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The Role of Religiosity to Address the Mental Health Crisis of Students: A Study on Three Parameters (Anxiety, Depression, and Stress)

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ABSTRACT

Religiosity is a construct that has interesting implications in the mental health issues of youths. This study examines the role of religiosity on anxiety, depression, and stress using 148 Muslim students studying Islamic studies at undergraduate provision in an Islamic University as sample. Results indicated that the level of religiosity among the participants ranged from moderately religious to highly religious. The mean levels of anxiety, depression, and stress among the participants were moderate, and a significant number of students suffered from severe psychological distress. Female students were reported to experience significantly slightly more stress than male students. Furthermore, the relationship between religiosity, anxiety, and depression was significantly negative but not stressful. Further analysis found that religiosity serves as a protective factor for depression. Meanwhile, some religiosity components (i.e., avoidance of sinful acts and frequent conduct of recommended acts) were found to be a significant protective factor against anxiety and depression, respectively. Thus, in retrospect, mental health and religion appear to converge on managing psychological distress. As so to speak, this is a vital point in the emerging mental health services in which the incorporation of religious components into clinical practice may show good promising results in aiding the recovery process of psychological health issues. Likewise, embedding religiosity

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in one's life, or being religiously minded, reflected in daily life manifestation, is linked with better mental health outcomes.

Keywords: Islam, Malaysia, mental health, religious studies, young adults

INTRODUCTION

Mental disorders have incapacitated almost a million people across the globe. A recent report by World Health Organization (2019) revealed that depression causes the leading worldwide disability, followed by 800 000 suicide-death cases involving youths and adults (15-29 years old). Furthermore, more than one billion people are affected by mental illness throughout their lifetime. Hence, mental disorders are considered one of the major contributors to the Global Burden of Disease (Rehm & Shield, 2019).

Young adults in higher education's mental health conditions were persistent due to life transitions from adolescence to adulthood (Royal College Psychiatrists, 2011). The university's daily demands exceptionally require students to squish their emotional, intellectual, financial, and great energy to fulfil the tasks and achieve excellent academic performances (Saleem et al., 2013). It was documented in the literature that there was an exacerbation in the onset of psychological symptoms and an increase in the number and severity of mental health disorders such as depression, anxiety, and psychological distress among university students (Hunt & Eisenberg, 2010; Pedrelli et al., 2015). Storrie et al. (2010) systematically analysed 11 articles with 18,580 participants on the prevalence of mental health issues among students from English-speaking countries globally. They found that depression, anxiety, and psychotic disorders were highly prevalent among university students.

Statistics have shown that the number of Malaysian adults suffering from mental health issues is depressing. For example, the National Health and Morbidity Survey 2015 revealed that about 29.2% of Malaysian adults aged 16 years and above experienced mental health problems (Institute for Public Health, 2015). Some other studies also share similar results whereby the prevalence of psychological distress among university students in Malaysia are higher in anxiety, depression, and stress (Md Nordin et al., 2010; Shamsuddin et al., 2013). Additionally, senior students in some universities reported experiencing more anxiety symptoms than freshmen and sophomores (Rashid et al., 2021).

The Malaysians' stigma on mental health conditions and misperceptions of mentally ill individuals remain high in society. People with mental health problems were viewed as 'crazy' and triggered them to stay in silence than seek help from institutionalised mental health care and professionals (Hanafiah & Van Bortel, 2015). The demand to seek Muslim faith healers for Muslims with mental illness is also at its peak due to the belief in the metaphysical existence virtue (i.e., *jinn*/ demons) which caused the mental illness (Razali & Tahir, 2018). This desire to meet the complementary or alternative healers instead of conventional health providers

may be developed and maintained by cultural inclusion of religious teachings such as predestined matters, have shaped a belief on the attribution of the mental illnesses were originated by supernatural elements (Choudhry et al., 2016). Moreover, it was found that the belief in the effectiveness of faith or traditional healers strengthened the hindrance of conventional help-seeking services in low- and middle-income countries (van der Watt et al., 2018), including Malaysia.

