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Research Paper

Mental Health Issues and Coping Strategies in Religious Minority: A Study of Muslim Students in Higher Education

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ABSTRACT

This study aims to analyze the mental health of the Muslim students enrolled in the central universities of Delhi, develop an understanding about the stressors and coping strategies adopted by them, and identify the mechanism present in the central universities to address mental health issues. The results reveal that stress was experienced by 47.8% of the participants out of which 27.8% experienced mild level of stress, 10 % had moderate stress, and 10% had severe stress. 76.7% suffered from anxiety where 8.9% participants had mild anxiety, 27.8% had moderate anxiety, 20% had severe anxiety, and 20% had extremely severe anxiety. Depression was experienced by 64.4% of the total sample where 26.7% reported mild depression, 26.7% reported moderate depression, 6.7% reported severe depression, and 4.4% reported extremely severe depression. The analysis highlights the significant impact of religious discrimination, identity-based bullying, and cultural insensitivity on the mental health of minority students. The experiences of exclusion, stereotyping, and fear of violence contribute to heightened levels of stress, anxiety, and depression, hindering these students to feel secure or welcomed in academic settings. To tackle these challenges, it is crucial to guarantee the accessibility of mental health services while fostering an atmosphere that integrates and respects religious diversity.

Keywords: *mental health, coping strategies, university students, religious minority*

Mental health has emerged as a major concern among university students globally. Numerous research studies highlight the prevalence of stress, anxiety, and depression in this demographic population (Shamsuddin, et al., 2013; Aldiabat, et al., 2014; Radeef, et al., 2014; Shete & Garkal, 2015; Deb, et al., 2016). There is a considerable amount of stress on the young students and they need to adjust to the new environment and be accepting of new relations and situations (Bhargava & Trivedi, 2018). This poses immense stress regarding future prospects; thus, it requires proper adaptation to deal with stress for fulfilling their dreams and aspirations. According to Heins there are two major sources of stress among college students: a) academic expectation and achievements, and b) social factors like maintaining and developing social connections (Ji & Zhang, 2011).

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Each individual is exposed to stress at some point in their lives and young people experience stress mainly due to the transition phase and demands of life and academics. Inadequate adaptation or maladaptive coping can increase the risk of mental health problems among young people. For an optimal functioning and maximum productivity of youth, it is vital to provide and maintain the optimal mental wellbeing (Chadda, 2018).

As per the United Nations Population Fund, India has the world's largest population of about 356 million young people (Chadda, 2018). The youth stage requires the individuals to adapt to the changes in themselves and the demands of the environment for overall development and growth. The mental health illnesses among youth cause immense burden of disease and high mortality across the globe. The onset of mental health disorders is most likely to occur in young age or adolescence (Kessler, et al., 2007). Mokdad et al. reported depression to be the third leading cause of disability for 15-24 years old globally and suicide to be the leading cause of death among 15-29 years old in high-income countries, thus mental health problems are a threat for the young people (Christensen, Reynolds, & Cuijpers, 2017). The ever-increasing pace of the world adds on to the burden of mental health among the youth along with addiction of internet (Chadda, 2018). Youth are also at a danger to be exposed to violence as a victim and a perpetrator which affects the mental wellbeing (Christensen, Reynolds, & Cuijpers, 2017). Approximately 25% of the youth population suffers through mental disorders in the world (Patel, Flisher, Hetrick, & McGorry, 2007). The National Mental Health Survey (2015-16) of India reported the occurrence of mental disorders among the 18-29 years age group at 7.39% and 9.54% for lifetime prevalence (Gururaj, et al., 2016). Suicide is the leading cause of death among young people of South India (Aaron, et al., 2004) which is highly alarming.

Students of universities across the world are at a risk for mental health disorders due to exposure to various stressors in their personal and academic life. The Muslim youth is at an added risk for poor mental health due to increased exposure to social exclusion, discrimination and growing intolerance in the country. The excessive stress as a result of these factors might lead to the development of anxiety and depressive disorder among the Muslim youth. The present study aims to assess the mental health problems among Muslim youth, current stressors in their lives, and coping strategies adopted by them. The university/college plays an integral role in maintaining and promoting mental health among the students. Thus, it becomes essential to also identify the mechanisms present in the universities in preventing and addressing mental health problems.

In the era of Islamophobia, a difficult environment has been constructed for the Muslim youth across the globe. Muslim youth feel misunderstood, unsupported, bullied, and discriminated in different settings, which brings them at a risk to poor mental health (Tahseen, Ahmed, & Ahmed, 2018). The radical Hindu nationalist groups in India have established the Muslim community as 'Others' and several mob violence cases against Muslims accused of cow slaughtering have occurred; these acts have been on an increasing trend due to the political silence observed in the country (Siyech & Narain, 2018). The feeling of 'other', discrimination and fear of violence based on the religious identity has induced additionally stress to the existing pressure of academic and personal life challenges among Muslim youth as compared to their counterparts.

In the Indian context, a study on mental health problems of religious minorities remains unexplored. The changing environment and increase in hate crimes towards Muslims may be

a source of distress among the community. Thus, attention is required to assess the prevalent mental distresses among them and understand the factors posing a risk of mental illnesses or developing risk behaviors. Muslims being a minority in India face a lot of challenges like discrimination, seclusion, stress, etc. Muslims continue to face deeply rooted discrimination that hinders their path of getting education in eminent institutes, jobs, finding homes, admissions of children in their choice of schools. The interplay between religious identity and academic life can profoundly affect the emotional well-being of Muslim students. Discrimination, stereotyping, cultural alienation, and the effort to manage numerous identities can intensify stressors and hinder academic achievement. Furthermore, socio-political dynamics and widespread Islamophobia may exacerbate these issues, resulting in a complicated environment for mental health outcomes. Thus, to assist Muslim youth grow and live a healthy life, we must understand their mental health and their coping strategies and provide appropriate facilities to address mental health issues.

Muslim youth like any young person faces these challenges along with an added load of discrimination, social exclusion, conflicts due to religious identity and practices, and violence which has been termed as the underlying factors of Islamophobia by several authors. Thus, Muslim youth are at a double risk of mental health problems and require care, protection, and support to eliminate this risk. Comprehending how Muslim students perceive and manage these pressures is crucial for developing effective interventions and promoting inclusive campus settings. This study seeks to address a gap in the current literature by investigating the mental health experiences and coping strategies of Muslim students in India. This study aims to elucidate the mental health challenges, stressors, and resilience tactics of this demographic group in order to inform policymakers, educators, and mental health professionals about their special needs. The findings aim to enhance the formulation of inclusive policies and interventions that foster comprehensive well-being and academic achievement among Muslim students in India.

