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Religiosity and Psychological Well-Being: Evidence from a Cross-Sectional Study of Muslim University Students

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Abstract

Religion holds a primary place in social and cultural life of Muslim societies and still influences the way people perceive psychological suffering and well-being. Using sociological approaches that understand religiosity as a sociocultural coping tool, this paper will explore the relationship between participation in Islamic religious activities and mental health among Muslim higher education students in Pakistan. The quantitative, cross-sectional type of research design was used, and a group of 150 students enrolled at the University of Sargodha was invigilated using a structured questionnaire to measure their religious practices and self-reported psychological well-being. Reliability analysis revealed that internal consistency was reasonable (Cronbach's α =.72). Correlation Pearson and simple linear regression analyses were performed using SPSS. The results indicate a statistically significant positive correlation between religiosity and mental health ($r = .33$, $p < .001$), and the result of religiosity determines 10.8% of the variance of the mental health outcomes ($R^2 = .108$). These findings indicate that religious involvement acts as an effective, albeit incomplete coping tool to psychological health among Muslim youth. The contribution of the study to sociological literature is that everyday religious practices play a culturally constructed role in subjective mental health construction, but religiosity does not replace an overall structural support and professional mental health services.

Keywords: Religiosity; mental health; Muslim Student; psychological well-being; religious coping

Introduction:

Mental health has become a major sociological and social health issue, especially in the case of young adults who deal with their academic requirements, identity development, and socio-economic insecurity. University students are a particularly vulnerable group of people who can be affected by stress in psychology caused by pressure of performance, future employment and change of social roles. In societies, where religion is still profoundly engraved in the daily affairs, religion-based practices and meanings are significant social resources by which individuals decipher and address psychological issues.

Religion in Muslim-majority settings like Pakistan is not only a belief system but a social institution that is socially structured and that determines the way people live, their morals and how they cope. Religious practices such as daily prayer, fasting, and religious remembrance are ingrained in the social life fabric and in most cases mobilized during stressful moments or emotional struggle (Renard,

2023). Sociologically, these practices might have an impact on mental health by offering meaning, emotional regulation, and normative reassurance as opposed to having a direct effect on psychological symptoms reduction.

The available literature in the sociology of religion and health is that religiosity may serve as a coping resource that fosters psychological health by culturally ingrained meaning-making and social control (Pargament & Exline, 2021). In various cultural contexts, empirical research has found that there are positive relationships between religious participation and well being measures such as reduced stress and enhanced emotional stability (Koenig, 2012; Hollinger and Makula, 2021). But sociological studies too are warning of the dangers of homogenising religiosity as a blanket against every kind of danger. In certain settings, religious interpretations can contribute to stigmatization of mental illness or prevent the effect of people seeking professional help, which makes questions of religion and mental health complex (Anjum & Aziz, 2024).

These are especially intricate among the Muslim youth. College students tend to negotiate between the demands of religion, academic obligations and the social demands of the present day. In Pakistan, where mental health services are still scarce and stigmatization is still high, informal or religious coping channels are the main sources of how young people cope with psychological pain (Alqasir, 2024). Although these strategies can be emotionally soothing and morally instructive, they do not work in all social situations, and individuals will interpret them differently and have access to other support modes.

Although there is increasing cross-cultural literature on the topic of religion and mental health, little empirical data has been conducted with respect to Muslim university students in South Asia. A large part of the current literature either subsumes psychological models which overemphasize the role of social context or views religiosity as a fixed belief system as opposed to a lived social practice. This gap is filled by the current research, which takes a sociological view of religiosity as a sociocultural resource of coping and investigates how it correlates with mental health among Muslim university students in Pakistan.

Through the investigation of the engagement into the daily religious practices of Islam and self-reported psychological well-being, the proposed research aims at making a contribution to an otherwise more contextually oriented interpretation of how religion intersects with mental health within a Muslim-majority society. In contrast to the use of a causality, the study explores the relationship between the religiosity and mental health outcomes in the context of a more general set of social and cultural coping resources accessible to the youth. In that way, it provides empirically informed knowledge that can be applied to sociological theory, to mental health studies and culturally sensitive methods of youth wellbeing.

The current research aims to investigate the relationship between mental health and the practice of Islamic religious beliefs among the Muslim students in the university. In particular, it investigates the connection between religiosity and self-reported psychological well-being, evaluates the degree to which religiosity is used as a sociocultural coping tool to deal with psychological stress, and the level of association that religious activity accounts to difference in the mental health outcomes across Muslim youth in their universities.

Literature Review:

The sociological study of mental health highlights the fact that social, cultural, and institutional environments influence psychological well-being more than personal or biomedical situational components (Cockerham, 2013). In this view, religion is an important social institution that gives meaning, moral dignity, and culturally approved sources of coping. In recent years, the understanding of religiosity has shifted towards a conceptualized and socially embedded practice, which helps people to make sense of distress and manage the emotional reactions (Hollinger and Makula, 2021).

