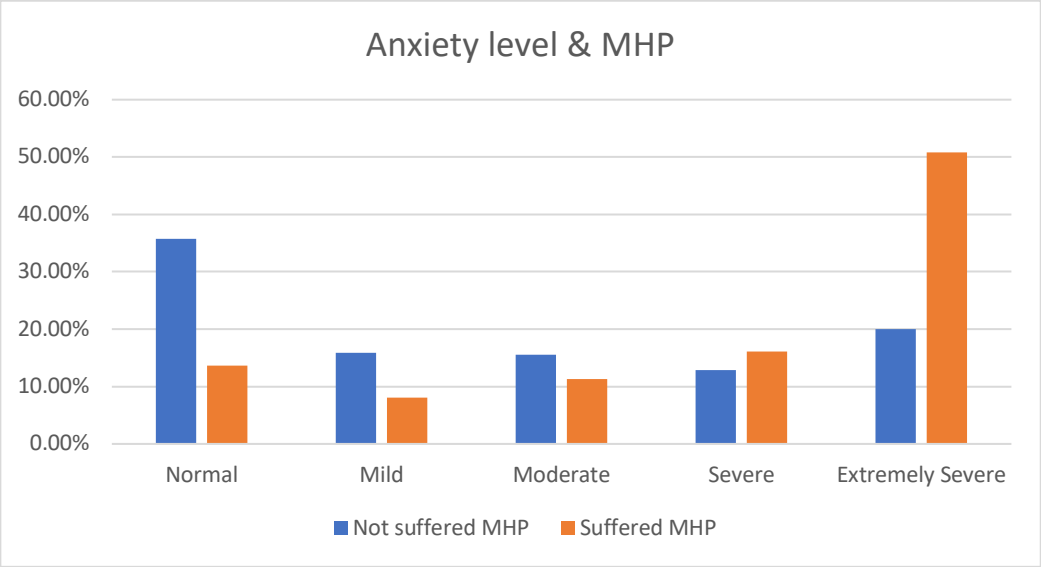
Levels	Dimensions	History of MHP	
		Not suffered	Suffered
Normal	*Depression*	685 (32.9%)	16 (12.9%)
	Anxiety	744 (35.7%)	17 (13.7%)
	Stress	1112 (53.3%)	23 (18.5%)
Mild	*Depression*	334 (16%)	17 (13.7%)
	Anxiety	331 (15.9%)	10 (8.1%)
	Stress	322 (15.4%)	20 (16.1%)
Moderate	*Depression*	670 (32.1%)	28 (22.6%)
	Anxiety	323 (15.5%)	14 (11.3%)
	Stress	395 (18.9%)	30 (24.2%)
Severe	*Depression*	215 (10.3%)	21 (16.9%)
	Anxiety	270 (12.9%)	20 (16.1%)
	Stress	197 (9.4%)	32 (25.8%)
Extremely Severe	*Depression*	181 (8.7%)	42 (33.9%)
	Anxiety	418 (20%)	63 (50.8%)
	Stress	60 (2.9%)	19 (15.3%)

Figure 4.38
Bar diagram comparing depression level by history of mental health problem



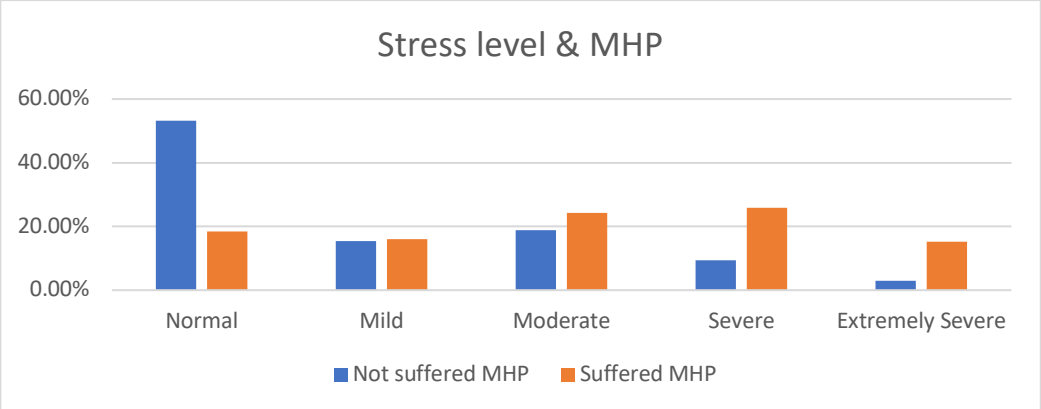
Students who have suffered from mental health problem in past, have reported higher level of depression compared to students who have not suffered the same. The major difference was found in extremely severe depression level. In this study, those students who have not suffered from any kind of mental health problem in the past, have reported mostly normal level of depression which is not so alarming.

Figure 4.39
Bar diagram comparing anxiety level by history of mental health problem



Again, students who have previously suffered from mental health problem were found to have more (severe and extremely severe) anxiety compared to their counterpart.

Figure 4.40
Bar diagram comparing stress level by history of mental health problem



Stress was also higher (severe and extremely severe) among students who have previously suffered from mental health problem compared to students who have not suffered mental health problem.

4.1.3 Correlations between dimensions of RAS and dimensions of DASS

Pearson product moment correlations was computed for each pair of dimensions of Religious Activities Scale (RAS) and Depression Anxiety Stress Scale (DASS) by taking their raw scores to see if there is any association or relationship in between two in the entire sample as well as each levels of the explanatory variables.

Entire sample: correlation between dimensions of RAS and dimensions of DASS

Table 4.21
Correlation between dimensions of RAS and dimensions of DASS in entire sample

Entire sample			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.07	-.08	-.12
Moral Imperative	-.07	-.06	-.10
Religious Solidarity	-.09	-.03	-.10

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the entire sample of this study. It was found that depression was negatively correlated with acceptance belief (r=.-07), moral imperative (r= -.07) as well as religious solidarity (r= -.09).

Similarly, Anxiety and Stress were also negatively correlated with subscales of the religious activities scale (RAS) as found in the study. Therefore, it can be said that the practice of religious activities was associated with reduced depression, anxiety and stress.

Male students: correlation between dimensions of RAS and dimensions of DASS

Table 4.22
Correlation between dimensions of RAS and dimensions of DASS in male students

Gender: Male			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.03	-.081	-.135
Moral Imperative	-.09	-.104	-.147
Religious Solidarity	-.132	-.092	-.160

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the male participants of the sample. It was found that the stress of male participants was most negatively correlated with religious solidarity (r=.-160), moral imperative (r= -.147) as well as acceptance belief (r= -.135).

Similarly, depression and anxiety were also found to have a negative association with acceptance belief, moral imperative and religious solidarity.

Female students: correlation between dimensions of RAS and dimensions of DASS

Table 4.23
Correlation between dimensions of RAS and dimensions of DASS in female students

Gender: Female			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.088	-.09	-.10
Moral Imperative	-.05	-.03	-.07
Religious Solidarity	-.066	-.006	-.06

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually

for the female participants of the sample. It was found that the stress of female participants was most negatively correlated with acceptance belief (r=.-10), moral imperative (r= -.07) as well as religious solidarity (r= -.06).

Similarly, depression and anxiety were also found to have a negative association with acceptance belief, moral imperative and religious solidarity.

Urban students: correlation between dimensions of RAS and dimensions of DASS

Table 4.24
Correlation between dimensions of RAS and dimensions of DASS in urban students

Habitat: Urban			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.135	-.069	-.093
Moral Imperative	-.151	-.019	-.150
Religious Solidarity	-.162	-.060	-.120

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the urban participants of the sample. It was found that the depression of urban participants was most negatively correlated with religious solidarity (r=.-162), moral imperative (r= -.151) as well as acceptance belief (r= -.135).

Similarly, stress was also found to have a negative association with acceptance belief (-.093), moral imperative (-.15) and religious solidarity (-.12).