Significance of the study

Approximately 4.4% of the global population has depressive disorders, whereas 3.6% suffers from anxiety disorders (WHO, 2017). Depression is the primary contributor to disease burden among young women worldwide, whereas mental health disorders substantially influence youth suicides. University students are more susceptible to mental health issues owing to academic expectations, emotional demands, and stressors associated with acclimatizing to new surroundings (Rodgers & Tennison, 2009; Devi & Mohan, 2015). University life frequently introduces pressures, including substantial workloads, relationship dynamics, and increased autonomy, which may adversely affect academic achievement and overall well-being if not managed well. Inadequate coping strategies and support elevate the likelihood of mental health disorders, such as anxiety and depression (Kessler et al., 2007; Corley, 2013).

Muslim students, as a minority in India, encounter heightened problems, including discrimination and marginalization, which intensify their mental health burdens. Nonetheless, there is a paucity of studies regarding the mental health of Muslim university students. In light of the increasing incidence of hate crimes and prejudice, it is imperative to evaluate their mental health and formulate appropriate coping mechanisms and support structures. Early detection, prevention, and intervention are essential for enabling Muslim students to achieve their educational and personal goals, so benefiting both themselves and society.

METHODOLOGY

The objectives of the study are to assess the mental health problems of the Muslim students, explore the stressors that contribute to mental health experiences, coping strategies adopted by them, and presence of support services offered by the universities. In accordance with the purpose of this study, descriptive research design has been used. Mixed method i.e., both qualitative and quantitative methods were used to carry out the study. Concurrent triangulation design of mixed method was used for the study where the quantitative and qualitative data were collected and analyzed separately at the same time with the findings converging in the conclusion. The research was conducted in 3 central universities of Delhi where 90 Muslim students were interviewed using purposive sampling technique.

Inclusion and Exclusion Criteria: Students studying in central universities under distance mode of study programme have not been included in this study as they lack the features of a regular mode study programme. The students enrolled in regular mode study programme have been included as they experience increased involvement with the institution/ department, higher daily-based curricular engagements, frequent participation in different in-campus activities, increased face-to-face interaction with fellow students and faculty etc.

The study used the following tools for collecting primary data:

1. **Semi-structured Interview Schedule:** The semi-structured interview schedule consisted of questions related to socio-demographic and family information along with open ended questions related stress exposure, feelings experienced under stress, personal coping strategies utilized under stress, mechanisms present at the university level to address mental health concerns of the students.
2. **Depression Anxiety Stress Scale – 21 (DASS-21):** DASS-21 is a self-report scale developed which contains 21 items which measures the characteristic attitudes and symptoms of depression, anxiety and stress (Lovibond & Lovibond, 1995). It is a short version of the original DASS-42 scale consisting of 42 items. The DASS-21 contains 21 items which has 7 items for each emotional state i.e., depression, anxiety and stress. The items in the depression sub-scale consist of statements related to low mood, low self-esteem, hopelessness, devaluation of life and negative outlook of future. The anxiety sub-scale caters to fear response and psychological arousal, skeletal muscle effects and situational anxiety. The stress sub-scale focuses on persistent arousal, tension, difficulty in relaxing, nervousness, agitation, irritability and impatient (Lovibond & Lovibond, 1995).

   Each item on the scale is scored on a 4-point likert scale where 0 = did not apply to me at all (never), 1 = applied to me to some degree, or some of the time (sometimes), 2 = applied to me to a considerable degree or a good part of time (often) and 3 = applied to me very much or most of the time (almost always). The scores are obtained from each sub-scale by adding the score of each item in the sub-scale and then multiply it by 2 to calculate the final score.
3. **Brief COPE Questionnaire:** Coping strategies are measured by the Brief COPE questionnaire which contains 14 sub-scales. It contains 28 items pertaining to 14 coping strategies: active coping, emotional support, use of instrumental support, positive reframing, planning, humor, acceptance, religion, self-distraction, denial, substance use, behavioral disengagement, venting and self-blame (Carver, 1997). It is rated at a 4-point Likert scale ranging from 1= I don't do this at all, 2 = I do this a little bit, 3 = I do this a medium amount and 4 = I do this a lot.

Quantitative Data was analyzed using SPSS through administration of Descriptive Statistics, Correlations, and One-Way ANOVA. Qualitative Data was analyzed in the form of case studies.

Limitations

The sample size of the study is small. The study relies on the data obtained through self-reported questionnaire by the participants, thus it may contain certain potential biases about self. Other stakeholders such as students of other religious background, teachers and administration of the universities would have enriched the study but have not been included in the present study.

Ethical Considerations

The participants were informed about the purpose and objectives of the study. Informed consent of the participants was taken through consent forms. The estimated time for administration of tool was conveyed to the participants and they were aware about their right to withdraw from the study at any time. Anonymity and confidentiality of the participants has been ensured.

Implications for Future Research

The present study can serve as a baseline for a wide and in-depth study exploring various other aspects of mental health among minority communities. This study opens the gateways for the future comprehensive study which may include broader sample size and other stakeholders for a deep understanding about the mental health concerns and mechanisms to prevent and enhance the mental health of minority groups. It could also serve as a baseline for future study on comparative analysis of minority and majority religious groups.

RESULTS

Socio-demographic profile of students

The demographic data outlines the socio-demographic factors of the participants in terms of age, gender, caste, accommodation, and course enrollment. The majority of participants (62.22%) are aged 18-22 years, followed by 32.22% in the 23-27 age range, and a minor percentage (5.56%) aged 28-32 years. The sample has a virtually balanced gender distribution, with 53.3% males and 46.7% females. Concerning caste, 53.3% of participants are from the upper caste, whilst 46.7% belong to the lower caste. Regarding living arrangements, the majority of participants (38.9%) reside in hostels, followed by 33.3% residing at home and 27.8% in rented housing. As for academic levels, 48.9% are enrolled in bachelor's programs, 36.7% in master's programs, and 14.4% are pursuing M. Phil/Ph.D. studies. This diverse demographic profile provides extensive coverage of the student body.

