RESEARCH PAPER

Association between Religion and Mental Health Status among Female Hostel Students of BHU, AMU, and DU: A Cross-Sectional Study

Shalini Singh[1], Dr. Shikha Singh[2]

[1]Research Scholar, Department of Prasuti Tantra, Faculty of Ayurveda, Institute of Medical Sciences, Banaras Hindu University, Varanasi

[2]Assistant Professor, Department of Prasuti Tantra, Faculty of Ayurveda, Institute of Medical Sciences, Banaras Hindu University, Varanasi

ABSTRACT

Mental health is a vital part of total well-being. It impacts how we think, feel and act, how we cope with stress and how we relate to others (World Health Organisation [WHO], 2022). The influence of religion on mental health may be due to emotional support, purpose, hope, resilience and social inclusion. Previous research has indicated that religious and spiritual coping can help people cope with stress and psychological suffering, especially in tough life situations. Therefore, this study was conducted to find out the association between religion and mental health conditions among female hostel students of BHU, AMU and DU. A cross-sectional study approach was used, and data were collected from 543 respondents. Religion was treated as the independent variable, and mental health status as the dependent variable. Respondents were classified into four groups of mental health condition, including no symptoms, mild, moderate and severe. Descriptive statistics, mean, standard deviation and one-way ANOVA were utilised for the analysis. Out of 543 respondents, 392 were Hindu, 109 were Muslim, and 42 were Sikh, the results showed. Overall, 432 respondents (79.6%) were in the severe mental health group, 61 respondents (11.2%) in the moderate category, 33 respondents (6.1%) in the mild category, and 17 respondents (3.1%) had no symptoms. The greatest mean score of mental health was seen among Sikh respondents (36.90 ± 7.61), followed by Hindu respondents (35.67 ± 8.01) and Muslim respondents (34.92 ± 7.92). However, the ANOVA result indicated $F = 0.972$, $p > 0.05$; this revealed that religion was not substantially connected with mental health status. The study found a high prevalence of mental health problems across all religious groups, indicating the need for inclusive mental health support services in university hostels.

Keywords: Mental Health, Religion, Female Hostel Students, BHU, AMU, DU, Cross-Sectional Study.

How to cite this article: Singh S, Singh S. Association between Religion and Mental Health Status among Female Hostel Students of BHU, AMU, and DU: A Cross-Sectional Study. Int J Drug Deliv Technol. 2026;16(47s): 380-385. DOI: 10.25258/ijddt.16.47s.44

Source of support: Nil.

Conflict of interest: None.

Introduction

Mental health is an important aspect of health and general well-being. It enables people to deal with stress, realise their potential, learn well, work productively, and contribute to society (WHO, 2022). It encompasses emotional, psychological and social wellness and impacts on how a person thinks, feels and behaves as well as how they relate to others (WHO, 2022). Mental health is especially crucial for university students as this stage of life often involves academic pressure, emotional adjustments, social expectations, and job uncertainties (Aggarwal et al., 2023).

Female hostel students may face additional psychological obstacles as they are typically away from their families and are adjusting to a new academic and social setting. Living in a hostel can be a good experience for independence and contact with peers, but it can also raise stress, loneliness, sleep issues, emotional fragility and transition problems. Such conditions could adversely impact students' mental health and wellness.

Religion is one of the main sociocultural factors that can influence mental health and coping behaviour (Lucchetti et al., 2021). Religious ideas and practices can offer emotional consolation, moral guidance, hope, discipline, and significance in life (Koenig, 2012). Prayer, meditation, worship and engagement in religion can help individuals cope with stress and stay psychologically stable in stressful situations (Ano & Vasconcelles, 2005). Religion may also provide social support from family, community and shared beliefs, which can lead to higher psychological wellbeing (Francis et al., 2019).

But the relationship between religion and mental health is complex and not always straightforward. Religion may contribute to mental well-being if it encourages optimism, acceptance, forgiveness, emotional regulation and social connectedness (Lucchetti et al., 2021). Negative religious coping, guilt, dread or religious conflict may be connected with psychological distress, anxiety or depressive symptoms (Francis et al., 2019). Thus, the influence of religion on mental health may be a function of not only religious identity, but also religious practice,

spirituality, coping style and social support (Bonelli & Koenig, 2013).

Existing studies show that religion and spirituality could be connected with improved mental health, the magnitude of this association differs with demographic, cultural, assessment methodologies, and the style of religious coping (Lucchetti et al., 2021; Aggarwal et al., 2023). Some research suggests that positive religious coping may protect against stress and promote psychological adjustment, while negative religious coping may exacerbate emotional discomfort (Ano & Vasconcelles, 2005; Francis et al., 2019). Thus, religion may be a resource for coping, but it may not always have a direct statistical link with mental health.