Rural students: correlation between dimensions of RAS and dimensions of DASS

Table 4.25
Correlation between dimensions of RAS and dimensions of DASS in rural students

Habitat: Rural			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.058	-.109	-.136
Moral Imperative	-.042	-.046	-.085
Religious Solidarity	-.060	-.023	-.096

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the urban participants of the sample. It was found that the stress of rural participants was most negatively correlated with acceptance belief (r=.-136) followed by religious solidarity (r= -.096) and moral imperative (r= -.085).

Similarly, anxiety and depression was also found to have a negative association with acceptance belief, moral imperative, and religious solidarity.

Undergraduate students: correlation between dimensions of RAS and dimensions of DASS

Table 4.26
Correlation between dimensions of RAS and dimensions of DASS in undergraduate students

Education level: Undergraduate			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.088	-.119	-.148
Moral Imperative	-.093	-.092	-.147
Religious Solidarity	-.105	-.032	-.117

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance

belief, moral imperative and religious solidarity measured using RAS individually for the undergraduate participants of the sample. It was found that the stress of undergraduate participants was most negatively correlated with acceptance belief (r=.-148) followed by moral imperative (r= -.147) and religious solidarity (r= -.117).

Similarly, anxiety and depression was also found to have a negative association with acceptance belief, moral imperative, and religious solidarity.

Postgraduate students: correlation between dimensions of RAS and dimensions of DASS

Table 4.27
Correlation between dimensions of RAS and dimensions of DASS in postgraduate students

Education level: Postgraduate			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.041	-.012	-.036
Moral Imperative	-.045	.005	-.016
Religious Solidarity	-.043	-.003	-.054

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the postgraduate participants of the sample. It was found that the depression of postgraduate participants was most negatively correlated with moral imperative (r=.-045) followed by religious solidarity (r= -.043) and acceptance belief (r= -.041).

Similarly, anxiety and stress was also found to have a negative association with acceptance belief, moral imperative, and religious solidarity.

B.Ed. students: correlation between dimensions of RAS and dimensions of DASS

Table 4.28
Correlation between dimensions of RAS and dimensions of DASS in B.Ed. students

Education level: B.Ed.			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.111	-.028	-.042
Moral Imperative	-.027	-.003	-.014
Religious Solidarity	-.117	-.071	-.013

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the B.Ed. participants of the sample. It was found that the depression of B.Ed. students was most negatively correlated with religious solidarity (r=.-117) followed by acceptance belief (r= -.111) and moral imperative (r= -.027).

Similarly, anxiety and stress was also found to have a negative association with acceptance belief, moral imperative, and religious solidarity.

Research students: correlation between dimensions of RAS and dimensions of DASS

Table 4.29
Correlation between dimensions of RAS and dimensions of DASS in Research students

Education level: Research			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.039	-.0142	-.095
Moral Imperative	.028	.057	.050
Religious Solidarity	-.007	-.019	-.070

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the students pursuing research degree. It was found that the stress of research

students was most negatively correlated with acceptance belief (r=.095) followed by religious solidarity (r= -.07). Moral imperative was found to have a very weak positive correlation with stress (r=.05).

Similarly, depression and anxiety was also found to have a negative association with acceptance belief and religious solidarity.

College students: correlation between dimensions of RAS and dimensions of DASS

Table 4.30
Correlation between dimensions of RAS and dimensions of DASS in College students

Institution type: College			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.082*	-.098*	-.123*
Moral Imperative	-.086*	-.091*	-.137*
Religious Solidarity	-.103*	-.037	-.112*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the college students of the sample. It was found that the stress of college going students was most negatively correlated with moral imperative (r= -.137) followed by acceptance belief (r= -.123) and religious solidarity (r= -.112).

Anxiety and depression was also found to have a negative association with acceptance belief, moral imperative, and religious solidarity.

University students: correlation between dimensions of RAS and dimensions of DASS

Table 4.31
Correlation between dimensions of RAS and dimensions of DASS in University students

Institution type: University			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.068	-.032	-.051
Moral Imperative	-.026	.053	.045
Religious Solidarity	-.062	-.002	-.040

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the university students of the sample. It was found that the depression of university students was most negatively correlated with acceptance belief (r= -.068) followed by religious solidarity (r= -.062) and moral imperative (r= -.026).

Anxiety and stress was also found to have a negative association with acceptance belief and religious solidarity and positive association with moral imperative.

Hindu students: correlation between dimensions of RAS and dimensions of DASS

Table 4.32
Correlation between dimensions of RAS and dimensions of DASS in Hindu students

Religion: Hinduism			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.074	-.074*	-.102*
Moral Imperative	.077*	.070*	.110*
Religious Solidarity	-.097*	-.047	-.107*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually

for the Hindu students of the sample. It was found that the stress of Hindu students was most negatively correlated with acceptance belief (r= -.102) followed by religious solidarity (r= -.107) where moral imperative has a positive correlation (r=.110).

Depression and anxiety was also found to have a negative association with acceptance belief and religious solidarity and positive association with moral imperative.

Islamic students: correlation between dimensions of RAS and dimensions of DASS

Table 4.33
Correlation between dimensions of RAS and dimensions of DASS in Islamic students

Religion: Islam			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.106*	-.251*	-.227*
Moral Imperative	-.109*	-.122*	-.091
Religious Solidarity	-.029	.033	-.038

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the Islamic students of the sample. It was found that the anxiety of Islamic students was most negative but weakly correlated with acceptance belief (r= -.251) followed by moral imperative (r= -.122) where religious solidarity has a very weak positive correlation (r=.033).

Depression and stress was also found to have a negative association with acceptance belief and moral imperative and positive association with religious solidarity.

Unreserved category students: correlation between dimensions of RAS and dimensions of DASS

Table 4.34
Correlation between dimensions of RAS and dimensions of DASS in Unreserved category students

Social category: Unreserved			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.106*	-.075*	-.130*
Moral Imperative	-.071*	-.026	-.111*
Religious Solidarity	-.109*	-.039	-.126*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the unreserved category students of the sample. It was found that the stress of unreserved category students was most negative but very weakly correlated with acceptance belief (r= -.13) followed by religious solidarity (r= -.126) and moral imperative (r= -.11).

Depression and anxiety was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Scheduled caste category students: correlation between dimensions of RAS and dimensions of DASS

Table 4.35
Correlation between dimensions of RAS and dimensions of DASS in Scheduled caste category students

Social category: Scheduled caste			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.082	-.132*	-.113*
Moral Imperative	-.107*	-.174*	-.191*
Religious Solidarity	-.132*	-.100*	-.144*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the scheduled caste category students of the sample. It was found that the stress of scheduled caste category students was most negative but very weakly correlated with moral imperative (r= -.191) followed by religious solidarity (r= -.144) and acceptance belief (r= -.113).

Depression and anxiety was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Scheduled tribe category students: correlation between dimensions of RAS and dimensions of DASS

Table 4.36
Correlation between dimensions of RAS and dimensions of DASS in Scheduled tribe category students

Social category: Scheduled tribe			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.052	-.029	-.045
Moral Imperative	-.143	-.117	-.120
Religious Solidarity	-.125	-.167	-.192

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the scheduled caste category students of the sample. It was found that the stress of scheduled caste category students was most negative but very weakly correlated with religious solidarity (r= -.192) followed by moral imperative (r= -.120) and acceptance belief (r= -.045).

Depression and anxiety was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Other backward class students: correlation between dimensions of RAS and dimensions of DASS

Table 4.37
Correlation between dimensions of RAS and dimensions of DASS in Other backward class students

Social category: Other backward class			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.032	-.094*	-.106*
Moral Imperative	-.056	-.059	-.040
Religious Solidarity	-.025	.045	-.013

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the other backward class students of the sample. It was found that the stress of other backward class students was most negative but very weakly correlated with acceptance belief (r= -.106) followed by moral imperative (r= -.40) and religious solidarity (r= -.013).

Depression and anxiety was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Students without disability: correlation between dimensions of RAS and dimensions of DASS

Table 4.38
Correlation between dimensions of RAS and dimensions of DASS in students without disability

Disability: Students without disability			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.073*	-.089*	-.116*
Moral Imperative	-.064*	-.051*	-.094*
Religious Solidarity	-.078*	-.022	-.088*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the students without disability. It was found that the stress of students without disability was most negative but very weakly correlated with acceptance belief (r= -.116) followed by moral imperative (r= -.094) and religious solidarity (r= -.088).

