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Exploring the salience of religious identity on the mental health of the Mauritian adult

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Received: 12 May 2023 / Accepted: 11 October 2023
Published online: 02 November 2023

Abstract
Religion is undeniably one of the core components of the Mauritian identity, with religious values and principles woven into the Mauritian fabric. Due to the existing gaps in the research of religion and mental health in the Mauritian community, this study sought to examine the impact of religious identity on the psychological well-being of the typical Mauritian. 276 quantitative responses were retrieved, and 12 participants from the 3 main religious groups in the country were interviewed for an in-depth analysis of their religious identities. Results strongly demonstrated positive links between the 3 dimensions of religious identity and total well-being; religious identity achievement [χ^2 (1680) = 2228 $p < 0.05$, Cramer's V = 0.537]; religious affirmation and belongingness [χ^2 (1620) = 2041, $p < 0.05$, Cramer's V = 0.523], and religious faith and practices [χ^2 (1620) = 1757, $p < 0.05$, Cramer's V = 0.487]. Religious practice strongly associated with emotional stability [χ^2 (246) = 296.15, $p < 0.05$, Cramer's V = 0.432] and happiness [χ^2 (48) = 73.86, $p < 0.05$, Cramer's V = 0.211]. Demographically, educational attainment did not affect religious identification in the Mauritian community. The findings clearly demonstrate the need for an integrative system with ingroup beliefs and traditions embedded into models of recovery for psychological disorders. Mental health professionals should consider alternative approaches, reeling in religion and spiritual dimensions of healing into conventional therapies. The role of religious settings in improving psychological treatment adherence and fostering mental well-being should not be downplayed.

Keywords Religious identity achievement · Religious identification · Religious practice · Psychological well-being · Emotional stability

1 Introduction

Religious values and principles are embedded into the Mauritian identity. Many theories and folklores on religion posit that it plays a major role in promoting a good mental health [7, 35, 85]. In Mauritius, each religion has a poignant historical background that dates to the independence of the country. Given the deep-rooted history of the different religious groups within the country, defining religion can be an intricate process, as each religion has its own distinct beliefs and practices. With the historical dilemmas its people have faced, religious identity has become more of a necessity than a pursuit of truth [29]. Religious beliefs offer justification for unavoidable grievances and propose established practices to

Supplementary Information The online version contains supplementary material available at https://doi.org/10.1007/s44202-023-00092-4.

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alleviate emotional conflicts [72]. It attributes rationality to mortality through afterlife dogmas. It is often hard to accept the death of loved ones, however through attribution of religiosity to the loss incurred, this grieving process is assuaged. Through association with an omnipotent power, religion helps to establish moral principles to live by; hence promoting harmonious living and a more peaceful society. Religious beliefs also encourage the development of social relationships through the sharing of principles and practices-creating a sense of ingroup belongingness, thereby promoting social engagement [61, 72].

1.1 An overview of the religious strata in Mauritius

The pluri-diversity of the Mauritian culture is represented by 3 major religious groups; Hinduism (n = 283,945), Roman Catholicism (n = 245,570), and Islam (n = 136,997) [77]. The Hindu religion came from Indian immigrants who were brought to Mauritius to work as indentured labourers for French and British colonies. Since a large number of labourers were brought from India, Hinduism has become the most followed and practiced religion around the country [95]. Hinduism in Mauritius also encompasses communities such as Tamil, Telegu and Marathi among others. Catholicism was introduced to the country by Dutch and French colonies, whereby respective slave owners demanded that slaves had to be baptised by the Catholic Church. Hence, many Creoles and Franco-Mauritians are now Catholics [43]. The Islamic religion akin to Hinduism, came from Indian indentured labourers. Rich merchants who came to Mauritius from other Indian regions also promoted the inclusion of Islam in the country. Most of them preached the teachings from the Sunni segment of Islam, accounting for most of the Muslims in Mauritius belonging to the Sunni culture (nearly 95%) [28].

