RESEARCH ARTICLE

Journal of Psychology, Health and Social Challenges

Journal homepage: www.jphasc.com

ISSN ONLINE: 3006-8800/PRINT: 3006-8797

Harnessing the Power of Religious Affirmations: A Boosting Strategy for Mental Health in University Students

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Abstract

This research paper examines the impact of religious affirmations on the mental health of students struggling with depression, anxiety, and stress using a pre-test and post-test design. Existing studies suggest that religious beliefs, practices, and participation in religious activities can positively contribute to the spiritual well-being and mental health of university students (Pong, 2018). The main objectives of the study were to investigate the effectiveness of religious affirmations for the reduction of depression, anxiety, and stress and enhancement of problem-solving skills and psychological well-being of university students. The study sample consisted of 20 university students of age group 18- 25 years. Purposive sampling was used. To achieve the objectives of the study, a booklet of religious affirmations comprising of eight sessions was prepared, and the standardized scales I-e DASS-21, religiosity scale, and psychological well-being scales were used. Pre and posttest analysis indicates a significant decrease in depression, anxiety, and stress scores and an improvement in psychological well-being and problem-solving skills of the participants. Religious affirmations may be a promising intervention for the reduction of depression, anxiety, and stress, and the enhancement of problem-solving skills and psychological wellbeing, among university students. Thus, incorporating spiritually grounded approaches into mental health support could improve student well-being by addressing their unique needs.

***Keywords**: Religious Affirmations, Mental Health, Problem-Solving Skills, Psychological Well-being*

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Pages 8-15 /Received, February 23, 2025, Revision Received April 26, 2025, Accepted May 6, 2025, Published May 10, 2025

Journal of Psychology, Health and Social Challenges
Journal homepage: www.jphasc.com
ISSN ONLINE: 3006-8800/PRINT: 3006-8797

1. Introduction

Good mental health is critical to overall well-being and affects how people relate to others, how they make decisions and manage stress. Mental well-being is a core element of health affecting how people function emotionally, cognitively, and socially. However, mental health is often neglected, especially in developing countries like Pakistan where the mental health issues are frighteningly common. A key finding of the World Health Organization (WHO, 2022) is that mental disorders are the leading 'years lived with disability' and thus have a significant influence on the well-being of people worldwide. In Pakistan alone, 50 million people suffer from some form of mental illness, with almost 90 percent of these cases suffering from common mental health problems that are unable to access proper care because of a lack of mental health professionals (Siham, 2020).

In particular, studies have found high rates of depression, anxiety, and stress among university students (Auerbach et al., 2019). Social, academic demands, and career planning, are major causes of the decline in students' mental health (Saleem et al., 2013). In fact, a study of university students showed that more than 60% of students during the 2020–2021 academic year suffered from mental health problems (Lipson et al., 2022). The implications for academic performance, physical health and overall well-being (Eisenberg, 2007; Ribeiro, 2018) are serious. Anxiety, depression and stress suffer by students are the most prevalent among the various mental health problems. Research has shown that mental health problems commonly occur at adolescence, early adulthood, and the consequences last into later life (Erskine, 2015; Patel, 2007). At the same time, anxiety and depression in university students can seriously interfere with their ability to solve problems, creating bad academic performance and poor quality of life (Duan, 2020; Yang & Moon, 2013).

Mental health problems among students are commonplace, but conventional treatment strategies tend to address clinical interventions to the exclusion of use of religious or spiritual coping mechanisms. In some countries such as Pakistan, where Muslims constitute the majority, religious practices are a large source of emotional support. Religion is functionally used by many students as a means for coping with stress, depression and anxiety because it offers psychological comfort (Gorsuch & Smith, 2008). And there is often a connection between religious practices like prayer and meditation with reduced stress responses and a better emotional well-being (Kataria et al., 2016; Bay et al., 2008). Levin and Chatters (1998) noted a growing focus on the relationship between religious involvement and mental health. Religion has been associated with better psychological well-being (Chatters & Taylor, 1995), fewer signs of depression (Musick et al., 1998), and reduced risks of psychiatric disorders (Koenig et al., 1993). Gurney and Rogers (2007) noted that religious adults demonstrate better coping strategies and personal efficacy. Additionally, research has demonstrated that more religiosity can make an individual more resilient to mental health problems by helping maintaining a sense of purpose, positive emotional support and positive coping strategies (Koenig, 2019; Radzi, 2014). Furthermore, a study was undertaken to examine the role of religion in therapy as a treatment for depression with Muslim clients. Meer and Mir (2014) conclude that religious faith has a big impact on overall mental health. Additionally, recent research confirms that higher levels of religiosity are distinctively related with lower depression, lower anxiety, and better wellbeing (Koenig, 2019). Religion and spirituality have been shown to improve mental health outcomes, including reduced depression symptoms and enhanced life satisfaction (Coleman & Wallace, 2010; Holder et al., 2010).