Table 1: Socio-demographic profile of participants

Variable	Frequency	Percentage
Age (in years)		
18-22	56	62.22
23-27	29	32.22
28-32	5	5.56
Gender		
Male	48	53.3
Female	42	46.7
Caste		

Variable	Frequency	Percentage
Upper	48	53.3
Lower	42	46.7
Accommodation		
Home	30	33.3
Hostel	35	38.9
On rent	25	27.8
Course Enrolled		
Bachelor's	44	48.9
Master's	33	36.7
M. Phil/Ph. D	13	14.4

Mental health problems experienced by the Muslim Students

The results reveal that 52.2% of the participants experienced normal level of stress, 27.8% had mild stress, 10% experienced moderate stress, and 10% had severe level of stress. Further, 27.8% of the participants experienced moderate anxiety, 23.3% had normal level of anxiety, 20% fell under severe level of anxiety, 20% had extremely severe anxiety, and only 8.9% experienced mild anxiety.

Table 2: Stress, Anxiety, and Depression among Muslim Students

	Stress		**Anxiety**		**Depression**	
	N	**%**	**N**	**%**	**N**	**%**
Normal	47	52.22	21	23.33	32	35.55
Mild	25	27.78	8	8.89	24	26.67
Moderate	9	10	25	27.78	24	26.67
Severe	9	10	18	20	6	6.67
Extremely Severe	-	-	18	20	4	4.4
Total	90	100	90	100	90	100

Additionally, the table illustrates that 35.6% of the participants experienced normal level of depression, 26.7% mild depression, 26.7% moderate depression, 6.7% severe level of depression, and 4.4% extremely severe depression.

To further illustrate these challenges, the following case study presents the personal experience of a 19-year-old male, studying in a Bachelor's course of a university in Delhi, indicating symptoms of moderate stress, extremely severe anxiety, and mild depression, recalled*, "In 2nd grade, parents of a classmate told him not to be friends with me because I was a Muslim".* He also remembered, *"During my boarding school days in Darjeeling I was called 'Katwa' because of my religious practice. This really made me feel unhappy. Whenever in a Pakistan-India cricket match, India would win; they would tease me by saying 'We won from your team'. After any terror attack, they taunted me that your family i.e., Pakistan had done. I was offended and stressed by these remarks. I just ignored their comments."* He is also stressed by the amount of hatred that he sees on social media against the Muslim community. His boarding school taunts and religious slurs intensified his distress, showing how identity-based bullying can have long-term psychological impacts. Social media hostility of Muslims adds to his stress, making it hard for him to escape the prejudiced environment. The approach of ignoring these remarks illustrates a prevalent coping strategy among those who are often marginalized, yet it does not diminish the

significant emotional impact these encounters impose. This narrative highlights the impact of social exclusion and discrimination rooted in religious identity as key stressors that can lead to mental health issues such as anxiety and depression, especially among minority youth (Sheridan, 2006).

While the previous case illustrates the role of social discrimination in shaping stress, the next narrative offers another perspective, focusing on anxiety experienced from the anti-Muslim atmosphere, fear of lynching, and religious based discrimination. A 22-years-old male, studying in a central university of Delhi, indicates extremely severe anxiety and mild depression. Along with family financial constraints, academic pressure, and uncertainty of future career prospects, he experienced anxiety due to anti-Muslim atmosphere in the country, he expressed, *"the growing communalism and marginalization of minority to create a large vote bank, people are promoting and enjoying the hate crimes like lynching, due to this I don't feel safe even in the Capital city of country and while traveling in train if people are discussing politics, I am unable to express my opinions as even a rational argument will get me the tag of anti-national".* Further, he discussed about being fearful of lynching, he reported, *"I cannot carry non-vegetarian food items from hometown to Delhi as someone might beat me and falsely accuse me for carrying beef"*. Additionally, he experienced discrimination based on his Muslim identity, he shared, *"in an interview the attitude of the interviewer changed after realizing my religious identity".* He also reported a history of mental health issues and receiving treatment from psychiatrists for anxiety and panic attacks in past. In terms of coping strategies, the participant doesn't seek help from others due to lack of trust in people, and he prefers smoking and offering prayer to cope with stressors. The student's anxiety and mild depression are exacerbated by personal, social, and political stressors, specifically family financial problems, academic pressure, fear of lynching, and religious discrimination. The participant is worried about the country's growing anti-Muslim sentiment, including communalism and lynching. He lives in dread and insecurity due to the unfavorable political climate. The fear and insecurity created in the participant's life as a result of political marginalization, has deep impacts on mental health, causing anxiety and vulnerability. The participant's coping strategies, such as smoking and praying, reflect a reliance on self-soothing behaviors instead of pursuing external assistance. The history of anxiety and panic attacks indicates a persistent nature of mental health issues, compounded by continuous stressors associated with his religious and social environment. The reoccurrence of mental health issues, despite previous treatment, underscores the necessity for continuous support and intervention.

Building on the themes of mental health issues, this case adds another dimension by exploring the experience of depression caused by academic pressure and feeling of 'othered' as a member of religious minority, which in turn compound the mental health problems faced by students. A 22-years-old female, studying in a Master's course of a university in Delhi, reported moderate stress, along with extremely severe anxiety and depression. Her academic stress arises from the pressure of exams and anxiety about performance, further intensified by a continuous sense of being an 'outsider' in the university community. She shared, *"I have viscerally felt being other and a part of Minority. I come from an insulated society where nobody goes out to study or marries outside the community. So, I fear of dropping out and not performing well in the education field. I have lacked accessibility to good knowledge at young age and this makes me feel at a back hand with respect to my classmates."* Her experience of being othered extends beyond academics. She has noticed that there is a lack of representation of Muslims in positions of achievement within the

university, which further discourages her from envisioning herself in such roles. She also expressed, *"If I say salam (greeting) to anyone on phone, then the entire room would get silent and heads turn to me."* She remembered experiencing discomfort when, after saying "Salam" on the phone, the whole room would fall silent, with heads turning towards her. Furthermore, she has come across derogatory graffiti aimed at Muslim students who utilize the campus library for prayer, reflecting the micro level of aggression against her community. She remarked, *"Being a Muslim I am always reminded by others that my beliefs and practices are not the norm"*. She recounted being asked why Muharram is celebrated and expressed frustration over how her religion is treated as unfamiliar, while Hindu festivals like Diwali are accepted without question. She also faces stereotypes such as Muslims are biryani eating people, living in ghettos, and being unclean which she finds derogatory. To avoid these negative stereotypes, she has consciously altered her behaviour, refraining from using traditional Islamic phrases (like *Mashallah* and *Alhamdulillah*) to make her peers more comfortable. She has also noticed that portraying oneself as a practicing Muslim is not seen as progressive. Over time, she has adopted a more "Western" vocabulary to fit into the liberal environment at the university.