Spirituality and religiosity were used interchangeably in academic papers and various public debates. The close relationship is understandable since all the main traditional world religions such as Islam, Christianity, and Jews does not essentially differentiate those two constructs. Islam, for example, considers religiosity and acts of worship as parts of spirituality. However, in modern psychological research and treatment, more refined definitions and understandings are paramount to promote greater research and, more importantly, to help culturally diverse mental health clienteles. Pargament (2011) stated that spirituality is the heart and soul of any religion. It describes personal connectedness with transcendence and generates a more individualistic meaning of life. Religion is the organised system that includes ways of worship, worldview, sacredness and spiritual components shared by a group of people. Spirituality does not necessarily need a religion to be manifested in a person.

Many research examined the associations between religiosity and psychological disorders, and there is evidence signify the importance of religion, religiosity, and religiousness in dealing with uprising issues in mental health globally (Weber & Pargament, 2014). Levin (2010) highlighted extensive scientific research on the study of religion-health connection portrays several promising evidence as primary preventions in the psychiatric population. The literature review showed several studies on the relationship between adolescent religiosity or spirituality and mental health. The evidence showed that nearly all studies demonstrated that adolescents with higher religiosity or spirituality were associated with good mental health (Wong et al., 2006). Meanwhile, Moreira-Almeida et al. (2006) found that frequent involvements in religious activities lead to positive psychological well-being. Furthermore, they discovered that mediators such as social support, belief system or cognitive framework, religious practices, spiritual direction, words to express stress, and religious multi-dimension explanations were fathomed to influence the health-promoting effects by the construct of religiosity.

A considerable amount of literature has been published on the relationships between religiosity and anxiety, and mixed results were found when the two variables were correlated. For example, Koenig (2009), in his review paper, studied the relationship between religion, spirituality, and mental health and reported that 36 studies have found that higher religious involvements were significantly associated with lesser anxiety or fear. On the other hand, ten

studies in the review documented greater anxiety, and the rest had no significant association. Moreover, many studies have been conducted to examine the relationships between anxiety and college students. For example, Forouhari et al. (2019), in their systematic review and meta-analysis of 13 articles (sample size of 5,620), found a negative relationship between anxiety and religious orientation alone, but an inverse result in internal religious orientation. Meanwhile, a significant negative relationship was found in the trait of anxiety when religious commitments were observed (Harris et al., 2002) and religious service attendance produced a significant negative correlation with, and a lower level of anxiety (Gonçalves et al., 2018; Jansen et al., 2010).

A large volume of published studies describes the association between religiosity and depression, and the results found were also mixed in nature. For example, in the review paper by Koenig (2009), he found that two-thirds out of 93 correlational-based studies reported significantly low rates of depression (i.e., either disorder or symptoms) among more religious people. The rest of the studies found no significant association between religiosity and depression, and only four studies reported a negative relationship between being religious and depression. Another study by Bonelli (2017), who systematically reviewed 43 studies on religiosity and/or spirituality among patients with psychiatric illnesses, found that 72% reported a positive association between religiosity/spirituality and mental health, 19% found mixed (positive and negative) results, 2% indicated no relationship, and 5% found a negative relationship.

Correspondingly, many studies have been conducted to examine the relationship between religiosity and stress. According to Ross (1990), strong religious belief is associated with lower psychological distress. In their meta-analytic of 35 studies on the relationship between religiosity and everyday psychological adjustments, Hackney and Sanders (2003) found that religiosity was associated with low distress when religiosity was considered a personal devotion. Furthermore, a higher level of religiousness intertwined with the exercise of positive religious copings was reported to reduce the stress among international Muslim students in New Zealand (Gardner et al., 2014). Similarly, in Malaysia, more young people in medical school engage with religion to cope with stress (Salam et al., 2013; Yusoff et al., 2011).