Forms of religious practice such as religious affirmations have been garnering attention recently as being a possible tool to enhance mental well-being. In fact, religious affirmations are positive, unconditional statements of which people learn to say to oneself to get a boost of self-esteem, to get off negative thoughts and promote emotional stability (Naperstack, 2000)

A study finds that reading religious affirmations plays a role in improving psychological distress (Inman, Iceberg, & McKeel, 2014). Affirmations help counteract negative thinking (Wiesenfeld et al., 2001), and religious participation may reduce distress and foster well-being through perceived social and emotional support (Pollner, 1989; Wikstrom, 1987). Religious affirmations, as a subset of positive affirmations, have shown promise in enhancing psychological well-being (Rana, 2018). Religious affirmations have consistently been associated with better mental health outcomes during stressful events. Positive religious coping fosters peace of mind and biological changes that improve mental well-being (Abdul-Rehman, 2017). A study in Karachi demonstrated that integrating religious affirmations with positive group psychotherapy significantly reduced depression (Khalid & Yousaf, 2020). Religious affirmations based on Qur'anic verses and hadiths* positively affect cognition and behavior (Banna, 2009). A study in Pakistan demonstrated that combining positive psychotherapy with religious affirmations significantly reduced depression levels, though no significant differences were observed when compared to psychotherapy alone (Khalid & Yousaf, 2020).

Emotional well-being, critical for effective problem-solving, is impaired by depression, anxiety, and stress (Bingham, 2004; Kargi, 2009). Depression impairs problem- solving abilities, creating a cyclical relationship where poor problem-solving exacerbates depression and vice versa (Heppner et al., 1985; Bower et al., 2008). Depressive rumination intensifies negative thinking and hinders adaptive problem-solving (Nolen-Hoeksema et al., 2000). Anxiety, while allowing for cognitive solution identification, often hinders solution implementation (Marx et al., 1992). It also impairs working memory efficiency and prolongs task completion times, affecting academic performance and problem-solving (Hadwin et al., 2005; Owens et al., 2012). Together, these studies emphasize the intertwined effects of mental health on cognitive functions and problem-solving. Number of researches emphasize the detrimental effects of stress on problem-solving abilities, linking it to elevated noradrenergic tone, hypervigilance, and narrowed attention focus, which impair creative thinking and flexible problem-solving (Martindale & Greenough, 2009; McEwen & Sandi, 2013; Shields et al., 2016). Stress has also been shown to hinder problem-solving tasks requiring creativity (Alexander et al., 2007).

Poor problem-solving is closely linked to psychological conditions such as agoraphobia, depression, and post-traumatic stress disorder (Brodbeck & Michelson, 1987; Heppner et al., 1985). Depression hinders cognitive functions like memory retrieval and interpersonal problem-solving, leading to a cycle of negative thinking and maladaptive solutions (Bower et al., 2008; Nolen-Hoeksema et al., 2000). Similarly, anxiety disrupts problem-solving efficiency by increasing mental effort and prolonging task completion (Hadwin et al., 2005). Stress further impairs creativity and flexible thinking, adversely affecting problem-solving (Martindale & Greenough, 2009).

Islamic teachings offer practical approaches to problem-solving by encouraging logical optimism, goal-setting, consultation, and trust in divine guidance (Munjjid, 2006). Incorporating Islamic principles into educational settings, such as guided inquiry learning,

Journal of Psychology, Health and Social Challenges
Journal homepage: www.jphasc.com
ISSN ONLINE: 3006-8800/PRINT: 3006-8797

enhances problem-solving skills and positive thinking in students (Astriani, Kmorudin, & Puspita, 2020). Quranic recitation has also been shown to alleviate tension, promote relaxation, and aid psychological healing (Banna, 2009; Latif, Saged & Yusoff, 2020).