Depression and anxiety was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Students with disability: correlation between dimensions of RAS and dimensions of DASS

Table 4.39
Correlation between dimensions of RAS and dimensions of DASS in students with disability

Disability: Students with disability			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.093	-.085	-.110
Moral Imperative	-.107	-.131*	-.154*
Religious Solidarity	-.176*	-.108	-.186*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the differently abled students in the sample. It was found that the stress of differently abled students was most negative but very weakly correlated with religious solidarity (r= -.186) followed by moral imperative (r= -.154) and acceptance belief (r= -.110).

Depression and anxiety was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Students from nuclear families: correlation between dimensions of RAS and dimensions of DASS

Table 4.40
Correlation between dimensions of RAS and dimensions of DASS in students from nuclear families

Family type: Nuclear			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.062*	-.084*	-.107*
Moral Imperative	-.050	-.146	-.095*
Religious Solidarity	-.078*	-.017	-.083*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the students from nuclear families. It was found that the anxiety of students from nuclear families was most negative but very weakly correlated with moral imperative (r= -.146) followed by acceptance belief (r= -.084) and religious solidarity (r= -.017).

Depression and stress was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Students from joint families: correlation between dimensions of RAS and dimensions of DASS

Table 4.41
Correlation between dimensions of RAS and dimensions of DASS in students from joint families

Family type: Joint			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.103*	-.094*	-.129*
Moral Imperative	-.099*	-.080*	-.111*
Religious Solidarity	-.110*	-.156	-.132*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the students from joint families. It was found that the anxiety of students from joint families was most negative but very weakly correlated with religious solidarity (r= -.156) followed by acceptance belief (r= -.094) and moral imperative (r= -.080).

Depression and stress was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Unmarried students: correlation between dimensions of RAS and dimensions of DASS

Table 4.42
Correlation between dimensions of RAS and dimensions of DASS in unmarried students

Marital status: Unmarried			
	Depression	Anxiety	Stress
Acceptance Belief	-.081*	-.089*	-.122*
Moral Imperative	-.076*	-.062*	-.106*
Religious Solidarity	-.093*	-.030	-.103*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the unmarried students. It was found that the stress of students was most negative but very weakly correlated with acceptance belief (r= -.122) followed by moral imperative (r= -.106) and religious solidarity (r= -.103).

Depression and anxiety was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Married students: correlation between dimensions of RAS and dimensions of DASS

Table 4.43
Correlation between dimensions of RAS and dimensions of DASS in married students

Marital status: Married			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.038	-.098	-.059
Moral Imperative	-.007	-.049	-.055
Religious Solidarity	-.080	-.082	-.094

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the married students. It was found that the anxiety of married students was most negative but very weakly correlated with acceptance belief (r= -.098) followed by religious solidarity (r= -.082) and moral imperative (r= -.049).

Depression and stress was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Students previously not suffered from mental health problem: correlation between dimensions of RAS and dimensions of DASS

Table 4.44
Correlation between dimensions of RAS and dimensions of DASS in students previously not suffered from mental health problem

History of mental health problem: Not suffered			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.045*	-.052*	-.080*
Moral Imperative	-.053*	-.039	-.085*
Religious Solidarity	-.074*	-.009	-.081*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance

belief, moral imperative and religious solidarity measured using RAS individually for the students previously not suffered from mental health problem. It was found that the stress of students previously not suffered from mental health problem was most negative but very weakly correlated with moral imperative (r= -.085) followed by religious solidarity (r= -.081) and acceptance belief (r= -.080).

Depression and anxiety was also found to have a very weak negative association with acceptance belief, moral imperative and religious solidarity.

Students previously suffered from mental health problem: correlation between dimensions of RAS and dimensions of DASS

Table 4.45
Correlation between dimensions of RAS and dimensions of DASS in students previously suffered from mental health problem

History of mental health problem: Suffered			
	Depression	**Anxiety**	**Stress**
Acceptance Belief	-.216*	-.236*	-.271*
Moral Imperative	-.167	-.179*	-.170
Religious Solidarity	-.213*	-.211*	-.259*

Pearson product-moment correlation was computed by pairing the scores of Depression, Anxiety and Stress measured using DASS and Scores of Acceptance belief, moral imperative and religious solidarity measured using RAS individually for the students previously suffered from mental health problem. It was found that the stress of students previously suffered from mental health problem was most negative but weakly correlated with acceptance belief (r= -.271) followed by religious solidarity (r= -.259) and moral imperative (r= -.170).

Depression and anxiety was also found to have a weak negative association with acceptance belief, moral imperative and religious solidarity.

4.2 Inferential Statistics

Here presented a series of statistical significance test according to the order of variables presented in descriptive section. The researcher tried to find out statistical significance of interdependencies, correlations and mean difference between the levels of each independent and dependent variable pair. For testing mean difference, the researcher has computed Chi-square test of independence and One-way ANOVA as normality of the distribution is assumed.

Chi-square test of independence was computed to see if the frequencies in each dimensions of religious activities scale varies significantly within the levels of depression, anxiety and stress levels. The following tables exhibits all the results of separate Chi-square test of independence together for each of the three levels of RAS and DASS for the entire sample consisting of 2210 participants.

Table 4.46
Summary of Chi-square test of independence between dimensions of RAS and dimensions of DASS

	Depression	**Anxiety**	**Stress**
Acceptance Belief	χ^2 = 38.275, df=8, p<.01	χ^2 = 26.2, df=8, p<.01	χ^2 = 44.19, df=8, p<.01
Moral Imperative	χ^2 = 51.139, df=8, p<.01	χ^2 = 15.56, df=8, p<.05	χ^2 = 16.61, df=8, p<.05
Religious Solidarity	χ^2 = 59.213, df=8, p<.01	χ^2 = 8.71, df=8, p>.05	χ^2 = 27.342, df=8, p<.01

Details of the chi-square analysis and crosstabulation is presented in the following pages.

Table 4.47
Chi-square test of independence between depression and acceptance belief

Levels of depression		Levels of acceptance belief (AB)			Test result	Remarks
		Low	**Moderate**	**High**		
Normal	Count	72	199	430	χ^2 = 38.275, df=8, p<.01	Statistically significant relationship was found
	% within AB	34.4%	27.4%	33.8%		
Mild	Count	34	123	194		
	% within AB	16.3%	16.9%	15.2%		
Moderate	Count	46	219	433		
	% within AB	22.0%	30.2%	34.0%		
Severe	Count	26	93	117		
	% within AB	12.4%	12.8%	9.2%		
Extremely Severe	Count	31	92	100		
	% within AB	14.8%	12.7%	7.8%		

A statistically significant interaction { $\chi^2(8) = 38.275, p<.01$} was found between the levels of depression and levels of acceptance belief. It was found that lower level of depression (normal and mild) is related to high level of acceptance belief.

Table 4.48
Chi-square test of independence between depression and moral imperative

Levels of depression		Levels of moral imperative (MI)			Test result	Remarks
		Low	**Moderate**	**High**		
Normal	Count	270	289	142	χ^2 = 51.139, df=8, p<.01	Statistically significant relationship was found
	% within MI	31.3%	29.0%	40.5%		
Mild	Count	147	152	52		
	% within MI	17.1%	15.3%	14.8%		
Moderate	Count	228	380	90		
	% within MI	26.5%	38.2%	25.6%		
Severe	Count	108	90	38		
	% within MI	12.5%	9.0%	10.8%		
Extremely Severe	Count	109	85	29		
	% within MI	12.6%	8.5%	8.3%		

A statistically significant interaction { $\chi^2(8) = 51.139, p<.01$} was found between the levels of depression and levels of moral imperative. It was found that lower level of depression (normal and mild) is related to high level of moral imperative.