Her mental health was affected significantly some months ago, when her anxiety and depression intensified during exams, and she wanted to contact a counselor, but no one was accessible in the vicinity. Although her university offers therapy services, she doesn't trust the authorities, and chose not to use it. Instead, she relieves stress by talking to friends, praying (which calms her body and anxiety), reading, and traveling. The student's narrative reflects the intersectionality of mental health and religious identity, showing how being part of a religious minority can heighten stress, anxiety and depression. Constant reminders of her 'otherness' through microaggressions, such as offensive remarks and exclusion from social norms, are particularly harmful. The stereotypes, and lack of understanding and respect for her religious practices, emphasize how cultural insensitivity in academic spaces can lead to further marginalization of minority students (Shammas, 2009). The student's reluctance to seek therapy due to distrust in university authorities, coupled with her reliance on personal coping strategies such as talking to friends and praying, reflects a common pattern among minority students. Religious practices, such as prayer, frequently serve as a vital source of solace and comfort for marginalized individuals, and spirituality acts as a major coping strategy to manage stress (Pargament, Smith, Koenig, & Perez, 1998).

These case studies reveal the complex interplay of political, social, and personal stressors contributing to the participant's mental health struggles. Themes of anti-Muslim sentiment, fear of lynching, religious discrimination, environmental aggression, stereotyping, cultural insensitivity, cultural alienation, academic stress, and financial constraints create a challenging environment where anxiety and depression are intensified. The constant reminders for minority as 'other', offensive remarks, and exclusion from social norms, are particularly harmful. Research by Jasinskaja-Lahti et al. (2006) suggests that discrimination based on religious or ethnic identity can lead to increased stress, feelings of alienation, and mental health issues. The minority students experiences of vandalism and social media aggression against Muslims show how online animosity and microaggressions in actual spaces worsen the students mental health. Tynes et al. (2020) found that online discrimination and hate speech harm the mental health of minority groups. The student's reluctance to seek therapy due to distrust in university authorities, coupled with reliance on self-coping strategies, reflects a common pattern among minority students. Studies have shown that minority groups often avoid institutional mental health services due to mistrust

or perceived lack of cultural competence (Meyer, Schwartz, & Frost, 2008). This suggests the need for more culturally sensitive mental health services that acknowledge the unique challenges faced by marginalized groups like Muslims in India. To tackle these challenges, it is fundamental to comprehend the impact of identity-related stressors on mental health and to develop interventions that promote psychological and social support for affected individuals.

Correlation Analysis

From the table 2 it can be observed that the correlation coefficients are significant at 0.05 level and are indicating a positive relation between stress and anxiety, stress and depression, and anxiety and depression. The correlation coefficient value of stress and anxiety is 0.72, which shows that these two variables have strong positive linear correlation. The value of correlation coefficient between stress and depression is 0.62, which indicates a strong positive correlation for these variables. The correlation coefficient value of anxiety and depression is 0.50, which shows that these two variables have a moderate positive linear correlation. (Evans, 1996)

Table 3: Correlation Analysis

Correlations

		Stress	**Anxiety**	**Depression**
Stress	Pearson Correlation	1	.720**	.617**
	Sig. (2-tailed)		.000	.000
	N	90	90	90
Anxiety	Pearson Correlation	.720**	1	.500**
	Sig. (2-tailed)	.000		.000
	N	90	90	90
Depression	Pearson Correlation	.617**	.500**	1
	Sig. (2-tailed)	.000	.000	
	N	90	90	90

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

4. Relation of Stress, Anxiety, and Depression with socio-demographic profile

i) Relation of stress, anxiety, and depression with gender

ANOVA has been applied to find the relationship between variables stress, anxiety, and depression with respect to gender of the Muslim students at a significant level of 0.05.

Table 4: Relationship between Stress, Anxiety, and Depression with respect to Gender

ANOVA

		Sum of Squares	**Df**	**Mean Square**	**F**	**Sig.**
Stress	Between Groups	9.956	1	9.956	.237	.628
	Within Groups	3698.667	88	42.030		
	Total	3708.622	89			
Anxiety	Between Groups	10.679	1	10.679	.207	.650
	Within Groups	4532.476	88	51.505		
	Total	4543.156	89			
Depression	Between Groups	7.314	1	7.314	.106	.746
	Within Groups	6082.286	88	69.117		
	Total	6089.600	89			

The above table shows the relationship between stress, anxiety, and depression with respect to gender. The significant values for stress, anxiety, and depression with respect to gender are more than 0.05. The test is statistically non-significant; therefore, there exists no significant difference in terms of gender for stress, anxiety and depression. A probable cause this result can be that the Muslim students are experiencing stress, anxiety, and depression due to the Muslim identity they possess in the growing intolerance towards their community. There can be other reasons contributing to this which the current study has not been able to identity. In line with the present study, research revealed that university students experienced moderate level of stress irrespective of the gender (Gonmei & Devendiran, 2017).

ii) Relation of stress, anxiety, and depression with caste

ANOVA has been applied to find the relationship between variables stress, anxiety, and depression with respect to caste at a significant level of 0.05.

Table 5: Relationship between Stress, Anxiety, and Depression with respect to Caste

ANOVA

		Sum of Squares	Df	Mean Square	F	Sig.
Stress	Between Groups	165.753	1	165.753	4.117	.045
	Within Groups	3542.869	88	40.260		
	Total	3708.622	89			
Anxiety	Between Groups	228.013	1	228.013	4.650	.034
	Within Groups	4315.143	88	49.036		
	Total	4543.156	89			
Depression	Between Groups	68.600	1	68.600	1.003	.319
	Within Groups	6021.000	88	68.420		
	Total	6089.600	89			

The above table illustrates the relationship between stress, anxiety, and depression with respect to caste. The significant values for stress and anxiety with respect to caste are less than 0.05. Therefore, a significant difference exists for stress and anxiety in terms of caste (upper and lower). Now, the significant value for depression with respect to caste is more than 0.05. Thus, there exists no significant difference in terms of caste for depression among Muslim students.

iii) Relation of Stress, Anxiety, and Depression with courses enrolled in the university

ANOVA has been applied to find the relationship between variables stress, anxiety, and depression with respect to courses at a significant level of 0.05.