This research article aims to examine the effect of religious affirmations on stress, anxiety, depression, problem solving skills and psychological well-being. For university students, religious affirmations may be a low barrier and a useful means for improving mental health and improving problem solving. They help students to learn to cope with stress, anxiety and depression, as well as to promote positive mental health. The purpose of this research is to investigate if religious affirmations can be a way to reduce depression, anxiety, stress and enhance psychological well-being, and problem- solving skills in university students. The research underscores the complex interplay between mental health, and problem-solving while highlighting the potential therapeutic benefits of religious affirmations.

Scholarly studies show that affirmations are good for the well-being of a human mind, and religious affirmations are especially useful in treating depressed individuals (Khalid & Yousaf, 2020). University students suffer from a range of stressors including academic stress, the transition to adulthood, and independence: all of which impair the students' problem-solving ability (Beiter et al., 2015; Bhadargade, 2020). Depression and anxiety disorders are widely reported all over the world (Sarokhani et al., 2013), and university students are even more likely to develop depressive disorders than the entire population (Ibrahim et al., 2013; Adams et al., 2013).

In Pakistan competitive life style, changing family dynamics and lack of social support complicates mental health problems (UN Development Program, 2021). Further, stigma and a lack of access to mental health care, particularly in the underdeveloped countries, hampers effective interventions (WHO, 2022). Given the availability of a significant youth population in Pakistan (UN Population Fund Report, 2017), literature on factors that may be preventive against various mental health issues identified among the youth is lacking (WHO, 2020).

This gap brings out religious influence as a subject of study on mental health (Koenig et al., 2011). Few research has found a relationship between religious affirmations and lowered stress levels, as well as improved problem-solving abilities of students. Since the majority of the people of Pakistan is Muslim (96.47%) and Islam pays much importance to mental aspect of health as Holy Quran emphasizes on it declaring that mind is a sacred gift of Allah (Ahles et al., 2016; Hamidi et al., 2010), religious affirmations can be a positive coping strategy. Studies have shown that Quranic practices, such as recitation, can reduce sadness, stress and anxiety (Kazemi et al., 2004; Mirbagher et al., 2010).

To fill this gap this study seeks to investigate the impact of religious affirmations on university students' mental health, psychological well-being and problem-solving skills.

2. Method

2.1 Research Design:

A one-group quasi-experimental pretest-posttest design has been used in the current study that compared the experimental groups before and after the intervention.

2.2 Sample

Sauro and Lewis (2016) recommended a sample of 15 participants based on the Confidence level (90%) and margin of error (20%) for studies following pre- post-test design. Hence, the present study included a sample of 20 university students, aged 18-25 years, studying at Shifa Tameer-e-Millat University (STMU), Islamabad, Pakistan after screening the 50 participants. Participants who scored moderate to high on religiosity and mild, to moderate, on depression, anxiety and stress scale (DASS-21) are selected.

The inclusion criteria for the selection of the participants for this research are: the individual who has scored mild, to moderate, on DASS -21 scale, and moderate to high on the religiosity scale are included. Exclusion criteria for the selection of participants used in this study were as followed with each factor listing those not included in this research: Individuals with diagnosed mental health condition, those who cannot read or write, those who are already undergoing therapy, non-Muslims are also excluded, participants who are not willing to participate, participants under 18 years and above 25 years

2.3 Instruments

Subsequent instruments were used for the present research:

2.3.1 Demographic Sheet: The demographic sheet includes age, gender, marital status, socioeconomic situation, level of education, medical history, psychological history, university, religion, and family system.