Table 4.49
Chi-square test of independence between depression and religious solidarity

Levels of depression		Levels of religious solidarity (RS)			Test result	Remarks
		Low	**Moderate**	**High**		
Normal	Count	223	373	105	χ^2 = 59.213, df=8, p<.01	Statistically significant relationship was found
	% within RS	31.0%	29.5%	46.7%		
Mild	Count	127	192	32		
	% within RS	17.7%	15.2%	14.2%		
Moderate	Count	189	460	49		
	% within RS	26.3%	36.4%	21.8%		
Severe	Count	80	137	19		
	% within RS	11.1%	10.8%	8.4%		
Extremely Severe	Count	100	103	20		
	% within RS	13.9%	8.1%	8.9%		

A statistically significant interaction { $\chi^2(8) = 59.213, p<.01$} was found between the levels of depression and levels of religious solidarity. It was found that lower level of depression (normal and mild) is related to high level of religious solidarity.

Table 4.50
Chi-square test of independence between anxiety and acceptance belief

Levels of anxiety		Levels of acceptance belief (AB)			Test result	Remarks
		Low	**Moderate**	**High**		
Normal	Count	71	205	485	χ^2 = 26.272, df=8, p<.01	Statistically significant relationship was found
	% within AB	34.0%	28.2%	38.0%		
Mild	Count	36	115	190		
	% within AB	17.2%	15.8%	14.9%		
Moderate	Count	32	114	191		
	% within AB	15.3%	15.7%	15.0%		
Severe	Count	19	111	160		
	% within AB	9.1%	15.3%	12.5%		
Extremely Severe	Count	51	181	249		
	% within AB	24.4%	24.9%	19.5%		

A statistically significant interaction { $\chi^2(8) = 26.272, p<.01$} was found between the levels of anxiety and levels of acceptance belief. It was found that lower level of anxiety (normal and mild) is related to high level of acceptance belief.

Table 4.51
Chi-square test of independence between anxiety and moral imperative

Levels of anxiety		Levels of moral imperative (MI)			Test result	Remarks
		Low	**Moderate**	**High**		
Normal	Count	280	354	127	χ^2 = 15.560, df=8, p<.05	Statistically significant relationship was found
	% within MI	32.5%	35.5%	36.2%		
Mild	Count	150	131	60		
	% within MI	17.4%	13.1%	17.1%		
Moderate	Count	119	166	52		
	% within MI	13.8%	16.6%	14.8%		
Severe	Count	105	141	44		
	% within MI	12.2%	14.1%	12.5%		
Extremely Severe	Count	208	205	68		
	% within MI	24.1%	20.6%	19.4%		

A statistically significant interaction { $\chi^2(8) = 15.560, p<.05$} was found between the levels of anxiety and levels of moral imperative. It was found that lower level of anxiety (normal and mild) is related to high level of moral imperative.

Table 4.52
Chi-square test of independence between anxiety and religious solidarity

Levels of anxiety		Levels of religious solidarity (RS)			Test result	Remarks
		Low	**Moderate**	**High**		
Normal	Count	247	421	93	χ^2 = 8.711, df=8, p>.05	No statistically significant relationship was found
	% within RS	34.4%	33.3%	41.3%		
Mild	Count	102	203	36		
	% within RS	14.2%	16.0%	16.0%		
Moderate	Count	108	196	33		
	% within RS	15.0%	15.5%	14.7%		
Severe	Count	102	165	23		
	% within RS	14.2%	13.0%	10.2%		
Extremely Severe	Count	160	281	40		
	% within RS	22.3%	22.2%	17.8%		

No statistically significant interaction { $\chi^2(8) = 8.711, p>.05$} was found between the levels of anxiety and levels of religious solidarity. Levels of anxiety and levels of religious solidarity is found to be independent of each other.

Table 4.53
Chi-square test of independence between stress and acceptance belief

Levels of stress		Levels of acceptance belief (AB)			Test result	Remarks
		Low	**Moderate**	**High**		
Normal	Count	105	313	717	χ^2 = 44.191, df=8, p<.01	Statistically significant relationship was found
	% within AB	50.2%	43.1%	56.2%		
Mild	Count	31	132	179		
	% within AB	14.8%	18.2%	14.0%		
Moderate	Count	31	166	228		
	% within AB	14.8%	22.9%	17.9%		
Severe	Count	27	87	115		
	% within AB	12.9%	12.0%	9.0%		
Extremely Severe	Count	15	28	36		
	% within AB	7.2%	3.9%	2.8%		

A statistically significant interaction { $\chi^2(8) = 44.191, p<.01$} was found between the levels of stress and levels of acceptance belief. It was found that lower level of stress (normal and mild) is related to high level of acceptance belief.

Table 4.54
Chi-square test of independence between stress and moral imperative

Levels of stress		Levels of moral imperative (MI)			Test result	Remarks
		Low	**Moderate**	**High**		
Normal	Count	418	521	196	χ^2 = 16.615, df=8, p<.05	Statistically significant relationship was found
	% within MI	48.5%	52.3%	55.8%		
Mild	Count	131	158	53		
	% within MI	15.2%	15.8%	15.1%		
Moderate	Count	165	199	61		
	% within MI	19.1%	20.0%	17.4%		
Severe	Count	105	91	33		
	% within MI	12.2%	9.1%	9.4%		
Extremely Severe	Count	43	28	8		
	% within MI	5.0%	2.8%	2.3%		

A statistically significant interaction { $\chi^2(8) = 16.615, p<.05$} was found between the levels of anxiety and levels of moral imperative. It was found that lower level of stress (normal and mild) is related to high level of moral imperative.

Table 4.55
Chi-square test of independence between stress and religious solidarity

Levels of stress		Levels of religious solidarity (RS)			Test result	Remarks
		Low	**Moderate**	**High**		
Normal	Count	334	663	138	χ^2 = 27.342, df=8, p<.01	Statistically significant relationship was found
	% within RS	46.5%	52.4%	61.3%		
Mild	Count	121	187	34		
	% within RS	16.8%	14.8%	15.1%		
Moderate	Count	137	258	30		
	% within RS	19.1%	20.4%	13.3%		
Severe	Count	90	120	19		
	% within RS	12.5%	9.5%	8.4%		
Extremely Severe	Count	37	38	4		
	% within RS	5.1%	3.0%	1.8%		

No statistically significant interaction { $\chi^2(8) = 27.342, p<.01$} was found between the levels of stress and levels of religious solidarity. It was found that lower level of stress (normal and mild) is related to high level of religious solidarity.

One-way ANOVA was computed to see if the mean score of depression, anxiety and stress varies significantly through the different levels of *acceptance belief, moral imperative and religious solidarity.* The following tables exhibits the result of separate One-way ANOVA tests for each of the three above mentioned variables in a composite manner.

On fulfilling the assumptions of One-way ANOVA i.e.
i) depression, anxiety and stress score was considered individually as dependent variable and a acceptance belief, moral imperative and religious solidarity as independent variable.
ii) levels of each independent variables are independent of each other
iii) the dependent variable is at the interval or ratio level and is normally distributed

iv) the variances of the dependent variable for each level of the independent variable are equal.

the results in the Table 4.56 to Table 4.58 are all valid and has not violated the main assumptions underlying the One-way ANOVA test. Results for each variable has been interpreted below in order.

Acceptance Belief and Depression, Anxiety, Stress

Table 4.56
One-way ANOVA taking mean depression, anxiety, stress score & levels of acceptance belief

	Acceptance belief			
	Low (n=719)	Moderate (n=1266)	High (n=225)	F-Test Result *df* = 2, 2206
Depression	7.35	7.63	6.78	F = 7.803, p=.000, S*
Anxiety	6.32	6.70	5.85	F = 8.786, p=.000, S*
Stress	8.10	8.33	7.27	F = 14.481, p=.000, S*

S* - Statistically significant result

It was found that the mean difference in depression score was statistically significant {F=7.803, p<.01} across levels of acceptance belief where students with high acceptance belief were found to have significantly lower level of depression (m=6.78) compared to moderate level of acceptance belief (m=7.63) and low acceptance belief (m=7.35).

Similarly, mean difference in anxiety score was statistically significant {F=8.786, p<.01} across levels of acceptance belief where students with high acceptance belief were found to have significantly lower level of anxiety (m=5.85) compared to moderate acceptance belief (m=6.70) and low acceptance belief (m=6.32).