Religiosity as a Sociocultural Coping Resource

In the sociological religion and health, religiosity should be considered as a sociocultural coping

mechanism instead of a protective deterministic element. This view is informed by the middle-range sociological theory that states that cultural practices and meanings, without causal and therapeutic validity, enable individuals to cope with uncertainty, anxiety and experiencing psychological strain. Religious activities provide the interpretive systems that enable people to contextualize pain in the context of morally significant stories and, thus, to facilitate emotional comfort and resilience (Pargament and Exline, 2021).

Religiosity plays a significant role in the day-to-day living of the Muslim-majority societies like Pakistan. The Islamic rituals of daily prayer, fasting, and religious recollection are not only manifestations of personal religious beliefs but disciplined practices that govern the time, discipline behavior, and assure normative coherence (Renard, 2023). Such practices can lead to psychological health as they bring continuity, emotional control, and a feeling of moral order, especially to the youth struggling with academic stress and social confusion.

Sociological studies however warn that not all religiosity is good. Stigma around mental illness can also be supported by religious meanings when the distress of psychological state is seen as a manifestation of a lack of faith or moral decline (Anjum & Aziz, 2024). This ambivalence reveals the significance of investigating religiosity as a conditional coping mechanism the impact of which is determined by the social setting, perception, and availability of other support sources.

Social Dimensions of Mental Health and Well-Being

This study conceptualizes mental health and well-being as subjective psychological conditions, constructed by social meanings and cultural norms, and not as clinical or diagnostic conditions. Mentally, sociologically, mental health demonstrates how people feel about being emotionally stable, their ability to cope, and how they work in certain social circumstances (Cockerham, 2013). Well-being experiences among the students of different universities are closely connected with academic stress, future insecurity, and social and highly structured expectations.

The way mental health is interpreted in Muslim circles often goes through religious and moral prisms, which influence the way in which psychological distress is perceived, handled, and expressed (Alqasir, 2024). In turn, the subjective measurements of well-being are especially relevant to the sociological investigation, because they represent culturally mediated distress and resilience experiences that are not limited to clinical scales. Social stigma, gendered norms and lack of access to formal healthcare services also contribute to mental health coping and help-seeking patterns in Pakistan. The available empirical studies on the health-seeking behavior in Punjab support the idea that the moral interpretation of illness and structural factors tend to discourage people to seek professional care, so they should use informal and culturally approved coping mechanisms, such as religious resources (Mushtaq et al., 2024).

There have been positive links between religiosity and subjective well-being indicators such as less stress and better emotional regulation that have been reported in empirical research across different settings (Koenig, 2012; Pargament and Exline, 2021). However, sociological studies always remind that these kinds of associations are not to be taken as causal and are to be placed in a context of larger structural conditions, access of mental health services, and social attitudes of the society toward psychological illness.

Religion and Psychological Coping among University Students

A student population in a university is one of the most important groups in which the connection between the religiosity and mental health is examined. Being an emerging adult, students are under increased academic pressure, negotiating their identities, and having doubts about their future paths. In Pakistan, mental health facilities are scarce, and stigma continues to define the behaviors of help-seeking, which in most cases compel youth to use informal or religious coping mechanisms (Alqasir, 2024).

A sociocultural coping view can suggest that religious involvement of the university students can

serve as an easily accessible, socially acceptable means of coping with psychological stress. Simultaneously, excessive dependence on religious coping can postpone professional help in situations of serious mental health problems. This dualistic position underscores the importance of balancing sociological investigations that emphasize the positive and negative aspects of religiosity. Although there is increased attention to both religion and mental health in various parts of the world, very little empirical studies have been done on Muslim university students in South Asian settings. In this gap, the current research will consider the relationship between participation in Islamic religious activities and subjective mental health outcomes in Muslim university young people and the religiosity in the context of its wider sociocultural framework, the topic of religiosity is not seen as an independent or decisive variable.

Methodology

The research design was a quantitative and cross-sectional study design, which aimed to investigate the relationship between religiosity and mental health among Muslim university students. The research was carried out in one of the universities named Sargodha University, Pakistan with a total number of students of 22,850. A stratified random sampling method which is probability based was employed, the students were stratified into level of study (undergraduate and postgraduate), the students were randomly chosen based on enrolment or class lists within the stratum. The study was done on 150 students, which is sufficient to identify moderate associations using correlation and regression analyses. The structured and self-administered questionnaire was used to elicit data about the Islamic religious practices and self-reported psychological well-being on a Likert type response. The internal consistency of the instrument was acceptable (Cronbach's $\alpha = .72$). Data collection was done face to face in an informed consent setting and confidentiality and voluntary participation assured under institutional ethics. The data were analyzed using SPSS; Pearson was employed in order to test the correlation between the variables and simple linear regression was employed in order to determine to which degree religiosity can explain variation in mental health outcomes. The level of statistical significance was taken to be at the.05 level and results were considered to be associative and not causal.