There are many studies on religion, spirituality and mental health. But few studies have been done on female hostel students in university settings in India. Hostel females may encounter difficulties that are particular to them, such as academic workload, separation from home, social adjustment, lifestyle changes, and connections with peers. Hence, it is crucial to find out whether religion is significantly related to the mental health of female hostel students of BHU, AMU and DU.

Objectives

The major objective of this study was to evaluate the relation of religion with mental health status among female hostel students of BHU, AMU and DU.

H0 null hypothesis.

H_0: There is no statistically significant association between religion and the mental health status of female hostel students of BHU, AMU and DU.

Alternative Hypothesis

H1: There is a statistically significant relation between religion and mental health status among female hostel students of BHU, AMU and DU.

Research Methodology:

The present study is a cross-sectional study conducted among hostel-living girls between the ages of 19 and 30 years, Banaras Hindu University, Aligarh Muslim University and Delhi University. The total sample size was 543, 181 for each university. The Kessler Psychological Distress Scale (K10), developed by Ronald C. Kessler, was used to collect data. (Kessler et al., 2002)

Study area:

Research Study Area

Fig. 1 Study Area

The study was conducted on female hostel students of Banaras Hindu University, Aligarh Muslim University and University of Delhi. The overall sample comprised of 543 female hostel students of BHU, AMU and DU. The respondents were categorised into three groups on the basis of religion, namely. Hindu, Muslim and Sikh. Number of Hindu respondents=392 Number of Muslim respondents = 109, Number of Sikh respondents=42.

In this present study, religion was used as an independent variable and mental health score was taken as dependent variable. Mental health score was regarded as a continuous variable; a greater score indicates higher levels of mental health concerns. Socio-demographic data were considered as other background variables such as university, age, socioeconomic status, family type, academic level and location of residence.

Statistical approach utilised Descriptive statistics frequency and percentage were used to describe the distribution of respondents according to religion Mean and standard deviation were calculated and mental health ratings were compared across Hindu, Muslim and Sikh respondents. Because mental health score was a continuous variable, one-way analysis of variance (ANOVA) was used to test if the mean mental health score was substantially different across religious groups. … statistical significance was defined as a p-value < 0.05. The outcome of ANOVA for the present analysis was $F = 0.972$, $p > 0.05$, suggesting that there was no significant difference in the mean mental health score with respect to religion. So, the null hypothesis was accepted.

Results

Figure 2 shows the relationship between religion and the mental health status of the respondents. Out of 543 respondents, the majority was from Hindu religion (392), then Muslims with 109 respondents and finally Sikhs with 42 respondents.

Table 1: Association between Religion and Mental Health Status of Respondents

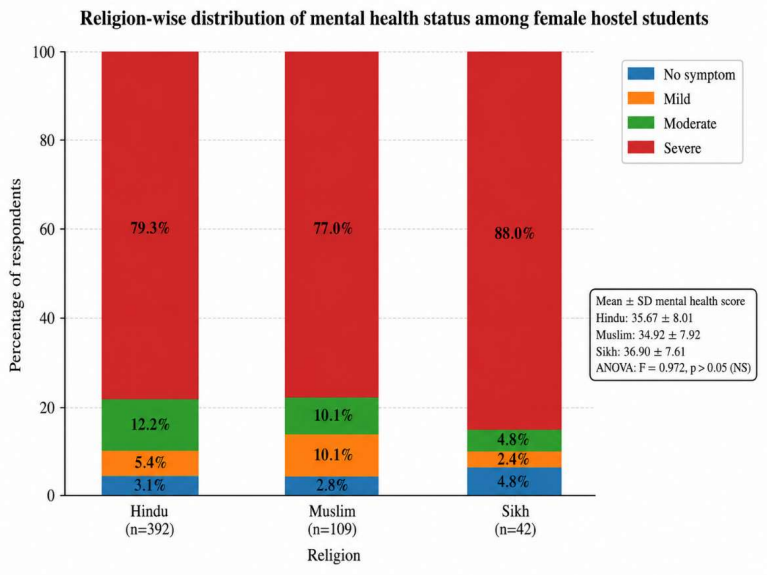

Figure 2. Religion of female hostel students based on their mental health status.