Table 6: Relationship between Stress, Anxiety and Depression with respect to Courses

ANOVA

		Sum of Squares	Df	Mean Square	F	Sig.
Stress	Between Groups	354.245	2	177.122	4.594	.013
	Within Groups	3354.378	87	38.556		
	Total	3708.622	89			
Anxiety	Between Groups	556.675	2	278.338	6.074	.003
	Within Groups	3986.480	87	45.822		
	Total	4543.156	89			

ANOVA						
		Sum of Squares	**Df**	**Mean Square**	**F**	**Sig.**
Depression	Between Groups	700.665	2	350.333	5.656	.005
	Within Groups	5388.935	87	61.942		
	Total	6089.600	89			

The above table illustrates the relationship between stress, anxiety, and depression with respect to courses (Bachelor's, Master's, and M. Phil/Ph. D). The significant values for stress, anxiety, and depression with respect to courses are less than 0.05. Therefore, a significant difference exists for stress, anxiety, and depression among Muslim students in terms of courses.

Stressors experienced by Muslim Students

The analysis suggests that some of the sources of stress are common among the youth regardless of their religious identity whereas the Muslim students are exposed to additional stressors linked to their religious identity.

Table 7: Stressors present in the lives of Muslim Students (N=90)

Stressor Experienced	**Frequency**	**Percentage**
Academic Pressure	66	73.33
Family related Stress	36	40.00
Expectations of family	13	14.44
Relationship (love and friendship)	11	12.22
Uncertainty of Career/Future	35	38.89
To fit in the university environment	7	7.78
No freedom of expression/Keeping opinion to self	10	11.11
Financial Constraint	13	14.44
Health problems	3	3.33
Discrimination/judgment/stereotypes/other feeling	51	56.67
Current Political Scenario	15	16.67
Anti-Muslim Environment/ Intolerance towards Muslims	51	56.67
Fear of Lynching	19	21.11
Committing sins/Missing prayers/Balancing Religion and college	9	10.00
Living alone	4	4.44
Lack of knowledge due to family background/schooling	5	5.56

The maximum percentage of the participants experienced stress related to academics followed by discrimination, anti-Muslim environment, family related stress, and uncertainty of career or future. Low proportions of the participants experienced stress due to fear of lynching and current political scenario followed by expectations of family, financial constraints, relationship issues, low freedom of expression, difficulty in balancing college and religious practices, difficulty to fit in the university environment, lack of knowledge, and living alone.

Coping Strategies employed by the Muslim Students

In a stressful event, individuals adopt various strategies to deal with the situation effectively which are known as coping strategies. Different individuals deal with stress through

different coping strategies. The several coping strategies utilized by the participants are reflected in the table below.

Table 8: Coping Strategies used by the Muslim Students to deal with Stress

	Brief COPE scale (%)					
Coping Items	**1**	**2**	**3**	**4**	**Don't do**	**Usually do**
I turn to work or other activities to take my mind off things.	10	34.44	30	25.56	10	90
I concentrate my efforts on doing something about the situation I'm in.	6.67	36.67	31.11	25.56	6.67	93.33
I say to myself "this isn't real."	45.56	32.22	10	12.22	45.56	54.44
I use alcohol or other drugs to make myself feel better.	92.22	5.56	2.22	0	92.22	7.78
I get emotional support from others.	22.22	45.56	18.89	13.33	22.22	77.78
I give up trying to deal with it.	46.67	35.56	16.67	1.11	46.67	53.33
I take action to try to make the situation better.	5.56	23.33	46.67	24.44	5.56	94.44
I refuse to believe that it has happened.	56.67	28.89	8.89	5.56	56.67	43.33
I say things to let my unpleasant feelings escape.	25.56	37.78	27.78	8.89	25.56	74.44
I get help and advice from other people.	12.22	28.89	37.78	21.11	12.22	87.78
I use alcohol or other drugs to help me get through it.	91.11	5.56	3.33	0	91.11	8.89
I try to see it in a different light, to make it seem more positive.	8.89	26.67	45.56	18.89	8.89	91.11
I criticize myself.	15.56	42.22	22.22	20	15.56	84.44
I try to come up with a strategy about what to do.	3.33	28.89	50	17.78	3.33	96.67
I get comfort and understanding from someone.	13.33	38.89	34.44	13.33	13.33	86.67
I give up the attempt to cope.	48.89	33.33	15.56	2.22	48.89	51.11
I look for something good in what is happening.	6.67	32.22	43.33	17.78	6.67	93.33
I make jokes about it.	32.22	38.89	15.56	13.33	32.22	67.78
I do something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	17.78	24.44	36.67	21.11	17.78	82.22
I accept the reality of the fact that it has happened.	6.67	20	43.33	30	6.67	93.33
I express my negative feelings	21.11	41.11	26.67	11.11	21.11	78.89
I try to find comfort in my religion	7.78	13.33	22.22	56.67	7.78	92.22

	Brief COPE scale (%)					
Coping Items	**1**	**2**	**3**	**4**	**Don't do**	**Usually do**
or spiritual beliefs.						
I try to get advice or help from other people about what to do.	10	34.44	35.56	20	10	90
I learn to live with it.	7.78	32.22	33.33	26.67	7.78	92.22
I think hard about what steps to take.	5.56	28.89	38.89	26.67	5.56	94.44
I blame myself for things that happened	25.56	37.78	24.44	12.22	25.56	74.44
I pray or meditate.	7.78	25.56	28.89	37.78	7.78	92.22
I make fun of the situation.	40	37.78	13.33	8.89	40	60

1 = I don't do this at all, 2 = I do this a little bit, 3 = I do this medium amount, 4 = I do this a lot

Table 10 illustrates the 14 subscales of the Brief COPE Scale. These subscales can be categorized under two broad headings – adaptive coping and maladaptive coping. The adaptive coping strategies include the active coping, emotional support, using instrumental support, positive reframing, planning, humor, acceptance, and religion. The maladaptive coping strategies include self-distraction, denial, substance use, behavioral disengagement, venting, and self-blame (Carver, 1997).

Table 9: Adaptive and Maladaptive Coping Strategies

Coping Strategies	**Percentage**
Adaptive Coping	**87.71**
Active Coping	93.89
Emotional Support	82.23
Using Instrumental Support	88.89
Positive Reframing	92.22
Planning	95.56
Humor	63.89
Acceptance	92.78
Religion	92.22
Maladaptive Coping	**58.61**
Self-Distraction	86.11
Denial	48.89
Substance Use	8.34
Behavioral Disengagement	52.22
Venting	76.67
Self-Blame	79.44

Mechanism established in the Universities to address mental health concerns of students

54.4% participants stated that counseling facility is provided in their college or university whereas 36.7% reported no counseling facility offered by the administration of the college

or university. 8.9% were not aware about the facility being offered or not. The data reveals almost equal distribution of provision and unavailability of counseling facilities provided by the colleges/universities.