2.3.2 Depression Anxiety Stress Scale (DASS): A self-report measure of anxiety, depression, and stress called the (DASS) was developed by Lovibond in 1995 and is utilized in a variety of settings. A 21- item self-administered questionnaire called the DASS is the shorter version and is used to assess the severity of depressive, anxious, and stressed emotional states. On a 4-point scale, the Participants respond with 0 and 3 increased scores on each subscale signify greater levels of stress, anxiety, or depression. According to the findings (Aguilar-Parra et al., 2014), the internal consistency for the DASS-21 subscales was 0.80 for the depression subscale, .73 for th anxiety subscale, .81 for the stress subscale, and 0.90 for the DASS-21 overall score.

2.3.3 Problem-solving inventory (PSI): In 1982, Heppner and Peterson developed PSI. The PSI measures a person's awareness of and evaluation of his or her problem-solving skills or style, providing a comprehensive assessment of that person as a problem-solver. Considering that it is a self-report tool, it evaluates perceptions of problem- solving rather than real problem-solving abilities (Dixon, Heppner, & Witty, 1995). There are 35 items in the PSI. Low scores indicate behaviors and attitudes typically associated with successful problem-solving. High scores indicate poor problem-solving behaviors and attitudes. Strong empirical evidence for the internal consistency of PSI is provided by alpha coefficients across a range of populations. The inventory's alpha coefficient is 0.90 (Heppner et al. (1995).

2.3.4 Religiosity Scale: There are a total of 5 reverse-scored items in it. It is a five-point Likert scale, with 1 indicating strong agreement and 5 indicating strong disagreement. Scores on the scale range from 0 to 25 (Wilkes & Howell, 1986). With a Cronbach alpha reliability of 0.91, higher scores are more reliable indicators of religiosity (Anil, 2012).

2.3.5 Ryff Psychological Well-Being Scale: It has 42 items and provides results for each of the scale's six domains. Overall, the scale examines psychological well-being (Ryff, 1995). The composite score was employed for the present study. For all 42 items, an item score ranging from 1 to 6 was provided. Scores range from 6 to 252. A higher score reflects more well-being (Wilson et al., 2013). The scale's reliability ranges from
0.66 to 0.79.

2.4 Data Analysis

SPSS V 25 was employed. Before and after the intervention, the psychometric properties of scales were assessed after first analyzing the frequency and percentage of demographic variables. To compare the means of the two scores obtained before and after the therapy sessions, a paired sample t- test was carried out.

Journal of Psychology, Health and Social Challenges
Journal homepage: www.jphasc.com
ISSN ONLINE: 3006-8800/PRINT: 3006-8797

2.5 Procedure

The researcher approached university students with the approval of the relevant authorities for the collection of data. Following the approval, students were approached for screening purposes. Furthermore, a researcher explained the study details to the participants. With the consent, 50 participants were screened for religiosity, depression, anxiety, and stress. In addition, the confidentiality of information and anonymity of participants was also respected.

After the pre-testing, the researcher provided therapy comprising of eight sessions to the screened participants (n=20) based on the booklet containing Religious Affirmations grounded on Quranic Verses for depression, anxiety, stress, and problem-solving. The duration of the sessions 30-40 minutes each. All sects in Pakistan agreed on Quranic affirmations, as they are Islamically accepted across different schools of thought. Considering that a booklet was developed.

In the **first stage,** an assessment (pre-test) was done one week before the intervention in which all the information regarding the

Process of the research was provided to the respondents. Then in the **second stage** of intervention, rapport building and history taking was done and religious affirmations therapy was given in a form of a booklet containing religious affirmations for depression, anxiety, stress, and problem-solving. Also, there was a talk on the importance of each affirmation during the session. The coping cards of religious affirmations from the developed booklet were given to the participants after each session. In the **third stage**, after 4 weeks' participants were contacted again for post-testing and then the scores of pre and post testing were compared. The eight intervention sessions are summarized briefly as follows:

Session 1:

The session began with rapport-building and history-taking, followed by reading/reciting the first four religious affirmations (with reference to these verses from the Quran 57:4, 42:40, 42:41, 76:22) from the booklet provided. The clients were requested to focus upon the recitation and its translation while being completely relaxed. When the recitation and translation was completed, the clients were asked to give feedback regarding what they understood from these verses. After that, the clients were oriented regarding the importance of positivity in our religion and how positivity impacts our daily life. Then the participants were taught with the help of qur'anic affirmations that they are never alone, divine power is always with them, and Allah will always be there to put things right for them. They were then given cards with these affirmations to remember and take action on them in future.