Stress was also found to be significantly lower {F=14.481, p<.01} in students with high acceptance belief (m=7.27).

Moral Imperative and Depression, Anxiety, Stress

Table 4.57
One-way ANOVA taking mean depression, anxiety, stress score & levels of moral imperative

	Moral imperative			
	Low (n=862)	Moderate (n=996)	High (n=351)	F-Test Result *df* = 2, 2206
Depression	7.47	7.09	6.30	F = 7.571, p=.001, S*
Anxiety	6.35	6.14	5.83	F = 1.799, p=.166, NS#
Stress	8.09	7.57	7.11	F = 7.012, p=.001, S*

NS# - Not Statistically Significant, S* - Statistically significant result

It was found that the mean difference in depression score was statistically significant {F=7.571, p<.01} across levels of moral imperative where students with high moral imperative were found to have significantly lower level of depression (m=6.30) compared to moderate level of moral imperative (m=7.09) and low moral imperative (m=7.47).

But, mean difference in anxiety score was not statistically significant {F=1.799, p>.05} across levels of moral imperative where students with moral imperative were found to have significantly lower level of anxiety (m=5.83) compared to moderate moral imperative (m=6.14) and low moral imperative (m=6.35).

Again, stress was also found to be significantly lower {F=7.012, p<.01} in students with high moral imperative (m=7.11).

Religious Solidarity and Depression, Anxiety, Stress

Table 4.58
One-way ANOVA taking mean depression, anxiety, stress score & levels of religious solidarity

	Religious solidarity			
	Low (n=719)	Moderate (n=1265)	High (n=225)	F-Test Result *df* = 2, 2206
Depression	7.49	7.12	5.86	*F* = 7.803, *p*=.000, S*
Anxiety	6.30	6.23	5.42	*F* = 8.786, *p*=.000, S*
Stress	8.17	7.65	6.44	*F* = 14.481, *p*=.000, S*

S* - Statistically significant result

It was found that the mean difference in depression score was statistically significant {F=7.803, p<.01} across levels of religious solidarity where students with high religious solidarity were found to have significantly lower level of depression (m=5.86) compared to moderate level of religious solidarity (m=7.12) and low religious solidarity (m=7.49).

Similarly, mean difference in anxiety score was statistically significant {F=8.786, p<.01} across levels of religious solidarity where students with high religious solidarity were found to have significantly lower level of anxiety (m=5.42) compared to moderate religious solidarity (m=6.23) and low religious solidarity (m=6.30).

Stress was also found to be significantly lower {F=14.481, p<.01} in students with high religious solidarity (m=6.44).

A ***Multivariate Analysis of Variance (MANOVA)*** was conducted to assess if there were significant differences in the linear combination of *depression score*, *anxiety score*, and *stress score* between the levels of *acceptance belief*, moral imperative, and *religious solidarity*.

Due to unique properties of the data, some of the covariance matrices could not be calculated. As a result, Box's M test could not be conducted.

A correlation matrix was calculated to examine multicollinearity between the dependent variables. All variable combinations had correlations less than 0.9 in absolute value, indicating the results are unlikely to be significantly influenced by multicollinearity. The correlation matrix is presented in Table 4.59.

Table 4.59
Correlations between Dependent Variables in MANOVA

Variable	Depression Score	Anxiety Score	Stress Score
1. Depression Score	-	.66	.69
2. Anxiety Score	.66	-	.76
3. Stress Score	.69	.76	-

Table 4.60
MANOVA results for depression score, anxiety score, and stress score by levels of acceptance belief, moral imperative and religious solidarity

Variable	**Pillai**	***F***	***df***	**Residual *df***	***p***	η_p^2
Acceptance belief level	0.01	2.80	6	4402	.010	0.00
Moral imperative level	0.00	0.80	6	4402	.571	0.00
Religious solidarity level	0.01	3.01	6	4402	.006	0.00

It was found that the main effect for *acceptance belief levels* was significant, F(6, 4402) = 2.80, p = .010, η^2_p = 0.00, suggesting the linear combination of *depression score*, *anxiety score*, and *stress score* was significantly different among the levels of *acceptance belief*. The main effect for *moral imperative levels* was not significant, F(6, 4402) = 0.80, p = .571, η^2_p = 0.00, suggesting the linear combination of *depression score*, *anxiety score*, and *stress score* was similar for each level of *moral imperative*. The main effect for *religious solidarity level* was significant, F(6, 4402)

= 3.01, p = .006, η^2_p = 0.00, suggesting the linear combination of *depression score*, *anxiety score*, and *stress score* was significantly different among the levels of *religious solidarity*. The MANOVA results are presented in Table 4.60.

From the findings of previously conducted one-way ANOVAs and MANOVA, it can be said that depression, anxiety and stress were significantly low among students with high acceptance belief and religious solidarity leading to their overall religious activities.

4.3 Hypothesis Testing

Based on the result of significance tests, all the hypotheses are verified according to their order –

- **$H_0$1**: There is no significant relationship between students' depression and their religious activities measured in terms of acceptance belief, moral imperative and religious solidarity.

  Findings: A statistically significant interaction { $\chi^2(8) = 38.275, p<.01$} was found between the levels of depression and levels of acceptance belief.

  A statistically significant interaction { $\chi^2(8) = 51.139, p<.01$} was found between the levels of depression and levels of moral imperative.

  A statistically significant interaction { $\chi^2(8) = 59.213, p<.01$} was found between the levels of depression and levels of religious solidarity

  Decision: Null hypothesis $H_0$1 is *rejected*.

- **$H_0$2**: There is no significant relationship between students' anxiety and their religious activities measured in terms of acceptance belief, moral imperative and religious solidarity.

  Findings: A statistically significant interaction { $\chi^2(8) = 26.272, p<.01$} was found between the levels of anxiety and levels of acceptance belief.

A statistically significant interaction { $\chi^2(8) = 15.560, p<.05$} was found between the levels of anxiety and levels of moral imperative.

No statistically significant interaction { $\chi^2(8) = 8.711, p>.05$} was found between the levels of anxiety and levels of religious solidarity.

Decision: As statistically significant relationship was found on two out of three levels of religious activities, the null hypothesis $H_0 2$ is rejected.

- **$H_0 3$**: There is no significant relationship between students' stress and their religious activities measured in terms of acceptance belief, moral imperative and religious solidarity.

  Findings: A statistically significant interaction { $\chi^2(8) = 44.191, p<.01$} was found between the levels of stress and levels of acceptance belief.

  A statistically significant interaction { $\chi^2(8) = 16.615, p<.05$} was found between the levels of anxiety and levels of moral imperative.

  No statistically significant interaction { $\chi^2(8) = 27.342, p<.01$} was found between the levels of stress and levels of religious solidarity.

  Decision: As statistically significant relationship was found on two out of three levels of religious activities, the null hypothesis $H_0 3$ is rejected.

- **$H_0 4$**: Religious activities performed by the students do not have significant effect on their depression, anxiety and stress altogether.

  Findings: The main effect for *acceptance belief levels* was significant, $F(6, 4402) = 2.80$, $p = .010$, $\eta^2_p = 0.00$, suggesting the linear combination of *depression score*, *anxiety score*, and *stress score* was significantly different among the levels of *acceptance belief*.

  The main effect for *moral imperative levels* was not significant, $F(6, 4402) = 0.80$, $p = .571$, $\eta^2_p = 0.00$, suggesting the linear combination of *depression score*, *anxiety score*, and *stress score* was similar for each level of *moral imperative*.

The main effect for *religious solidarity level* was significant, $F(6, 4402) = 3.01$, $p = .006$, $\eta^2_p = 0.00$, suggesting the linear combination of *depression score*, *anxiety score*, and *stress score* was significantly different among the levels of *religious solidarity*.

Decision: As statistically significant effect was found on two out of three levels of religious activities, the null hypothesis $H_0 4$ is rejected.