Results

The section will give the empirical findings of the research on the relationship between religiosity and mental health in Muslim university students. All findings are represented according to the APA 7th edition and focused on clarity, accuracy, and statistical comments.

Correlation Analysis

Table 1: Correlations

		DV	IDV
DV	Pearson Correlation	1	.329**
	Sig. (2-tailed)		.000
	N	150	150
IDV	Pearson Correlation	.329**	1
	Sig. (2-tailed)	.000	
	N	150	150

*. Correlation is significant at the 0.01 level (2-tailed).

Pearson's product–moment correlation analysis was conducted to examine the association between engagement in Islamic religious practices (independent variable) and self-reported mental health

(dependent variable). As shown in Table 1, a statistically significant positive correlation was observed between religiosity and mental health, $r(148) = .329$, $p < .001$.

The strength of the correlation shows the moderate level of association, which implies that the greater the extent of religious practices, the higher the perceived psychological well-being among Muslim university students. On the sociological level, this result confirms previous studies that present religiosity as a culturally-mediated coping mechanism helping to improve subjective well-being through meaning, emotional reassurance, and normative stability (Pargament and Exline, 2021; Hollinger and Makula, 2021).

More significantly, probability-based stratified random sampling is used in the study, which increases the interpretative validity of the association by minimizing selection bias and increasing representativeness among the members of the university population. In that sense, the observed correlation is better to be attributed to larger trends in Muslim Muslim university students, but not a product of convenience sampling (Bryman, 2016).

Regression Analysis

Table 2: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.329a	.108	.102	4.50175

a. Predictors: (Constant), IDV

The simple linear regression analysis was performed to identify how religiosity is used to explain the variation in mental health outcomes with religiosity as the predictor variable and mental health as the outcome variable.

The regression model generated $R^2 = .108$ and $R = .329$, which shows that the variables of religiosity explain 10.8 percent of the variance of self-reported mental health. The adjusted R^2 of (.102) is used to verify that the model is stable even with sample size. The percentage of explained variance is relatively low but has a substantial meaning in sociological research where mental health is predetermined by the combination of interacting social, cultural, and structural variables (Cockerham, 2013).

Table 3: ANOVAa

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	360.381	1	360.381	17.783	.000b
	Residual	2979.069	147	20.266		
	Total	3339.450	148			

a. Dependent Variable: DV

b. Predictors: (Constant), IDV

Religiosity was utilized as the independent variable, and mental health was used as the dependent variable in conducting a standard linear regression analysis to further investigate the relationship that was predicted between religiosity and mental health. The ANOVA findings reveal that the general regression model is significant, $F(1, 147) = 17.78$, $p < .001$. This result proves that religiosity plays a significant role in explaining the variation in mental health scores and that the model is more appropriate than a null model that has no predictors (Field, 2018).

Table 4: Coefficients

			Unstandardized Coefficients	Standardized Coefficients		
	Model	B	Std. Error	Beta	T	Sig.
1	(Constant)	22.475	1.326		16.950	.000
	IDV	.196	.047	.329	4.217	.000

a. Dependent Variable: DV

The coefficients table indicates a positive and statistically significant standardized regression coefficient of religiosity ($\beta = .329$, $t = 4.22$, $p < .001$). This implies that the more Islamic religious practices are undertaken, the more perceived psychological well-being is engaged. The unstandardized coefficient (B =.196) indicates that every unit of believer changes in religiosity will modify the mental health scores by an approximate 0.20 unit.

Sociologically, this effect size supports the meaning that religiosity plays a supportive but not a dominant role in explaining mental health as an explanatory factor. This is in line with sociological critiques, which warn of over-emphasizing the cultural factors at an individual level and ignoring the larger structural forces of cultural factors like academic stress, economic insecurity, and accessibility of mental health services (Cockerham, 2013; Alqasir, 2024).

Discussion

This paper investigated the relationship between religiosity and mental health among Muslim students in the Pakistani university in the context of a sociocultural framework on coping. The results show that there is statistically significant positive correlation between Islamic religious practices participation and the self-reported mental health. Even though this relationship is moderately significant, the findings indicate that religiosity is a significant yet incomplete coping factor to support psychological well-being in Muslim youth.