DISCUSSION

The results reveal that stress was experienced by 47.8% of the participants out of which 27.8% experienced mild level of stress, 10% had moderate stress, and 10% had severe stress. 76.7% suffered from anxiety where 8.9% participants had mild anxiety, 27.8% had moderate anxiety, 20% had severe anxiety, and 20% had extremely severe anxiety. Depression was experienced by 64.4% of the total sample where 26.7% reported mild depression, 26.7% reported moderate depression, 6.7% reported severe depression, and 4.4% reported extremely severe depression. Similarly, a study revealed that students suffered from depression – moderate (27.5%) and severe or extremely severe (9.7%), anxiety – moderate (34%) and severe or extremely severe (29%) and stress – moderate (18.6%) and severe or extremely severe (5.1%) (Shamsuddin, et al., 2013). Another study on the students of Indian universities illustrated prevalence of moderate (37.7%), severe (13.1%) and extremely severe (2.4%) depression (Deb, et al., 2016).

The Pearson's coefficients are significant at 0.05 level, thus there exists a definite positive relation between stress and anxiety, stress and depression, and anxiety and depression. One-way ANOVA was applied to assess the relationship between stress, anxiety, and depression with respect to gender, caste, and courses enrolled by the participants. The significant values for stress, anxiety, and depression with respect to gender was found to be statistically non-significant, thus there is no significant difference due to gender on stress, anxiety and depression. This finding is similar to a study which reported that depression scores among male and female were not statistically significant (Bayram & Bilgel, 2008). The study reveals that university students experienced moderate level of stress irrespective of the gender (Gonmei & Devendiran, 2017). Although there exists a significant difference for stress and anxiety with respect to caste, however no significant difference is reflected for depression due to caste. In case of courses there is significant difference in stress, anxiety and depression of the participants.

University life is demanding in terms of academic workload, attending class, preparing assignments, and performing well in examinations, which induces stress and other mental health issues amongst students. A study reported that difficulty in class work is a determinant of emotional disturbances among university students and statistically drew significant association of this stressor with depression, anxiety and stress (Radeef, Faisal, Ali, & Ismail, 2014). Past studies have stated that majority of the university students suffered stress in their lives (Campbell, Svenson, & Jarvis, 1992; Gonmei & Devendiran, 2017). The dominant factor leading to stress among the students was perceived to be social and family factors (Gonmei & Devendiran, 2017). These mental health issues faced by students as a result of academic pressure and associated social factors further exacerbate by the social identity linked to their status as a member of religious minority.

The Muslim students face a lot of stressors that are faced by other students belonging to different religions and cultures like academic pressure, uncertainty of career, family related stress, relationship, financial constraints, health problems and living alone. Additionally, they face certain specific stressors (external and self-induced) due to their Muslim identity like anti-Muslim environment, discrimination or stereotypes related to their practices or

culture, fear of lynching, lack of freedom of expression, difficulty to fit in the university environment, stress due to current political scenario, lack of knowledge due to family background or schooling, and difficulty in balancing religious practices and college activities.

To live a functional life and perform well in the university the students adopt certain coping strategies that aid them to deal with the stressors present in their environment. According to a WHO Report coping strategies differ as per the gender, age, community, family background, and personal experiences (Redhwan, Sami, Karim, Chan, & Zaleha, 2009). The adaptive coping strategies were utilized by 87.71% of the students while 58.61% maladaptive coping strategies. The adaptive coping strategies included active coping (94%), emotional support (82%), using instrumental support (94%), acceptance (93%), religion (92%), planning (89%), positive reframing (82%), and humor (64%). The maladaptive coping constituted self-distraction (86%), self-blame (79%), venting (76%), behavioral disengagement (52%), denial (49%), and substance use (8%). Studies showed that majority of the students used spiritual connection (Ismail, 2015), prayers (Redhwan, Sami, Karim, Chan, & Zaleha, 2009) and are less prone to utilize substance abuse (Walker, Ainnette, Wills, & Mendoza, 2007) as a coping strategy to deal with stress. For effective coping, a combination of individual efforts and institutional efforts are essential to maintain and enhance the mental health of the students. In the present study the participants reported that 54.4% of the universities and the colleges under these universities offer counseling facilities whereas 36.7% don't have a mechanism of counseling, and 8.9% of the students did not know about the facility being offered or not.

The present study and past studies suggest that mental health problems are prevalent among university and require immediate attention from students and university administration to assist the students in coping with the mental health problems. Research indicates that exposure to violence or the fear thereof, predicated on one's identity, can result in increased stress and anxiety. A study examined the capacity of ethnic and religious violence to trigger trauma, stress, and enduring mental health issues in minority populations (Noh, Kaspar, & Wickrama, 2006). The fear of lynching documented in the case studies corresponds with the experiences of numerous Muslims who feel threat from identity-based violence across India. The American Psychological Association (APA), 2016 emphasizes that ethnic and religious discrimination elevates the likelihood of mental health conditions, especially anxiety and depression, in marginalized groups. This resonates with research on fear and social anxiety in contexts where minority encounter public scrutiny and hostility. A study indicates that the fear of lynching or hate crimes, religious discrimination and Islamophobia profoundly affects the psychological health of marginalized populations, rendering them more vulnerable to anxiety and depression, and overall psychological distress (Kennedy-Turner, Côté-Lussier, & Helly, 2023).

To combat growing prejudice and intolerance, people must learn about all religions, including their own, and actively share their beliefs. Social harmony requires respecting others' liberty and choices. Additionally, people should feel comfortable discussing and seeking mental health help, showing a willingness to consult professionals. Acclimating to college life, setting achievable goals, improving study habits, and managing time can also lessen stress (Ji & Zhang, 2011). Acquiring stress management and adaptive coping skills improve resilience and wellbeing.

India's diverse terrain requires people to accept and appreciate religious and regional communities and their customs. Multicultural activities at the community level assist understand varied socio-cultural traditions. Religious groups under discrimination or harassment need support and assistance for communal cohesion. Establishing a collective to help victims of religious hate crime cope is crucial. Critical analysis, engagement with affected populations, and understanding occurrences from their perspective are needed to combat fraudulent and malicious social media posts and promote empathy and authenticity.