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Chapter V

Discussion and Conclusion

Chapter V Discussion and Conclusion

The main purpose of the study was to find out the effect of religious practices on depression, anxiety and stress as well as overall mental health of higher education student in West Bengal. The present cross-sectional study on religious practices and mental health purposively selected universities and colleges from twenty one out of twenty-three districts of West Bengal. The subsequent sections of this chapter provide a summary of the significant findings. Provided conclusions based on findings in connection to each research question, analyzed noteworthy findings and emphasized the need for additional research by noting the limitations of the present study.

5.1 Summary of Findings

- It was found that male students were more engaged in religious practices (m=33.55) than female students (m=30.70) but the consistency of practices was higher in females (sd=10.835) than their male counterparts (sd=12.923). Also, the male participants were found to be in remarkably better position than female students in terms of religious solidarity (mean difference = 1.55).

- It was found that students of rural areas were more engaged in religious practices (m=32.13) than of urban areas (m=29.81). They have shown higher level of religious practices in all three dimensions of the religious activities scale. Urban students were also found to have practiced religious activities to a good extent.

- It was found that the students in colleges did practice more religious activities (m=32.25) compared to the students studying at universities (m=28.47). The difference was persistent across all three dimensions of the measure. Even the consistency of religious practices among college

students (sd=11.182) was higher than that if university students (sd=12.075).

- It was found that the Islamic students (m=38.95) consistently practiced religious activities much more than the students of other religions i.e. Hinduism and Christianity. Hindu students were found to have least acceptance belief (m=10.95), moral imperative (m=6.15) as well as religious solidarity (m=12.53). The results showed that the Christian students were too close (mean difference = 4.45) to Islamic students in terms of religious solidarity.

- The results found Other Backward Class (OBC) students as the most practitioner of religious activities (m=33.89) compared to the other social categories from which students participated in this study. It was also seen that the degree of acceptance belief was lowest among scheduled tribe (ST) students (m=11.17), moral imperative (m=6.40) and religious solidarity (m=12.64) was lowest among scheduled caste (SC) students at higher education level.

- It was found that the students with some kind of disability practiced more religious activities (m=33.35) compared to the students without any kind of disabilities (m=31.13). The difference was persistent across all three dimensions of the measure.

- It was found that the students from joint families performed more religious activities (m=32.90) compared to the students from nuclear families (m=30.59). The mean difference was persistent across all three dimensions of the measure but the consistency of practice was lower among students from joint families.

- It was found that although the married students perform a little more religious activities (m=31.58) in overall but, moral imperative and religious solidarity was higher among unmarried students (m=7.13,

m=13.07 respectively). Acceptance belief was found to be more of married students (m=11.80) than of unmarried students.

- It was found that the students who have suffered from mental health problem in past, practiced noticeably less religious activities (m=27.71) than students who have not suffered from mental health problems (m=31.69). The mean difference was persistent across all three dimensions of the measure.

- It was found that depression, anxiety as well as stress were negatively correlated with all the three dimensions of religious practices i.e., acceptance belief , moral imperative and religious solidarity and the relationship was statistically significant.

- Association between religious practices and depression, anxiety and stress was more negative among students with Islamic religious belief than that of Hinduism and Christianity which was also statistically significant.

- Association between religious practices and depression, anxiety and stress was more negative among other backward class students than of students from other social categories.

5.2 Conclusions

Each research question was validated in respect to the study's findings.

- ***Research Question 1:*** • *How far are religious activities practised by young adults studying at colleges and universities in West Bengal?*

  The study covered 2210 higher education students studying at various colleges and universities in West Bengal and found that a good amount of religious practices are (mean = 32.03 out of 60) are done by the students irrespective of their variations in personal and social indicators.

- ***Research Question 2:*** *How do different social and demographic factors contribute to various religious practices?*

  Religious practices as explored in the study showed found some variations with gender, habitat, religion, social category, marital status and disability. Female, college going students, students from the rural localities, from Islamic background and students without any kind of disability were found to doing more religious practices than their counterparts in this study.

- ***Research Question 3:*** *Does religious practice reduce anxiety, depression and stress?*

  Religious practices, measured in terms of acceptance belief, moral imperative and religious solidarity were found to have negatively associated with depression, anxiety and stress level. It indicates that, students who did more religious practices had lower levels of depression, anxiety and stress as found in this study.

- ***Research Question 4:*** *Is religious practice associated with good mental health?*

  Lower levels of depression, anxiety and stress are indicative of good mental health as per various medical and psychological researches. There are so many other factors which are also responsible for good mental health. But, in the present study, the theoretical assumptions that, reduced depression, anxiety and stress are significant indicators of good mental health, are found to be associated with religious practices.

5.3 Discussion

How does religious practise affect us, especially in the psychological field is a matter of concern among the researchers around the world. Stress, depression, and anxiety are becoming more common among students and depression is a big reason why people kill themselves. WHO says that stress and depression are the second leading cause of suicide among 15-29-year-olds. Studies have shown that students suffer from anxiety and depression. But religion is where I look for answers to this question in my research.

Indians are mostly religious, and they do more religious things than people in many other countries. 97 percent of people in India believe in a creator, God, or natural power, according to Pew Research Centre and other independent studies, and 85 percent know or practise their religion. It is true that religion is important at many points in life, from birth to death. So, it is my job to figure out if there is a link between religious behaviour and mental health.

Before the 1800s, there was a strong link between mental health and religion. Also, many religious institutions were in charge of protecting people with mental health problems or figuring out what was wrong with them. People used to pray regularly in places like temples, mosques, and churches, which gave them moral support on

an individual and group level and indirectly helped them keep their peace of mind. In other words, people used to get moral and ethical support from their fellow religious members, priests, and people who worked full-time in religious institutions. Later, Sigmund Freud says, there was a change in the way people thought about this. He found a link between religion and neurosis and other mental problems.

So, there are two ways to look at religion and health. However, since the second half of the 20th century, some work has been done on this subject. Emotional rationale therapy and cognitive behavioural therapy became very popular in the 1980s. They kept saying that religion has a good effect on people, especially when it comes to depression and anxiety. When this happens, there are some mixed results. Religion and the case of depression are strongly linked in a good way. But, as many studies have shown, anxiety has nothing to do with religion.

In Indian society, the current body of research has tried to find out how religious practises of younger people affect their mental health in terms of depression, anxiety, and stress.

Spirituality and mental health are interconnected through multiple dimensions. Spirituality requires connecting at three layers, i.e., the self, others and the Other, to attain maximum wellbeing. Mental health, similarly, is a state of well-being that allows the individual to realise his maximum potential. Mental Health Literacy in Higher Education Students - Reavley - 2012 - Early Intervention in Psychiatry - Wiley Online Library, n.d. Findings showed that knowledge of the effect of religious fabeliefnd and spirituality on mental health is essential for good clinical practice. Private religious practice was more frequent among severely suffering patients and was more inversely related to physical health outcomes. Factors like forgiveness, spiritual experience, religious affairs etc., were identified as predictors of mental health conditions. Findings also claimed that religiously active individuals report lesser traits of depressive symptoms. Stronger religious beliefs promote students' mental health. More attention must be paid to teaching

theoretical and practical issues of religion. Sufism has the prowess of acting as a critical reminder of its deep commitment to helping Muslim consciousness against the ever-growing materialism and consumerism. RSIPAS may be used to identify training needs or evaluate training efforts related to integrating clients' religious or spiritual beliefs in mental and behavioural health treatment. One area of specific prominence has been exploring the links between religion and mental health, particularly religion and obsessional neurosis. Jonas Kolb and Erol Yildiz (2019). The study's findings on Muslim diversity in Austria show how complex, complex, ambivalent, and hybrid the everyday religious practice of individuals directly on the ground is or can be. This article asserts the requirement of theology that recognises and takes seriously the changed realities of life of the persons practising Islam. This study shows that despite significant differences between western and Muslim societies, many common historical points could and should be the basis for sincere and constructive dialogue. Collaborating with Muslims through mental health services to address their issues and enhance well is more likely to contribute to the well-being of other non-Muslims. The researchers expanded previous studies on family conflict and preteens' depression and anxiety. The researcher evaluated whether private religious practices mediated family conflict. According to Steensland and colleagues (2000), 52.5% of preadolescents were Evangelical Protestants. Study examines Christian denominations, religious beliefs, and mental health of college students. Depression, anxiety, and religiosity were measured. Findings support the hypothesis that religion plays a protective role against depression (Vasegh & Mohammadi, 2007; Ferenczi et al., 2022). Religiousness is linked to higher gratitude, and an increase in appreciation may increase subjective well-being (Ferenczi et al., 2021). Findings of this study showed a significant relationship between the component of immanent hope and stress, anxiety, and depression.