Mental health status	Hindu No.	Hindu %	Muslim No.	Muslim %	Sikh No.	Sikh %	Total No.	Total %

No symptom	12	3.1	3	2.8	2	4.8	17	3.1
Mild	21	5.4	11	10.1	1	2.4	33	6.1
Moderate	48	12.2	11	10.1	2	4.8	61	11.2
Severe	311	79.3	84	77.0	37	88.0	432	79.6
Total	**392**	**100.0**	**109**	**100.0**	**42**	**100.0**	**543**	**100.0**
Mean ± SD	**35.67 ± 8.01**		**34.92 ± 7.92**		**36.90 ± 7.61**		**35.61 ± 7.99**	

Statistical test: One-way ANOVA; $F = 0.972$; $p > 0.05$.

Table 1 presents the distribution of respondents by religion according to mental health status. The majority of respondents in all religious groups fell into the severe mental health category. 79.3% of Hindus, 77.0% of Muslims and 88.0% of Sikhs indicated severe mental health difficulties among the respondents. Sikh respondents had slightly higher average mental health scores, followed by Hindu and Muslim respondents. But the ANOVA yielded $F = 0.972$, $p > 0.05$, indicating no significant difference in mental health scores among the religious groups. Therefore, religion was not shown to be significantly related to the mental health status of the respondents.

NS = Not significant; SD = Standard deviation; $p > 0.05$ No statistically significant difference. Of the Hindu respondents, 3.1% (12 respondents) fell in the no-symptom category. 21 responses (5.4%) represented the mild group. 12.2% were in the moderate category (48 respondents). Most 311 responders 79.3% fell into the serious mental health group. In the no symptom group, 2.8% respondents were found among Muslim respondents, 3 respondents, 11 responders, 10.1% were in the moderate category. A further 11 respondents, 10.1%, were in the moderate category. The bulk, 84 responders, 77.0%, were in the serious mental health group. Of the Sikh respondents, 2 respondents, 4.8%, were in the no-symptom group. 1 responder (2.4%) was in the mild category. 4.8% of responders, 2, were in the moderate group. Most (37 respondents, 88.0%) were in the serious mental health group. 3.1% (17 responders) were asymptomatic in the overall sample. Mild mental health problems: 33 responders (6.1%). Sixty-one respondents (11.2%) reported moderate mental health difficulties. Most responders (n=432, 79.6%) had significant mental health problems. The mean mental health score was highest in Sikh respondents (36.90 ± 7.61) and lowest in Muslim respondents (34.92 ± 7.92) and Hindu respondents (35.67 ± 8.01). The average mental health score was 35.61 ± 7.99. There was no significant difference between the mean scores across religion groups, and the result of ANOVA was $F = 0.972$, $p > 0.05$. The p-value was more than 0.05. Hence, the difference in mental health scores between religions was not statistically significant. So the null hypothesis was accepted. This implies that religion was not in any 8 meaningful correlation with the mental health state of the respondents.

Discussion

The results of the present study showed that serious mental health problems were more prevalent among female hostel students of all the religious groups. This finding is consistent with the general idea that university students may have psychological distress because of academic pressure, social adjustment, emotional issues, and uncertainty about the future (Aggarwal et al., 2023). The high frequency of serious mental health problems in the present study implies that hostel students may need regular mental health screening and counselling help.

The present study indicated that Sikh respondents scored the highest on mental health, followed by Hindu and Muslim respondents. But the difference was not statistically significant. This shows that religion accounted for some heterogeneity in the data, but was not a strong independent factor related to mental health status in this group.

Religion is frequently regarded as a key coping resource as it may offer hope, emotional comfort, meaning, discipline and social support (Lucchetti et al., 2021). Religious coping can help people deal with stressful events by providing psychological strength and a sense of control in tough times (Ano & Vasconcelles, 2005). Similarly, religious involvement may also help promote wellbeing by facilitating social connectedness and positive coping behaviour (Francis et al., 2019). However, the results of the current study indicate that religious identity alone may not be enough to account for the variations in mental health among hostel girls.

This lack of statistical significance may be due to the uneven distribution of responders among religious groups. The number of Hindu respondents was far more than the number of Muslim and Sikh respondents. The Sikh group had the smallest sample size with only 42 responders. Unequal group

size may lower statistical comparison power and may influence the possibility of identifying significant differences.