With the advent of science, especially psychological medicine, mental health issues have become almost exclusively under the purview of mental health professionals grounded on empirical evidence and scientific traditions. In conservatively religious societies, this situation might pose a challenge in caring for and treating psychiatric illnesses. Their respected *ustadz* or religious scholars lead the community. Unfortunately, there are not many studies investigating the mental health issues of religious scholars and students in religious studies. This kind of investigation might pave the way for understanding further the

mental health issues in relation to religiosity and the presence of mental health problems among people of religion.

Consist of more than 60% of the multi-religious population, Muslims are the majority in Malaysia. Nevertheless, the data on Muslims mental health in Malaysia is insufficient and under discovery. Moreover, the authors observed that studies on the association of religiosity and mental health among Muslim students in Southeast Asia are scarce. Furthermore, studies on mental health among university students in Malaysia were mostly done on medical students, while there were few findings on students who took religious courses as their major. Therefore, the current study aims to investigate the relationship between religiosity and mental health issues (i.e., anxiety, depression, and stress) among Muslim university students specialising in Islamic studies in a Malaysian context to understand this phenomenon further and contribute to the body of knowledge. Additionally, to explore the level of religiosity and identify specific religiosity components that act as psychological aid towards psychological distress.

By understanding the status of religiosity of Muslim students who are formally studying religious courses daily, the current study may provide insights into how religious knowledge and activities signify as protective roles for psychological problems.

It is important to emphasise that the assessment of religiosity in this study understands that it will infer to the spiritual level and spirituality.

METHOD

Participants

Participants were undergraduate students who enrolled in religious studies at one of the Islamic universities in Klang Valley, Malaysia. They were recruited through purposive sampling since the study's inclusion criteria need Muslim participants who specialise in Islamic studies. Around 170 students were approached.

Measures

Sociodemographic Items. Information on age, gender, nationality, marital status, year of study, school of study, and two questions regarding their mental health status and help-seeking behaviours were asked: i) if they have experienced meeting mental health professionals (i.e., psychiatrist, clinical psychologist, counsellor) and ii) if they have met any religious practitioners for their mental health or psychological issues.

Religiosity. Olufadi (2017) established the Muslim Daily Religiosity Assessment Scale (MUDRAS) to access Muslim's conduct that is in line with the Islamic teaching. It is a 21-item self-report measure of daily religiosity with three components (i.e., sinful acts, recommended acts by Allah (i.e., God) and prophet, and engaging in bodily worship of Allah). The component of sinful acts brings the connotation of major and minor sins that Allah strongly prohibits, and the items are rated as "Never do this today =3" to "More than three times today =0". Next, recommended acts component is positive recommended acts commanded by Allah

and advocated by the Prophet Muhammad. The last component caters for religious activities' items obligated by Allah. The global score for this scale ranges from 0 to 10. Greater values posit a good relationship with Allah for the day. This scale has high internal consistency (α=.89; Olufadi, 2017). The current study has an acceptable internal consistency (α=.69) of the scale.

Anxiety. Beck Anxiety Inventory (BAI) was used to measure anxiety in this study (Beck, Epstein, et al., 1988). This instrument consists of 21 items rated from 0 (Not at all) to 3 (Severely-It bothered me a lot). Each item is descriptive of subjective, somatic, or panic-related symptoms of anxiety. The anxiety level severity is measured according to the total score ranges from 0 to 63 (Minimal=0–7, Mild=8–15, Moderate=16–25, Severe=26–63). The BAI scale has high internal consistency in the original (α=.92) and current study (α=.95).