Session 2:

The session began with a discussion of given religious affirmations (with reference to these verses from the Quran 2:286, 5:6, 50:16). The same practice was repeated in which the clients were asked to internalize the religious affirmations along with verses and their translation while encouraging the clients to look for blessings in disguises. Discussion upon the affirmations as conducted and the clients were told emphasizing the importance of faith in Allah that no matter where they are in their recovery, no matter what struggle they're dealing with, and no matter how many times they have broken down, they need to know that Allah has made them enough for themselves. They are worthy and no problem is heavier than their strength. At the conclusion, clients received coping cards to keep nearby for improved reflection.

Session 3:

The session started with the next three provided religious affirmations (with reference to following verses of the Quran 10:65, 94:6, 13:11). The clients were educated regarding the importance of remembering the good memories in life and being thankful for them. The value of self-worth is discussed. Participants were told they are their own healers and should place their hope in Him. Clients were given coping cards to keep handy for better reflection after the session.

Session 4:

Participants received four religious affirmations from the booklet at the start of the session (with reference to theses verses 3:134, 15:49, 15:4815:56). Discussions on the mercy of Allah, the value of optimism, and its effects on mental tranquility were carried out. The participant's attention is drawn to the fact that Allah has preserved an opportunity for us with every adversity, which serves to emphasize the message of hope. Coping cards were given to them to help them remember this concept in the future and to further reinforce it.

Session 5:

In this session participants were informed of the value of remembering Allah Almighty and the importance of having faith in a higher power with the help of the given affirmations (with reference to these verses 3:26, 8:30, 13:28). Discussion was held on Allah's plan and power, and Coping Cards were given to reinforce this idea.

Session 6:

The session opens with the next three religious affirmations from the provided booklet (with reference to these verses 3:186, 2:257, 1:5). Participants were told that difficulties are a test from Allah and that they should remain patient and calm and think of them as a means of growth and development. Coping cards of these religious affirmations were given to reinforce this idea.

Session 7:

In this session, a talk on the provided affirmations (with reference to these verses 2:110, 9:129, 14:7, 14:34) was held and a message of reward from Allah was extracted from the talk. We should trust in Allah and be grateful for the blessings and favors. He has bestowed upon us, as it is a promise from Allah that He will continue to give us more. Coping cards of these religious affirmations were provided at the end of the session.

Session 8:

In this session, the last three affirmations (with reference to these verses 3:160, 2:153, 40:60) from the booklet were read by the participants. They were made to contemplate on the importance of patience and prayer, as Allah assures us that He is with those who are patient and seek His help. Coping cards of these religious affirmations were given to reinforce this idea. Flash cards of these religious affirmations were given at the end.

. 3.RESULTS

This section comprised preliminary findings from the data, descriptive statistics for study variables, and for testing the hypothesis, paired sample t-test was applied.

In the present study, table 1, the sample consisted of 20 participants (100%). In terms of age distribution, the majority of participants were in the age range of 21-22 (60%), followed by those in the age range of 18-20 and 23-25, each accounting for 20% of the sample. All the participants are doing BS, n=20(100%), and are non- working, n=20(100%).

Regarding socioeconomic status, 12(60%) belong to the middle class and 8(40%) belong to the upper middle class. Furthermore, all 20(100%) are Muslims and all 20(100%) are unmarried. The family system composition showed that 16(80%) of participants belonged to a nuclear family, while the remaining 4(20%) were part of a joint family system. In terms of illness history, 5(25%) of participants reported a history of illness, while the majority 15(75%) reported no history of illness. Additionally, 6(30%) of participants reported a psychological history,

Journal of Psychology, Health and Social Challenges
Journal homepage: www.jphasc.com
ISSN ONLINE: 3006-8800/PRINT: 3006-8797

whereas the remaining 14(70%) did not indicate any psychological history.

The table 2 and 3 shows the mean, standard deviation, range, and Cronbach's alpha reliability coefficient for all the scales that were used before and after the intervention.