Universities should create a committee to help minorities facing stress or harassment owing to their identity and to combat religious hate speech and symbols. Student acceptance of other religions can be promoted via social harmony and human rights activities. In professional settings, ideological expression should be democratic and classrooms environment must be inclusive. Religious and cultural practices, including dress and eating habits must be respected. Senior minority students might organize support groups to help newcomers adjust. The university should prioritize counseling services, create student trust, and raise awareness about these services. Mental health and stress management training should be part of the curriculum. Workshops on interpersonal communication and community harmony and integration camps might foster inclusivity and understanding among students of diverse religious groups.

The government must enact and implement anti-discrimination laws to safeguard religious minority from rumors and suspicions, classifying any violence as hate crimes. Establishment of anti-discriminatory committees for minorities to file complaints and ensuring speedy trials is crucial. Media accountability and transparency are critical, with a need for verification of reports and monitoring of profiles disseminating anti-Muslim content and holding individuals accountable for religious polarization efforts. Additionally, Indian society should destigmatize mental health concerns and encourage people to seek psychological assistance.

CONCLUSION

Stress is a reality and everyone at one or the other walk of life is likely to experience it. It is a general phenomenon among individuals of all ages and youth is more prone to it due to immaturity, lack of experience in handling stressful situation, and the ever-changing demands of education and job. Despite stress playing a pivotal role in determining the mental health it is often ignored in the daily life. The findings of the study can benefit the different stakeholders to acknowledge stress, anxiety and depression present amongst the Muslim students and devising mechanisms to maintain, enhance and promote mental health among students. Catering to mental health is beneficial for the overall development of the students and provides an approach to the university to cultivate the talents and mitigate the fears of students in order to excel and enhance their performance in academics, relations, and overall performance.

The youth especially university students are at an ever-increasing risk to psychological problems. The number of cases of mental illness and suicide are rapidly increasing across the globe due to the pressure of growing competition, work load, low confidence, less self-efficacy, lifestyle changes, intolerance, and inefficient coping styles. Studies suggest there is an urgent need to emphasize on mental health services for students suffering severe or extremely severe depression (Deb, et al., 2016). Mental health problems among the students of university have negative consequences on individual, family, and the community. The

students suffering from or vulnerable to mental illness are at risk to harm themselves or others, academic drop outs, unemployment, and increasing burden on family and society. It is essential for the administrators, educators, and healthcare providers to develop "preventive mental health programs to create a supportive academic context that promotes students' psychosocial wellbeing, improves their productivity, enhance their success, saves their souls and money, and protects families and communities" (Aldiabat, Matani, & Navenec, 2014).

The verbatims of students illustrate the significant effects of social discrimination, religious marginalization, and cultural insensitivity on the mental wellbeing. This necessitates for a more inclusive, supportive, and culturally sensitive approach to mental health services in universities, ensuring that minority students feel safe and empowered to seek assistance without the fear of judgment or exclusion. To address these challenges, it is essential to ensure the availability of mental health services while also cultivating an environment that is inclusive and respectful of religious diversity. An inclusive system and environment at the university level needs to be devised where all the students feel being the part of the institution despite of their cultural, religion, regional, and lingual differences. At national level the key determinant of promoting mental health such as social inclusion, freedom from discrimination and violence and equitable economic participation opportunities need to be created to ensure good mental health among Muslim youth.

In India, there is tremendous scope for social workers to act as a bridge between students of diverse backgrounds and mental health assistance offered by universities. Social workers in university play a significant role to address students' mental health challenges by promoting awareness, reducing stigma, and offering culturally sensitive counseling. They provide prevention programs, individual and group therapy, and connect students to mental health care when needed. Social workers also advocate for accessible mental health services, collaborate with university staff to create supportive environments, and dispel misconceptions about mental illness. Their role is critical in ensuring students receive comprehensive mental health support, bridging the gap between students and mental health professionals.

REFERENCES

Aaron, R., Joseph, A., Abraham, S., Muliyil, J., George, K., Prasad, J., . . . Bose, A. (2004). Suicides in young people in rural southern India. Lancet, 363, 1117-18. https://doi.org /10.1016/S0140-6736(04)15896-0

Aldiabat, K. M., Matani, N. A., & Navenec, C.-L. L. (2014). Mental health among undergraduate university students: A background paper for administrators, educators and healthcare providers. *Universal Journal of Public Health, 2*(8), 209-214. https:// doi.org/10.13189/ujph.2014.020801

American Psychological Association. (2016). *Stress in America: The impact of discrimination.* Stress in America Survey. Retrieved from https://www.apa.org/news/ press/releases/stress/2015/impact

Bayram, N., & Bilgel, N. (2008). The prevalence and socio-demographic correlations of depression, anxiety, and stress among a group of university students. *Soc Psychiatry Psychiatr Epidemiol, 43*, 667-672. https://doi.org/10.1007/s00127-008-0345-x

Bhargava, D., & Trivedi, H. (2018). A study of causes of stress and stress management among youth. *IRA-International Journal of Management & Social Sciences, 11*(3), 108-117. http://dx.doi.org/10.21013/jmss.v11.n3.p1

Campbell, R. L., Svenson, L. W., & Jarvis, G. K. (1997). Perceived level of stress among university undergraduate students in Edmonton, Canada. *Perceptual and Motor Skills, 75*(2), 552-554. https://doi.org/10.2466/pms.1992.75.2.552

Carver, C. S. (1997). You want to measure coping but your protocol's too long: consider the brief cope. *International Journal of Behavioral Medicine, 4*(1), 92-100. https://doi .org/10.1207/s15327558ijbm0401_6

Chadda, R. K. (2018). Youth & mental health: Challenges ahead. *Indian Journal of Medical Research, 148*, 359-361. https://doi.org/10.4103/ijmr.IJMR_1585_18

Christensen, H., Reynolds, C. F., & Cuijpers, P. (2017). Protecting youth mental health, protecting our future. *World Psychiatry, 16*(3), 327-328. https://doi.org/10.1002/wps. 20437

Corley, L. (2013). Prevalence of mental health issues among college students: How do advisers equip themselves. *The Mentor an Academic Advising J, 15*. https://doi.org/1 0.26209/MJ1561292

Deb, S., R, B. P., Thomas, S., Vardhan, R. V., Rao, P. T., & Khawaja, N. (2016). Depression among Indian university students and its association with perceived university academic environment, living arrangements and personal issues. *Asian Journal of Psychiatry*(23), 108-117. https://doi.org/10.1016/j.ajp.2016.07.010

Devi, R. S., & Mohan, S. (2015). A study on stress and its effects on college students. *International Journal of Scientific Engineering and Applied Science, 1*(7), 449-456.