Depression. The Beck Depression Inventory-II (BDI-II) was used to measure depressive symptoms. The BDI-II consists of 21 items with a total score ranging from 0–63. The severity level of depressive symptoms is interpreted as minimal depression=0–13, mild depression=14–19, moderate depression=20–28, and severe depression=29–63. The scale depicted good internal consistency, with alpha coefficients of .86 and .81 for clinical and non-clinical populations, respectively (Beck, Steer & Carbin, 1988). The present study obtained an excellent internal consistency of α=.90.

Psychological Stress. Perceived Stress Scale (PSS) was used to assess how people perceive how stressful their lives are. It consists of 10 items with a total score ranging from 0–40. The low degree of the perceived stress is ranged 0–13, moderate stress is 14–26, and high perceived stress is 27–40. The original PSS administered to college students demonstrated good Cronbach's alphas ranging between .84 and .86 (Cohen et al., 1983) and acceptable alphas of >.70 for a wide range of populations (E. H. Lee, 2012). The present study revealed an acceptable internal consistency of α=.77 in measuring the stress level of the participants.

Procedures

Ethical clearance was sought from the institution before the study commenced. Two approaches were used in the participants' recruitment. First, through social media (e.g., university Facebook's group), and second, only Islamic studies students were invited through closed events. For the first method, Google survey forms were used. Meanwhile, the second method used a paper-and-pencil survey. All the participants have been informed either in a written or verbal form on the study's objective and the benefits and risks of involving them before they agreed to be involved. Furthermore, the assurance on anonymity and privacy of data, their rights to withdraw from the study at any time without consequences were informed.

Data Analysis

The study used descriptive statistics to describe the sociodemographic profile. An independent *t*-test was used to compare male and female respondents in their level of religiosity, anxiety, depression, and stress. One-way ANOVA was conducted to compare the year of studies and the psychological distress (i.e., anxiety, depression, and stress). Pearson *r* correlation was used to analyse the association between the variables. Finally, multiple linear regression was employed to estimate the role of religiosity and its component as a protective factor for anxiety, depression, and stress.

RESULTS

Sociodemographic Profile of the Participants

Out of 170 participants approached, 148 students had participated (87.06% response rate). The age of the participants ranged from 19 to 28 years old (M=22.9, SD=1.57). Equal number of males and females completed the survey (i.e., n=74, 50% for both gender). Students from different nationalities participated; Indonesian (n=1, 0.7%), Singaporean (n=2, 1.4%), Malaysian (n=142, 95.9%), Bruneian (n=2, 1.4%), and Thai (n=1, 0.7%). Majority of the students participated were single (n=144, 97.3%).

Participants were majoring in Islamic Jurisprudence and its Principles (41%; n=61; 30 males, 31 females), Qur'anic Studies and Prophetic Tradition (29.7%; n=44, 20 males, 24 females), and Fundamental Belief on Islam and Comparative Religion (29.1%; n=43; 24 males, 19 females). In terms of levels of study, 20.3% of first-year students, 18.9% second-year students, 27% third-year students, and 33.9% fourth-year students had participated in the studies.

In terms of mental health status and help-seeking behaviours, 14.2% of the participants had experience meeting with mental health professionals. The majority consulted the experts on their daily life's issues, career advice, and existential crisis. Around 5% of them consulted the expert due to psychological problems such as stress, anxiety, depression, and schizophrenia. The help-seeking trend from the religious practitioner for mental health issues is common among the participants. Around 12.1% of the participants indicated they had met religious practitioners, and 3.5% of them asking help due to stress, anger, depression, autism, and the impact of black magic and evil spirit (i.e., *jinn*). The results show that the help-seeking behaviours in relation to mental health consultations were similar for both mental health service providers and religious practitioners in this sample.

Descriptive Data on the Variables Measured

The scores of the Muslim Daily Religiosity Assessment Scale (MUDRAS), Beck Anxiety Inventory (BAI), and Beck Depression Inventory-II (BDI-II) and Perceived Stress Scale (PSS) for all the samples were presented in Table 1 below.