Table 4, a paired sample t-test was conducted to analyze and compared the difference between students who met the screening criteria. Before therapy, participants reported moderate levels of depression (M= 9.95, SD = 4.32), anxiety (M = 9.15, SD = 3.89), and stress (M = 11, SD = 2.99). Following therapy, significant improvements were observed in all three variables. The mean depression scores significantly decreased to 4.60 (SD = 3.251), with a 95% confidence interval ranging from 3.88 to 6.82. The t-value was significant (t= 7.64, p < .001), indicating an effect size (Cohen's d = 1.9). Similarly, the mean anxiety scores significantly decreased to 3.90 (SD = 3.076), with a 95% confidence interval ranging from 3.81 to 6.79. The t-value was significant (t = 7.59, p < .001), indicating an effect size (Cohen's d = 1.9). Moreover, the mean stress scores significantly decreased to 5.70 (SD = 2.793), with a 95% confidence interval ranging from 4.34 to 6.26. The t-value was significant (t=11.6, p < .001), indicating an effect size (Cohen's d = 2.74). In terms of problem-solving abilities (PSI), the mean score significantly decreased from 112 (SD = 23.56) before therapy which means an increase in problem-solving skills because low scores in PSI indicate greater problem-solving ability to 96.10 (SD = 26.01) after therapy. The 95% confidence interval ranged from 3.77 to 28.12. The t-value was significant (t = 2.74, p = .013), indicating an effect size (Cohen's d = 0.54). Furthermore, participants' psychological well-being (PWB) significantly improved from a mean score of 169 (SD = 30.9) before therapy to 187.4 (SD = 24.3) after therapy. The 95% confidence interval ranged from -29.7 to -6.98. The t- value was significant (t = -3.38, p = .001), indicating an effect size (Cohen's d= 0.86). These results indicate that therapy led to significant improvements in depression, anxiety, stress, problem-solving abilities, and psychological well- being among the participants.

Table 1

Demographic characteristics of the sample (N=20).

Variables	Frequency (f)	Percentage (%)
Gender		
Female	20	100
Male	0	0
Age		
18-20	4	20
21-22	12	60
23-25	4	20
Education		
BS	20	100
MS	0	0
Occupation		
Non-working	20	100
Working	0	0
Socioeconomic status		
Middle class	12	60
Upper middle class	8	40
Marital status		
Unmarried	20	100
Married	0	0
Religion		
Islam	20	100
Others	0	0
Family System		
Nuclear	16	80
Joint	4	20
Illness history		
Yes	5	25
No	15	75
Psychological history		
Yes	6	30
No	14	70

Table 2

Psychometric properties of scales and subscales before religious therapy (N=20)

Scales	M	SD	Range		A
			Potential	Actual	
Pre-depression	9.95	4.32	0-21	5-20	.83
Pre-anxiety	9.15	3.89	0-21	4-21	.70
Pre-stress	11.00	2.99	0-21	4-15	.60
RS	20.75	1.77	0-25	17-23	.62
Pre-PSI	112.05	23.56	35-210	69-156	.92
Pre-PWB	169.05	30.93	6-252	114-214	.92

Note. RS= Religiosity Scale, PSI=Problem Solving Inventory, PWB=Psychological Well-being Scale, N=20, M= Mean, SD=Standard Deviation, α= Cronbach's alpha

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ISSN ONLINE: 3006-8800/PRINT: 3006-8797

Table 3

Psychometric properties of scales and subscales after religious therapy (N=20)

			Range		
Scales	M	SD	Potential	Actual	A
Post-depression	4.60	3.25	0-21	0-10	.79
Post-anxiety	3.90	3.07	0-21	0-12	.77
Post-stress	5.70	2.79	0-21	0-10	.70
Post-PSI	96.10	26.01	35-210	58-146	.93
Post-PWB	187.40	24.26	6-252	141-230	.90

Note. PSI=Problem Solving Inventory, PWB=Psychological Well-being Scale, N=20, M= Mean, SD=Standard Deviation, α= Cronbach's alpha

Table 4

Mean, standard deviation, and t-values for scales and subscales before receiving religious therapy and after receiving religious therapy (N=20).