Spirituality and depression are vital areas of research that may lead to novel treatments for depressed individuals. This study found a negative link between depression and spirituality in India. Spirituality should be discussed with

depressed individuals to help them find meaning in life and cope with the disease. Many cancer patients in India suffer from depression, typically undetected or untreated. Spirituality and depression in cancer patients were inversely related in this study. Islam, as a way of life, has conferred protection against developing mental illness for a countless number of Muslims. Islamic teachings are the first value advice in Quranic verses, and other religious practices play an influential role in warranting human health. Sufism can serve as a critical reminder of its commitment to helping Muslim consciousness against the ever-growing materialism and consumerism plaguing the modern world. Stress, anxiety and depression are more common in male than female medical students. The sense of spirituality for female students is more vital than that in male students.

Religious activity could have positive and negative outcomes, such as contributing to developing psychiatric disorders or fostering a favourable mental attitude among the populace. Religious belief or action cannot be considered a fundamental source of psychological well-being. A correlation was discovered between religiosity and anxiety among Kargil's Muslim students. The data was collected using the Psychological Measure of Islamic Religiousness developed by Hisham Abu Raiya (2005, 2008).

The evidences on relationship between religion and mental health is growing rapidly. Overall studies indicate that religious practices or involvement is considered as a power resource for individuals to cope with depression, anxiety and stress. Up to 2010, forty four hundred had examined the relationship between religion/spirituality and depression in which 61% reported that religious involvement was associated with less depression or faster recovery from depressive state or religious based interventions have significantly reduced depressive symptoms (Koenig, 2012). Recent studies after 2010 have also been revealed the similar findings (Miller et al., 2014; Lorenz et al., 2019). Similarly, up to 2010, two hundred ninety nine studies had examined the relation between religiosity and anxiety (Koenig, 2012) where 45% reported less anxiety who are more religious. Other mental health problems like suicidal thought, personality

disorder, substance abuses etc. also have positive impact on religiousness. 79% studies reported greater life satisfaction, happiness and well-being among people those who are more religious (Koenig, 2012). In general, recent research confirms that religious practices have positive impact on mental health and psychological well-being among peoples including youth and adults.

The goal of this study was to find out how religious practises and the mental health of young adults, especially college and university students, are related. The researcher looked at the levels of depression, anxiety, and stress as signs of the mental health of the participants. Lower levels of these three things mean that the students' mental health is better. The study also looked at how religious practises vary and how depression, anxiety, and stress are related to different personal and social factors as well as the students' religious identities. When personal and social factors are changed, the results showed that the relationship is very different.

Female students have been found to be more religious than male students because they are more patient and pay more attention to detail. When it comes to doing a job right, they are much better than men in general. Also, religious practises may have given women strength, patience, and tolerance in a society where men are the majority.

This study found that students in rural areas did more religious things than students in cities. This could be due to the fact that people in rural India have believed in god and other natural forces for thousands of years. People who live in cities are so busy with life, work, and competitions that they only pay attention to religious practises that are old, conservative, and take up a lot of their time.

Marriage is a social institution that involves a lot of rituals that, by accident, draw people's attention to the religious and cultural parts of our society. In this study, too, it was found that married people are more involved in religious activities than single people, who haven't yet learned the social norms, rituals, and sermons.

Researchers found that students who follow Islam were more involved in religious activities than students who followed the other religions studied. The researcher

made a very interesting point when he said that Islam encourages people to be religious and thankful to the supreme while also keeping the supreme's honour.

Students from the Other Backward Classes were more religious because they came from religious minority groups, mostly Islam. So, they see religion as a way to keep their small group of people together and to keep their social bonds strong.

Students with some kind of disability were found to be less likely to take part in religious activities. This could be because of how it affects the parents, family, and society as a whole. Their faith in God's power is cut short because they see their current situation, where they can't live a normal life, as a curse. So, they don't have much hope for good things from the most powerful people, who have already taken away their normal lives.

It was also found that students with a history of mental health problems did less religious activities than students without a history of mental health problems. Because of their mental health problems, they have been through worse things in life.

Overall, the results of the study show that religious practises are linked to depression, anxiety, and stress in a bad way. This is something that has been found in many other studies, as we've already talked about. This may be because having faith in the supremacy of God has given people the courage to deal with problems and challenges in life. There have been a lot of studies that have found a strong positive link between religious practises and good mental health, and this study backs up those findings.

Even though there are a few results that can't be explained in general terms—for example, the link between religious practises and depression is sometimes negative and sometimes positive when other factors are taken into account—the research has shown in general that bringing people together, whether through culture, politics, or religion, helps to build a strong environment that can handle any kind of problem.

5.4 Limitations of the Study

There were several factors to this study that limits from capturing a true picture of what its conclusions indicated.

- Religious practices was only measured through acceptance belief, moral imperative and religious solidarity dimensions. There are so many other dimensions of religious activities which was not considered here.
- The study deals with only students those who are studying in colleges and universities of West Bengal. Other levels of education could not be covered.
- For evaluating the hypothesis, the researcher employed only a 5% level of significance.
- The researcher acknowledged that the responses provided by the participants are not all accurate and may contains error and biases which could not be identified and reduced.

5.5 Scope of Further Studies

Researchers in education can make important contributions to this topic in a number of ways. If the study had been done with high school students, the results might have been different about how religion affects depression, anxiety, and stress. Also, many other social indicators could be added to the list of ways to report a student's religious activities. With more advanced multivariate tools, the factors that were looked at in this study can be looked at in more depth to find out how religious practise affects other parts of life and if it can predict success and achievement. The person doing this study doesn't see it as an end in itself. Instead, he or she sees it as a way to keep learning about religious practises and study them to help people find better, more stable ways to live.

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Appendices

Appendix 1

Demographic Data Sheet

All the information in this schedule is strictly confidential and your information will be anonymously processed. Please answer all of the following questions as accurately as possible.

এই ফর্মের সকল তথ্য অত্যন্ত গোপনীয় এবং আপনার পরিচয় গোপন রেখে তা ব্যবহৃত হবে। অনুগ্রহ করে নিম্নোক্ত প্রশ্নগুলোর যথাসম্ভব সঠিক উত্তর প্রদান করুন।

1. Gender: **Male/Female/Others**
2. Age: …….. **(Years)**
3. Habitat: **Rural / Urban**
4. District: ……
5. Level of Education: **UG / PG / B.Ed. / Research**
6. Type of Institution: **College / University**
7. Religion: **Hinduism / Islam / Christianity / Others**
8. Social Category: **Unreserved / SC / ST / OBC**
9. Are you Differently Abled (প্রতিবন্ধী)? **Yes / No**
10. Family Type: **Joint / Nuclear**
11. Marital Status: **Unmarried / Married**
12. Have you previously suffered from any Mental Health problem? **Yes/No**
    পূর্বে কোন মানসিক সমস্যা ছিল- হ্যাঁ / না
13. If yes, kindly mention the type of Mental Health problem.
    হ্যাঁ হলে তা কেমন ছিল উল্লেখ করো - ……

……
Signature

Appendix 2

Religious Activity Scale

এই প্রশ্নপত্রে ২০ টি বিবৃতি আছে। প্রশ্নপত্রটি আপনার দৈনন্দিন জীবনের ধর্মীয় অনুশীলন বিষয় সম্পর্কিত। বিবৃতিগুলি আপনার অনুশীলনকে কতটা ভালভাবে বর্ণনা করে সে সম্পর্কে চিন্তা করুন। যথাযথ 'বক্স' এ টিক চিহ্ন দিয়ে আপনার প্রতিক্রিয়া নির্দেশ করুন। যদি আপনি কোন প্রতিক্রিয়া / উত্তর সম্পর্কে আপনার মত পরিবর্তন করেন তবে পুরোনো টিক চিহ্নটি কেটে নতুন 'বক্স' এ টিক চিহ্ন দিন।