Overall, the mean value of MUDRAS' score indicates that the students possessed a very good relationship with Allah for the

Table 1
Means and standard deviations of the variables

Variables	*M*	*SD*	Min	Max
MUDRAS	7.84	1.09	5	10
BAI	16.00	12.91	0	46
BDI-II	16.68	11.88	0	56
PSS	21.18	5.34	0	40

Notes. MUDRAS = Muslim Daily Religiosity Assessment Scale, BAI = Beck Anxiety Inventory, BDI-II = Beck Depression Inventory-II, and PSS = Perceived Stress Scale

day. Hence, it was presumed that they were moderate to highly religious. The mean scores for BAI, BDI-II, and PSS elucidated that the participants had moderate anxiety, depression, and stress levels. However, based on further analysis, 23.6% (n=35), 18.2% (n=27), and 13.5% (n=20) has severe level of anxiety, depression, and stress, respectively.

Differences between Genders and Year of Studies on Religiosity, Anxiety, Depression, and Stress

Independent sample t-test and one-way ANOVA were used to analyse for the comparison of the mean scores of the variables between genders and year of studies. The results showed that there were no significant differences between male and female participants in religiosity, anxiety, and depression scores, but not stress (Cohen's d=0.34). However, female students were significantly more stressed than male students, and the effect size was moderate. Meanwhile, no significant difference was found between the year of studies on the level of religiosity and mental health status. Please refer to Table 2.

Relationship between Religiosity, Anxiety, Depression, and Stress

In Table 3, only depression has a significant negative correlation with the total score of religiosities. In other words, the more religious someone is on that day, the lower their symptoms of depression. However, further analysis on the subscales of MUDRAS and its relationship with other measures was carried out. It was found that involving in recommended acts and engaging in bodily worships of God are negatively associated with depression symptoms. On the other hand, avoiding sinful acts are negatively associated with anxiety. In other words, the more someone prohibits himself from doing sinful acts, the lesser anxious he will be. Despite the fact that the relationships were significant, it is important to note that they were small. Furthermore, no significant relationships were found between the total score of religiosities or its subscales with stress.

In order to see if religiosity can be a protective factor for anxiety and depression, a multiple linear regression analysis was performed (Table 4). Based on the results, avoiding sinful acts is a significant protective factor of anxiety, and the variance accounted for is 18% (p=.03). Meanwhile, being religious may significantly protect someone from depression. The global score of MUDRAS found that the variance accounted for is 31.2% (p<.001). Further analysis on the subscales found that involvement in recommended acts (but not engaging in bodily worships of God) may protect someone from depression and the variance

Table 2
Differences between gender and year of study on religiosity, anxiety, depression, and stress

Variables	Gender							Year of Study									
	N	Male		Female		*t*	*p*	Year 1		Year 2		Year 3		Year 4		*F*	*p*
		M	*SD*	*M*	*SD*			*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Religiosity	148	7.72	1.08	7.97	1.10	-1.44	.15	7.87	1.22	8.00	0.94	7.93	0.92	7.68	1.22	0.64	.59
Anxiety	148	15.51	12.94	16.49	12.96	-0.46	.65	14.73	12.17	18.14	14.45	16.02	12.66	15.54	12.89	0.37	.78
Depression	148	17.69	12.02	15.66	11.74	1.04	.30	13. 23	9.64	19.82	13.70	17.50	13.13	16.32	10.70	1.59	.19
Stress	148	20.27	5.48	22.08	5.07	-2.09	.04	19.63	5.39	23.04	4.56	20.63	6.42	21.50	4.51	2.22	.09

Table 3
Correlation between religiosity, anxiety, depression, and stress

	Global Score MUDRAS	Sinful Acts	Recommended Acts	Engaging in Bodily Worships of God
BAI	-.13	-.19*	-.06	-.11
BDI-II	-.31**	-.14	-.29**	-.20*
PSS	-.10	-.03	-.08	-.08