	Before Therapy		After therapy				
Variables	M	SD	M	SD	P	T	Cohen's d
Depression	9.95	4.32	4.60	3.25	.000	7.64	-1.42
Anxiety	9.15	3.89	3.90	3.08	.000	7.59	-1.51
Stress	11	2.99	5.70	2.79	.000	11.6	-1.84
PSI	112	23.56	96.1	26.01	.013	2.74	-0.63
PWB	169	30.9	187.4	24.3	.003	-3.38	0.68

*Note. M=Mean, SD=Standard deviation, t= Test statistics, Cohen's d=Effect size, ***p<.001, **p<.01*

4. Discussion

This research article presents findings on the impact of religious affirmations on mental health i-e depression, anxiety, and stress, problem-solving skills, and psychological well-being among university students. The study also reveals the important therapeutic function of religious affirmations in promoting the overall recovery and increasing the level of adaptive psychological processes.

The prevalence of mental health issues among university students, especially in developing nations like Pakistan, has been increasing over the past decade. Students frequently encounter stress, anxiety, depressive symptoms, and even self-harm behaviors, with suicide being the fourth leading cause of death among individuals aged 15–29 years (WHO, 2021). Behavioral disorders, anxiety, and depression are among the major contributors to illness and disability in this age group (WHO, 2021). Studying the life of university students in Pakistan, Nayab et al., found that 39% of them suffered low mood, 36% anxiety and, 25% depression. Other mental deficits, as are the case with the ability to solve problems, have been associated with higher anxiety and depressive symptomatology (Kant et al., 2007). Kant and colleagues (2007) underlining the importance of early intervention if these symptoms worsen during the course of these formative years.

Religion plays an essential component in the sociocultural life of people of Pakistan and their psychological adjustment and functioning. Religion occupies a central role in the socio- cultural fabric of Pakistan, influencing individual coping mechanisms and emotional well-being. From an early age, individuals are exposed to religious practices, which shape their psychological support systems. Studies have shown that religion aids individuals in managing daily life stressors, offering emotional comfort and redefining adversities through a spiritual lens (Kim & Seidlitz, 2002). Recognizing this, the current study investigated religious affirmations as an intervention to address mental health challenges and enhance problem-solving skills and psychological well-being.

Religious affirmations are found to be effective in reducing the depression, anxiety, stress and enhancement of psychological well-being and problem-solving skills among university students base on pre-posttest design. These findings align with studies demonstrating that religious coping mechanisms contribute to lower levels of psychological distress and mental health problems (Rider et al., 2014; Tepper et al., 2001). Further, research also shows that religious affirmations are beneficial for improving cognitive emotional qualities (Deshmukh, 2012, Newman, 2001, Benson, 1996).

Journal of Psychology, Health and Social Challenges
Journal homepage: www.jphasc.com
ISSN ONLINE: 3006-8800/PRINT: 3006-8797

This paper therefore highlights the possibility of adopting religious affirmations into therapeutic practices for university students. However, certain constraints must be pointed out. For instance, the psychological state of the participants during the pre-test phase may have affected the finding of the study. Future research with larger sample sizes and control groups is recommended to validate and expand upon these findings.

This study highlights the therapeutic potential of religious affirmations in reducing mental distress and improving psychological well-being and problem-solving skills among university students. Religion-based interventions offer a culturally sensitive approach to mental health care, particularly in regions where spiritual beliefs are deeply ingrained in daily life. Whereas spirituality can be incorporated into therapy as intrinsic psychological needs, resiliency, and a means of helping patient to face and overcome life events. Subsequent research should investigate whether these results hold with other underserved groups and should also further assess the long-term positive psychological implication of religious affirmation

Ethical Considerations

Ethical approval was attained from the Ethical Review Board, Department of Psychology, STMU, and Ethics Committee, along with the head of the institutes. It was specified as the most important part of our research. It was done under the ethical guidelines of the American Psychological Association (APA). Full consent was obtained from the participants prior to the data collection No deception was done about the objective of the study. In addition, the confidentiality of information and anonymity of participants was respected. Any form of communication was done honestly and transparently. No offensive or unacceptable language was used. Participants had the right to withdraw at any stage if they want to do so. It was made sure that the information gathered throughout this research would not be used for anything besides the investigation of the study's findings. To properly end the therapeutic Process that will be started, a closure session was done.

Conflict of interest: None to declare

Funding disclosure: None to declare

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