In line with sociological approaches to religion and health, the findings reinforce the opinion that religious activities are embedded in culture and through which people make sense of distress and manage emotional reactions (Pargament and Exline, 2021). To Muslim university students, the element of prayer, fasting, and religious remembrance is not only a personal activity of worship but a socially patternized activity that gives order, moral support, and symbolic significance. Such practices could lead to psychological stability in social settings where there is academic pressure, economic uncertainty, and identity negotiation (Hollinger and Makula, 2021).

The modest explanatory capability of the religiosity ($R^2 = .108$) highlights the sociological insight that there are various intersecting social and structural determinants of mental health. Although it seems that religious engagement provides emotional reassurance and resources of the meaning-making, most of the variation in mental health outcomes is not explained by it. This observation corresponds to sociological critiques warning about reductionist interpretations that prioritize individual-level cultural or spiritual factors but do not consider more general determinants of academic stress, family expectations and other factors that restrict mental health service access (Cockerham, 2013; Alqasir, 2024). Religiosity then is to be seen as one of a number of coping resources as opposed to a holistic protective system.

The results also indicate an undetermined impact of religiosity in the mental health development. Even though religious practices might favor emotional control and resilience, religious senses might also be connected to the psychological burden in situations where distress is perceived through stigmatizing frames, including the belief of mental health problems as a deficiency in faith or righteousness (Anjum and Aziz, 2024). The experimental correlation that has been observed in the present research does not rule the possibility that there are religious interpretations or societal strains that may make people more distressed. This ambivalence drives the point that sociologically sensitive

studies are needed that would consider how religion is experienced and institutionally imposed as opposed to suppositively positive impacts.

In sociocultural coping, religiosity-mental health relationship is an expression of the power of religion in offering interpretive systems, which make suffering normal and one that fosters endurance. Religion can assist young people in framing psychological issues in narratives that have a moral basis and thus alleviate the sense of isolation or personal incompetence (Pargament, 1997). Nevertheless, the use of religious coping as a single method can also postpone the use of professional help, especially in the situations where the mental illness is still stigmatized and not yet accepted as an appropriate health issue. This conflict underscores the need to incorporate culturally competent mental health practices that would recognize the significance of religious beliefs and at the same time advance evidence-based psychological practice.

Finally, the results indicate that the roles played by religiosity among Muslim university students are at the subjective psychological wellness level, but not clinical mental health outcomes. Since the measure of mental health in this study was taken as self-reported indicators, the findings are perceived well-being, and not the diagnosed mental disorders. This difference is important, sociologically, because the subjective well-being is strongly associated with the cultural meanings, social norms, and interpretive paradigms. Religiosity can thus have an effect on the experience and perception of psychological distress as opposed to an effect on clinical symptoms.

Overall, the results substantiate the theoretical hypothesis according to which religiosity acts as a social cultural coping mechanism that exists in the context of the larger social frameworks. The fact that religious involvement is positively correlated with mental health is to be viewed as an indication of the supportive influence of religion on meaning-making and emotional regulation by Muslim youth and must not be overstated or considered as an alternative to the structural support or even professional mental health interventions.

Conclusion

This study examined the association between religiosity and mental health among Muslim university students in Pakistan through a sociocultural coping framework. The findings show that Islamic religious activities have a positive correlation with self-reported psychological well-being, meaning that religiosity is a valuable cultural and social coping mechanism in sexual youths to deal with daily stressors. Meanwhile, the limited explanatory value of religiosity also emphasizes a multidimensional character of mental health, and it helps to focus the attention on the impact of more global structural and social determinants of student well-being. The study does not present religion as a single or absolute solution, but as a means to derive meaning, emotional control, and normative reassurance complementarily in a context where religion is still social. Placing religiosity in a sociological perspective of coping, the study will help have a balanced interpretation of the role of religion in mental health as it is not only a supportive factor, but it is also limited. These results inform the significance of culturally sensitive mental health care that respects the role of religion and, at the same time, is responsive to structural contexts and the necessity of professional psychological assistance.

Limitations

Despite its contributions, the study has several limitations. To begin with, even though the study utilized probability based stratified random sampling technique, the study was carried out in one university of the public sector meaning that the results may not be applicable in other institutional and cultural settings. Second, the study design methods employed in the study (cross-sectional research design) does not allow making causal conclusions about the association between religiosity and mental health, thus, the results can be viewed as associative and not as directional. Third, self-reported data concerning psychological well-being were used to evaluate mental health and not clinical diagnostic tools and this could be affected by social desirability or cultural interpretations of

distress. Lastly, the operationalization of religiosity was mainly done based on the religious practices, and this fails to capture other aspects of religiosity, including intrinsic religiosity, a spiritual struggle and negative religious coping. The longitudinal designs, multi-institutional samples, and multi-dimensional measure of religiosity would permit a more in-depth analysis of the intersection of religion and mental health in Muslim youth in future research.

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