Notes. Global Score MUDRAS = Global Score Muslim Daily Religiosity Assessment Scale; BAI = Beck Anxiety Inventory, BDI-II = Beck Depression Inventory-II; PSS = Perceived Stress Scale; **Correlation is significant at the 0.01 level (2 tailed); *Correlation is significant at the 0.05 level (2 tailed)

Table 4
Multiple regression analysis for prediction of anxiety, depression, and stress by religiosity

Dependent variables	Independent variables	*B*	*p*
BAI	SA	-.18	.03
	RA	-.02	.81
	EBW	-.09	.29
BDI-II	SA	-.12	.13
	RA	-.25	.004
	EBW	-.11	.19
PSS	SA	-.02	.79
	RA	-.05	.55
	EBW	-.07	.45

Notes. SA = Sinful Acts; RA = Recommended Acts; EBW = Engaging with Bodily Worship of God; BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; PSS = Perceived Stress Scale; $p < 0.05$

accounted for is 25% (p=.004). Thus, there is no significant impact between religiosity components and variables associated except for sinful acts and recommended acts, which have showcased inverse patterns.

DISCUSSION

The current study examines the roles of religiosity on anxiety, depression, and stress among students who specialise in Islamic studies in an Islamic university. The results found that the status of religiosity among students of Islamic studies was considered moderate to high during the day they were assessed. Looking at their mental health status, participants had moderate anxiety symptoms, mild depression, and a moderate level of stress. Despite the mental well-being outcome, religiosity shades light of fascinating nuanced associations among the investigated symptoms.

No gender differences were significantly found in terms of the religiosity level. Though religion is known to be a patriarchal gendered, women were found to be more universally religious than men (Miller & Stark, 2002; Schnabel, 2017), and they have a strong tendency toward extrinsic personal religious orientation (i.e., people who pursue social acceptance and well-being through religiousness; Buzdar et al., 2014). This outcome provides an insight into the religion of Islam that Muslims, both men and women, shared an identical attitude in striving for the fulfilment of religious obligations and prohibitions. Moreover, it is in line with the statement from *Qur'an,* "O mankind, indeed We have created you from male and female and made you peoples and tribes that you may know one another. Indeed, the most noble of you in the sight of Allah is the most righteous of you. Indeed, Allah is Knowing and Acquainted" (The Qur'an: English Meanings, 2004, 49:13).

The previous study found a commonality for which psychological symptoms appeared greater in females than males (Altemus et

al., 2014). Incongruent from the literature, the current study revealed no significant difference between male and female students on anxiety and depression scores, thus implying both genders are potentially prone to psychological dismalness. However, there was a significant difference between male and female students on stress scores. This stress's result matches those observed in earlier studies, whereby female students were documented to have higher scores for stress than male students (Al-Sowygh, 2013; Pozos-Radillo et al., 2014). Aside, students in the third or fourth year were more anxious than first, or second-year students (Rashid et al., 2021) provided a different insight from this paper which found no significant difference between the year of studies and psychological distress. The researcher assumes that it may be due to the similar nature of courses taken by the students who specialised in Islamic studies throughout their four-year undergraduate degree (i.e., they were involved in taught courses and no compulsory capstone course in their final year). Hence, the students may share similar experiences in their different levels of studies, adapt well, and maintain their mental health status (i.e., no significant differences between the levels of studies). There was a significant, negative relationship between religiosity, anxiety, and depression for the association between variables, though no significant relationship was observed between religiosity and stress. The construct of religiosity, in which the ethics and Islamic values lies, transcending in the daily conducts, has actively engaged the Muslims in their day-to-day activities was operationalised in the study. These sacral activities benefit better mental health and likely hinder Muslims from begetting mental health issues. Studies in psychiatric and non-psychiatric samples support a frequent religious involvement buffers the stressor's effects of leading causes to mental health problems (Brown et al., 1990; Lorenz et al., 2019; Strawbridge et al., 1998). Hence, it clarifies the current results on the status of explored symptoms, which religiosity plays an incremental part in Muslim's well-being constitution.