Evans, J. D. (1996). *Straightforward statistics for the behavioral sciences.* Thomson Brooks/ Cole Publishing Co.

Gonmei, J., & Devendiran, C. (2017). Perceived stress and psychosocial factors of stress among youth. *International Journal of Academic Research and Development, 2*(6), 766-770.

Gururaj, G., Varghese, M., Benegal, V., Rao, G. N., Pathak, K., Singh, L. K., . . . Misra, R. (2016). *National Mental Health Survey of India, 2015-16: prevalence, pattern and outcomes.* Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS.

Hawton, K., Simkin, S., Rue, J., Haw, C., Barbour, F., Clements, A., . . . Deeks, J. (2002). Suicide in female nurses in England and Wales. *Psychological Medicine, 32*, 239-250. https://doi.org/10.1017/S0033291701005165

Ismail, A. A. (2015). Ways of coping and religious commitment in muslim adolescents. *Mental Health, Religion & Culture, 18*(3), 175-184. https://doi.org/10.1080/136746 76.2015.1027675

Jasinskaja-Lahti, I., Liebkind, K., & Perhoniemi, R. (2006). Perceived discrimination and well-being: A victim study of different immigrant groups. *Journal of community & applied social psychology, 16(4),, 16*(4), 267-284.

Jekielek, S., & Brown, B. (2005). *The transition of adulthood: Characteristics of young adults ages 18 to 24 in America.* Baltimore, MD: Annie E Casey Foundation. https:// doi.org/10.1002/casp.865

Ji, H., & Zhang, L. (2011). Research on college students' stresses and coping strategies. *Asian Social Science, 7*(10), 30-34. http://ilscertification.com/resources/transitionto adulthood.pdf

Kennedy-Turner, K., Côté-Lussier, C., & Helly, D. (2023). A Snapshot of Hate: Subjective Psychological Distress After a Hate Crime: An Exploratory Study on Victimization of Muslims in Canada. *Journal of muslim mental health, 17*(1), 14-31. https://doi.org/10.3998/jmmh.480

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry, 20*, 359–364. https://doi.org/10.1097/YCO.0b013e32816ebc8c

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales (2nd. Ed.).* Sydney: Psychology Foundation.

Meyer, I. H., Schwartz, S., & Frost, D. M. (2008). Social patterning of stress and coping: does disadvantaged social statuses confer more stress and fewer coping resources? *Social Science & Medicine, 67*(3), 368-379. https://doi.org/10.1016/j.socscimed.2008.03.012

Noh, S., Kaspar, V., & Wickrama, K. A. (2006, August). Overt and subtle racial discrimination and mental health: Preliminary findings for Korean immigrants. *American Journal of Public Health, 97*(7), 1269-1274. https://doi.org/10.2105/AJPH.2005.085316

Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion, 37*(4), 710-724. https://doi.org/10.2307/1388152

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *Lancet, 369*, 1302-13. https://doi.org/10.1016/S0140-6736(07)60368-7

Radeef, A. S., Faisal, G. G., Ali, S. M., & Ismail, M. K. (2014). Source of stressors and emotional disturbances among undergraduate science students in Malaysia. *International Journal of Medical Research & Health Sciences, 3*(2), 401-410. https://doi.org/10.5958/j.2319-5886.3.2.082

Redhwan, A. A., Sami, A. R., Karim, A. J., Chan, R., & Zaleha, M. I. (2009, December). Stress and coping strategies among management and science university students: a qualitative study. *The International Medical Journal, 8*(2), 11-15. https://doi.org/10.31436/imjm.v8i2.751

Rodgers, L. S., & Tennison, L. R. (2009). A preliminary assessment of adjustment disorder among first-year college students. *Archives of Psychiatric Nursing, 23*(3), 220-230. https://doi.org/10.1016/j.apnu.2008.05.007

Shammas, D. S. (2009). Post-9/11 Arab and Muslim American community college students: Ethno-religious enclaves and perceived discrimination. *Community College Journal of Research and Practice, 33*(3-4), 283-308. https://doi.org/10.1080/10668920802580507

Shamsuddin, K., Fadzil, F., Ismail, W. S., Shah, S. A., Omar, K., Muhammad, N. A., . . . Mahadevan, R. (2013). Correlates of depression, anxiety and stress among Malaysian university students. *Asian Journal of Psychiatry*(6), 318-323. https://doi.org/10.1016/j.ajp.2013.01.014

Sheridan, L. P. (2006). Islamophobia pre–and post–September 11th, 2001. *Journal of interpersonal violence, 21*(3), 317-336. https://doi.org/10.1177/0886260505282885

Shete, A. N., & Garkal, K. D. (2015). A study of stress, anxiety, and depression among postgraduate medical students. *CHRISMED Journal of Health and Research, 2*(2), 119-123. https://doi.org/10.4103/2348-3334.153255

Siyech, M. S., & Narain, A. (2018). Beef-related violence in India: an expression of Islamophobia. *Islamophobia Studies Journal, 4*(2), 181-194. https://doi.org/10.13169/islastudj.4.2.0181

Tahseen, M., Ahmed, S. R., & Ahmed, S. (2018). Muslim Youth in the Face of Islamophobia: Risk and Resilience. *Islamophobia and Psychiatry*, 307-319. https://doi.org/10.1007/978-3-030-00512-2_26

Tynes, B. M., English, D., Toro, J. D., Smith, N. A., Lozada, F. T., & Williams, D. R. (2020). Trajectories of online racial discrimination and psychological functioning among African American and Latino adolescents. *Child development, 91*(5), 1577-1593. https://doi.org/10.1111/cdev.13350

Walker, C., Ainnette, M. G., Wills, T. A., & Mendoza, D. (2007). Religiosity and substance use: Test of an indirect-effect model in early and middle adolescence. *Psychology of Addictive Behaviors, 21*(1), 84-96. https://doi.org/10.1037/0893-164X.21.1.84

World Health Organization. (2008). *The global burden of disease: 2004 update.* World Health Organization. Retreieved from https://iris.who.int/bitstream/handle/10665/43942/9789241563710_eng.pdf

World Health Organization. (2017). *Depression and other common mental disorders: global health estimates.* Geneva, Switzerland: World Health Organization. Retrieved from https://iris.who.int/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-eng.pdf

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Conflict of Interest

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