Another reason given is that religion isn't the only thing that affects mental health. Religious background may be less influential on mental health than academic stress, hostel environment, family support, socio-economic background, peer interaction, sleep quality, lifestyle choices and personal coping abilities. Previous research also revealed that the association between religion and mental health is a function of the type of religious coping, spirituality and personal belief, not only religious identity (Bonelli & Koenig, 2013; Lucchetti et al., 2021). This is also corroborated by studies demonstrating that positive and negative religious coping may have diverse consequences on mental health (Ano & Vasconcelles, 2005; Francis et al., 2019). Positive religious coping may relieve stress and help emotional adjustment while negative religious coping may increase anxiety, guilt, and psychological discomfort (Francis et al., 2019). Thus, future studies should add variables such as religious coping, spirituality, frequency of religious practice, prayer, perceived social support, and family environment to better understand the relationship between religion and mental health. Overall, the present study indicates that religion may provide emotional and social support to some students, but it was not found to be a statistically significant factor affecting mental health status. Mental health interventions in university hostel should be directed at all students, regardless of their religious background.

The analysis of variance using ANOVA revealed that $F = 0.972$, $p > 0.05$, which meant that the differences in mental health scores between the Hindu, Muslim and Sikh respondents were not statistically significant. This means that the variations noticed in the mean scores are due to chance and not necessarily a true difference in the wider population.

The non-significant result could be attributed to the unequal distribution of samples across religious groups. The largest category was Hindu respondents, while the smallest group was Sikh respondents. Such uneven distribution might impact the statistical power of comparison. This may also be attributed to the multidimensionality of mental health. Mental health is not defined by one element but by many intellectual, social, emotional, economic and lifestyle-linked factors. Hence, religion in itself cannot be the explanation for the mental health state of hostel girls. Another cause might be that religion was only measured as a category variable. Religious identity is not the same thing as strength of religious conviction, spirituality, religious practice or coping behaviour. Previous studies have found that religious coping and spirituality may be more meaningful indicators of mental health than religious category alone (Lucchetti et al., 2021; Francis et al., 2019). Thus, the lack of statistical significance does not imply that religion does not have an impact on mental well-being. It does not, however, mean that religion was not a substantial independent factor connected with mental health status in the present study.

Conclusion

The present study was undertaken to find the relationship of religion with mental health conditions among female hostel students of BHU, AMU and DU. The results revealed a very high prevalence of severe mental health disorders among the respondents of all faith groups. A total of 543 respondents and 432 respondents (79.6%) were in the severe group. The mean mental health score was found to be greatest in Sikhs, followed by Hindu and Muslim respondents. However, ANOVA yielded $F = 0.972$, $p > 0.05$, which suggested that the difference was not statistically significant. Hence, the null hypothesis was accepted.

It may be inferred that religion was not substantially connected with mental health status among the respondents. The results reveal that the mental health problems of female hostel students are more influenced by academic stress, hostel adjustment, family support, peer interactions, lifestyle choices, and personal coping resources. The study identified mental health concerns among all religious groups, so universities should provide all-inclusive counselling services, awareness programmes, stress management activities and student-friendly support systems for all hostel students.

References

1. Aggarwal, S., Wright, J., Morgan, A., Patton, G., & Reavley, N. 201 (2023). Religiosity and Spirituality in the Prevention and Treatment of Depression and Anxiety in Young People: A Systematic Review and Meta-Analysis. BMC Psychiatry. 23:729.
2. Ano, G. G., Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: a meta-analytic review. Journal of Clinical Psychology, 61(4), 461-480.
3. Bonelli, R. M., & Koenig, H. G. (2013). Mental disorders, religion and spirituality 1990 to 2010: A systematic evidence-based review. *Journal of Religion and Health, 52*, 657–673.
4. Francis, B., Gill, J. S., Yit Han, N., Petrus, C. F., Azhar, F. L., Ahmad Sabki, Z., Said, M. A., Ong Hui, K., Chong Guan, N., & Sulaiman, A. H. (2019). Religious coping, religiosity and depressive and anxiety

disorders amongst medical students in a multi-religious environment. International Journal of Environmental Research and Public Health, 16 (2), 259.

5. Koenig, H. G; (2012). Religion, Spirituality and Health: Research and Clinical Applications. ISRN Psychiatry 2012, 278730.
6. Lucchetti, G., Koenig, H. G., & Lucchetti, A. L. G. . (2021). Spirituality, religiousness, and mental health: A review of the available scientific data. World Journal of Clinical Cases 2021; 9(26): 7620-7631.
7. R. M. Bonelli and H. G. Koenig (2013). Religion and spirituality. Mental disorders, 1990 to 2010: A thorough evidence-based review. Journal of Religion and Health, 52, 657-673.
8. Ronald C. Kessler, Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., Walters, E. E., & Zaslavsky, A. M. (2002).
9. World Health Organization (2022). Mental health: Developing our reaction. WHO (World Health Organisation)