Based on the regression analysis, the wholeness of religiosity has a big role in protecting a person from depression. It is in line with what has been found in Koenig's (2009) systematic review whereby most of the correlation studies significantly low rates of depression (i.e., either disorder or symptoms) among more religious people. Another study that conducts similar research among Muslim university students supported that religious conduct helped to reduce students' depression (Nadeem et al., 2017). Replicating the notion of religiosity on mental health, two dimensions, namely recommended acts and prohibiting oneself from involving in sinful acts, may protect someone from depression and anxiety, respectively. These behaviours seem to operate as rehabilitative maintenance to the students under this study. At any rate, this study strengthens and complements other dimensions that may contribute to Muslims well-being, such as internal forgiveness (Abu-Raiya & Ayten, 2020),

prosociality (Ayten & Korkmaz, 2020), personality factors (Aghababaei & Tekke, 2018), and spirituality (Hodge et al., 2016). Notwithstanding, the results may not be generalised to every population because the sample in the current study is homogeneous. Future studies may want to test this with a more heterogeneous sample.

However, religious activities largely incorporate communal indulgence; hence there exist values of socialisation and togetherness, which understandably enhance the individual participants' mental health well-being. Religiosity scales are bound to have criticism in terms on how it measures comprehensively one's religious propensity and belief as well as its close cousin, spirituality. Spirituality, unlike religiosity, is a difficult construct to be measured by a quantitative scale. It is a larger and broader concept which, according to Pargament (2011), is defined as 'a search for the sacred'. It is not limited to the scope of organised religion but can be expressed individually in various ways, theistically and atheistically. The frequency of one going to mosque does not necessarily reflect his total confidence in God's compassion. Organisational religiosity, such as attending prayer service, could have an adverse relationship with depression, according to some studies (Strawbridge et al., 1998). The motivation of the religious behaviours should be explored further along the line of extrinsic versus intrinsic forms of religiosity (Power & McKinney, 2014). In the pursuit of understanding spirituality within the context of religion (i.e., Islam), a religiosity scale is used. In this study, the scale is being inferred to spirituality as well.

Most of the time, a large number of the literature has been concerned with the mental health status of medical students, since medical students were reported more persistent in the prevalence of anxiety, depression, and stress for its severity (Fawzy & Hamed, 2017; Hope & Henderson, 2014; Pacheco et al., 2017; Yusoff et al., 2011). This study contributes to the body of research by studying mental health status among students majoring in religious (i.e., Islamic) studies and its relationship with religiosity. Moreover, the data of the current study exemplified that students who take religious courses experience a manifestation of psychological disturbances due to the nature of the studies, which required the students to adhere to certain requirements for qualification, as it in line with previous literature (Bayram & Bilgel, 2008; M. F. Lee & Syaid, 2017) though they are non-medical students. In other words, many of our young adults in this country suffer from psychological problems, regardless of their gender, the discipline of study, or even religion.

An appropriate intervention such as integrated treatment, which devises an Islamic-conventional framework, is beseeched in tackling the rising mental health problems among religious studies students. Within the intervention program, the unremitting prejudices concurred by public opinions that individuals diagnosed with mental health problems as having a kind of punishment from God because of weak

Iman (i.e., faith), and issues or challenges faced by Muslims individuals usually are being stigmatised as being possessed by *jinns* (demons) or evil-spirit can be minimised. As a result, this intervention will encourage Muslim students to seek treatment and share the problems with mental health professionals.