আপনাকে নিশ্চিত করা হচ্ছে যে আপনার প্রতিক্রিয়াগুলির গোপনীয়তা বজায় রেখে শুধুমাত্র এই গবেষণার উদ্দেশ্যই ব্যবহার করা হবে। এই সহযোগিতার জন্য আপনাকে অসংখ্য ধন্যবাদ।

তত্ত্বধায়ক
ড. মুক্তিপদ সিন্‌হা
অধ্যাপক, শিক্ষাবিভাগ
যাদবপুর বিশ্ববিদ্যালয়

গবেষক
লিটন মল্লিক
শিক্ষাবিভাগ
যাদবপুর বিশ্ববিদ্যালয়

১) আমার ধর্মের প্রতি পূর্ণ বিশ্বাস আছে।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই নেই

২) আমি ধর্মীয় শৃঙ্খলা (Religious Discipline) গুলো মেনে চলি।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই নেই

৩) আমি আমার ধর্মের বিধান অনুয়ায়ি পবিত্র থাকার চেষ্টা করি।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই নেই

৪) আমি ধর্মীয় সাহিত্য বা ধর্মগ্রন্থ পড়ি।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই নেই

৫) আমি আমার ধর্মীয় স্থানে যাই।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই নেই

৬) আমি একাগ্র চিত্তে ধর্মীয় সাধনা করি।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই নেই

৭) আমি দৈনন্দিন জীবনের সকল ক্ষেত্রে আমার ধর্মের আদর্শ মেনে চলি।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই নেই

৮) ধর্মীয় কারণে উপবাস পালন করি।

- ☐ প্রতি বছর এবং নির্দেশিত সবগুলি করি
- ☐ প্রতি বছর কিন্তু সবগুলি করি না
- ☐ মতামত জানাতে চাই না
- ☐ কখনো করি, আবার কখনো করি না
- ☐ একদমই করি না

৯) আমি ধর্মীয় স্থানে প্রার্থনা করি।

- ☐ দিনে একাধিকবার
- ☐ দিনে একবার
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একবারও না

১০) আমি ধর্মীয় উপদেশমূলক সমাবেশে (Satsang / Ijtema / Prayer Service) অংশগ্রহণ করি।

- ☐ প্রতি সপ্তাহে
- ☐ প্রতি মাসে
- ☐ মতামত জানাতে চাই না
- ☐ প্রতি বছর
- ☐ একদমই না

১১) আমি ধর্মীয় স্থান (তীর্থ যাত্রা) দর্শন করেছি।

- ☐ একাধিকবার
- ☐ কয়েক বার
- ☐ জানাতে চাই না
- ☐ একবার
- ☐ একবারও না

১২) আমি ধর্মীয় আচার, শোভাযাত্রা, জনসমাবেশে অংশগ্রহণ করি।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই করি না

১৩) আমি খাবার পূর্বে বা পরে আমার সৃষ্টিকর্তার নাম স্মরণ করি।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই করি না

১৪) আমি ধর্মীয় কাজে আর্থিক সাহায্য করি।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই করি না

১৫) আমি সাক্ষাতের সময় ধর্মের বিশেষ সম্বোধনমূলক শব্দ ব্যবহার করে থাকি।

- ☐ সব সময়
- ☐ বেশিরভাগ সময়
- ☐ মতামত জানাতে চাই না
- ☐ মাঝে মাঝে
- ☐ একদমই করি না

Appendix 3

DASS 21 Bengali version

ডাস-২১ বাংলা ভার্সন (DASS-21 B V)

অনুগ্রহ করে নিচের প্রতিটি বিবৃতি পড়ুন এবং ০, ১, ২ অথবা ৩ এর মধ্যে গত সপ্তাহ ব্যাপী আপনার জন্য প্রযোজ্য যে কোন একটি সংখ্যায় গোল চিহ্ন দিন। এখানে কোন সঠিক বা ভুল উত্তর নেই। কোন বিবৃতির জন্য বেশী সময় ব্যয় করবেন না।

মানদন্ডটি (রেটিং স্কেল) নিম্নরূপ:

০ আমার জন্য একেবারেই প্রযোজ্য নয়

১ আমার জন্য অল্পমাত্রায় বা কখনো কখনো প্রযোজ্য

২ আমার জন্য বেশ কিছুমাত্রায় বা বেশখানিকটা সময়ের জন্য প্রযোজ্য

৩ আমার জন্য খুব বেশী বা বেশীরভাগ সময়ের জন্য প্রযোজ্য

১.	কোন উৎকণ্ঠা বা উত্তেজনামূলক কাজের পর আরামদায়ক অবস্থায় ফিরে আসা আমার জন্য কঠিন ছিল।	০	১	২	৩
২.	আমি বুঝতে পারতাম যে আমার গলা শুকিয়ে আসছে।	০	১	২	৩
৩.	ইতিবাচক কোন অনুভূতিই আমার মধ্যে কাজ করত না।	০	১	২	৩
৪.	আমার শ্বাসকষ্টের অনুভূতি হত (যেমন অতিদ্রুত শ্বাসপ্রশ্বাস, শারীরিক পরিশ্রম ছাড়াই নিঃশ্বাস বন্ধ হয়ে আসা)	০	১	২	৩
৫.	নিজে উদ্যোগী হয়ে কোন কাজ শুরু করা আমার জন্য কঠিন হত।	০	১	২	৩
৬.	আমার মধ্যে বিভিন্ন পরিস্থিতিতে অতিরিক্ত প্রতিক্রিয়া করার প্রবনতা ছিল।	০	১	২	৩
৭.	আমার শরীর কাঁপার অভিজ্ঞতা হয়েছিল (যেমন হাত কাঁপা)।	০	১	২	৩
৮.	আমার মনে হতো যে আমি খুব বেশী স্নায়ু চাপে ভুগছি।	০	১	২	৩
৯.	আমি এমন পরিস্থিতি সম্পর্কে দুশ্চিন্তাগ্রস্ত ছিলাম যেখানে আমি তীব্রভাবে আতঙ্কিত হতে পারি এবং এমন কোন কাজ করতে পারি যাতে অন্যরা আমাকে বোকা মনে করবে।	০	১	২	৩
১০.	আমার মনে হচ্ছিল , ভবিষ্যতে আমার ভালো কিছুরই আশা নাই।	০	১	২	৩
১১.	আমি অনুভব করতাম যে আমি খুব অস্থির হয়ে যাচ্ছি।	০	১	২	৩
১২.	আরাম বোধ করা আমার জন্য কঠিন হত।	০	১	২	৩
১৩.	আমি মনমরা এবং বিষণ্ন অনুভব করতাম।	০	১	২	৩
১৪.	আমার কাজে বাধা হয় এমন যে কোন জিনিসই আমার কাছে অসহ্য লাগত।	০	১	২	৩
১৫.	আমার মনে হত এই বুঝি আমি হঠাৎ তীব্রভাবে আতঙ্কগ্রস্ত হচ্ছি।	০	১	২	৩
১৬.	কোন কিছুতেই আমি বেশী আগ্রহী হতে পারতাম না।	০	১	২	৩
১৭.	আমি অনুভব করতাম ব্যক্তি হিসেবে আমার বিশেষ কোন মূল্য নেই।	০	১	২	৩
১৮.	আমি অনুভব করতাম আমি একটুতেই মনে ব্যাথা পাই।	০	১	২	৩
১৯.	শারীরিক পরিশ্রম না করলেও আমি হৃদপিন্ডের কাজ করা বুঝতে পারতাম (যেমন: হৃদস্পন্দন বৃদ্ধির অনুভূতি বা বুক ধড়ফড় করা, হৃদপিন্ডের স্পন্দনে ব্যাঘাত)।	০	১	২	৩
২০.	যথাযথ কারন ছাড়াই আমি ভীত-সন্ত্রস্ত বোধ করতাম।	০	১	২	৩
২১.	জীবনটা অর্থহীন বলে মনে হত।	০	১	২	৩