The current study showed an almost similar percentage of religious study students who sought mental health professionals or religious healers for their psychological issues. The Malaysian Muslim community largely tends to seek Islamic faith healers or *Ustadz* for psychological problems. However, despite the potential of integrating spirituality in the treatment, these healers might pose certain issues. Some of the healers discourage the usage of psychotropic drugs and are likely to diagnose *jinn* possession in severe treatable mental illness such as schizophrenia and bipolar mood disorders (Md. Sa'ad et al., 2017). This difficulty has brought mental health researchers to suggest that Muslim mental health professionals themselves should equip themselves with psycho-spiritual knowledge and change of attitude to have integration, rather than a complementary, form of mental health treatment in place (Razali et al., 2018). In treatment and therapy, the broader concept of spirituality is the main focus rather than religiosity alone. Spirituality is an encompassing approach that includes the meaning and connectedness with the transcendence (i.e., God), as well as the internal and external focus of religious copings. Further study might be needed to follow up these findings in inculcating awareness regarding mental health services among non-medical students. Specific for students specialising in religious study, exploring the intention, motivation, and outcome needs to be done when seeking religious healing treatment.

The integration of treatment requires the application of four components in approaching any mental health condition: biological, psychological, social, and spiritual. Spirituality as part of mental health treatment has been studied and elaborated on by many scholars. Spirituality does not necessarily equate to religiosity, but it does represent sacredness (Pargament, 2011). In Islamic tradition, there is an abundance of discussion on the spiritual approach in dealing with psychological distress with various emphases by different scholars. For example, the traditional Islamic scholars such as Imam Al-Ghazali emphasised on theological-psycho-spiritual approach while Ibn Taymiyyah and Ibn Miskawayh proposed the ethico-religious approach in handling psychological issues (Ssekamanya, 2016). There were other medieval scholars' approaches who were not as popular as the above named, such as Abu Zayd Muhammad Al-Balkhi. Al-Balkhi's form of therapy for depression and anxiety resembles modern rational-emotive and cognitive-behavioural therapy. Furthermore, he brought in psycho-spiritual value based on the Islamic creed in the treatment without emphasising ritualistic activities (Badri, 2013).

Despite the contributions of the current study to both body of knowledge and

clinical implications, there are limitations. First, the present research used a purposive sampling from the faculties of Islamic studies only from one Islamic university in Klang Valley of Malaysia, so caution should be considered when generalising the results. Second, pertaining to the religiosity scale that significantly contributed to the protective factors towards depression and anxiety, it is favourable to add more variables to the model. Religiosity is considered multi-facets in nature; therefore, the future researcher should broaden the usage of religiosity domains rather than religious practices alone, as measured by the scale used in the current study.

Finally, the present research was cross-sectional; thus, the result provided no causality on the intended variables in the study. Therefore, we could not ascertain the direction of the relationship between religiosity and psychological well-being scores. They become religious because of their anxiety or their intense ritualistic behaviour, partly the reason for their psychological distress. Abu-Raiya (2017) has discussed at length the studying of religiosity and spirituality in mental health. The area that has proved difficult to rectify is the clear definition of religiosity and spirituality and the methodological issues such as self-report and cross-sectional design. Therefore, it is recommended to investigate the underlying reasons, including the bio-psycho-socio-spiritual aspects, in the comparison between the causes of female and male students' stressors across the cultural interest. Reliance on the statistical study solely is inadequate to address the concerns regarding religion's specialty. Thus, a comprehensive and longitudinal study on religious studies' students, involving qualitative study to further explain to what extent attending religious studies has been helpful to individuals. Getting religious, associated with a sense of spirituality, has prevailed in better mental health.

CONCLUSION

In conclusion, the present study found that the students who specialised in Islamic studies in an Islamic university struggled with different degrees of psychological problems, although they were religious. However, the current study found that religiosity and its component was found to be a protective factor against depression and anxiety. In other words, religious lifestyle is closely related to lower levels of psychological distress. Therefore, the current study results also support the literature on the usefulness of religious-based intervention in psychotherapy. Therefore, we are promoting the mental health care service providers to be well-equipped with religious-based training intervention for young Muslim adults with mental health problems.

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