All the mentioned religious groups have their designated places of worship which are visible around the country in different regions [28]. The Mauritian religious background is complex and treasured by all Mauritians, partly because of its deeply rooted history of how they were introduced in the country during the chaotic and hard times before the independence. Each year, the government honours religions in Mauritius by declaring a holiday for each group, on their most significant religious ceremonies and the Mauritian culture being intertwined, often results in cross-cultural participation and appreciation from individuals within the society.

1.2 Exploring religious identity and religiosity

A social identity is formed when individuals define themselves according to their group belongingness [23], leading to the concept of religious identity, and the latter referring to the extent people identify to their religious groups across their lifespan. A religious identity is a never-ending in-group identification that offers a sacred worldview, unrivalled by affiliations to any other social groups [96]. Religion plays a crucial role in identity formation and the strength of religious identity is often dependent on demographic groups and epochs [64]. Few researchers believe that a religious identity is formed as from birth, while others adhere to the belief that life experiences determine the religious identity formation [20, 66], predominantly through the interaction of nature and nurture [26]. Religiosity is a reflection of religious identity, encompassing its ideology and its accepted religious traditions and practices in place [27, 38]. It offers a form of social identification anchored in a belief system that acts as a powerful tool in shaping psychological and social processes. Religiosity also revolves around the commitment towards one's religion, further anchoring the extent of practice and self-exploration of one's religious identity [88]. With time, religious identity has become a necessity rather than a pursuit for truth [29]. Life stressors, uncertainties and obstacles that are met along the way are more easily tolerated by believers than non-believers [44, 51, 53, 72]. The Mauritian religious identity is complex and deeply entrenched in our existing values due to its rich history and the generational transmission of cultural beliefs, moral values, and principles [73].

In western cultures, religious identity is given less important with age [17], because it is hypothesised that with increasing educational achievement, lesser significance is attributed to one's religion [78]. Jia and colleagues [39] posited that young adults experience an interval of transition and seek new adventures and affiliations, which often lead them to stray from their existing religious values. Additionally, the hardships faced by previous generations were far more challenging than the struggles faced by youngsters nowadays. Hence, the latter often do not feel the need to seek answers or purpose from religion [56]. Adults older than 40 are more likely to hold their religious views and identify strongly to their religious groups as compared to youngsters; a trend observed in most of the countries around the world, irrespective of their affluence [9]. People who identify more strongly to their respective religious groups tend to participate in more religious events and are more likely to benefit from the positive affect associated with such participation, hence the strong positive correlation between religiosity and mental health [8, 23].

1.3 Mental health embedded in religious doctrines

Religion holds an existential value that is unique and provides a sense of belongingness that cannot be matched by any other affiliations. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) has been modified to include a new dimension entitled "religious or spiritual problems", leading to the acknowledgement of the irrefutable link between mental health and religion by mental health practitioners [4]. Significant benefits to both physical and mental health have been linked to religious affiliations, particularly for those individuals suffering from mental disorders [46]. The use of religious coping mechanisms such as praying, meditating and listening to religious hymns are frequently reported as a nurturing strategy towards mental health [67, 80]. The majority of studies investigating the relationship between mental health and religion have focused on populations from Western cultures; findings which cannot be extrapolated to reflect the depth and richness of religious groups in Mauritius.

In Hinduism, devotees follow the scriptures of Rig and Atharva Vedas which both deal with beliefs and practices on how to nurture mental health [14, 22], while Karma, as defined by one's state of mind, allows people with mental illnesses to accept their fate; and at the same time, empowering them to improve and keep advancing in life [41, 81]. Other practices such as Yoga which stems from Hinduism contributes towards a healthier body and mind [93]. Catholics believe that mental illness is a fragment of human life, and practices such as confession [94] and penance [91] promote catharsis and relieve the feelings of alienation and shame brought by the person's actions [36]. The Roman Catholic Church has a rich repertoire of techniques that can be used in handling mental illnesses and problems that are likely to cause tension and stress in the long run [76]. Islam teachings help Muslims tolerate and adapt to daily life stresses. It promotes living in harmony with one another [69]. The way Muslims interact with one another and demonstrate their reverence through religiosity can enhance the individual's psychological well-being by forming healthy and long-lasting attachments, in line with Bowlby's Theory of Attachment [11]. It is generally believed that those who can master patience and resilience, the prime virtues in Islam, are better equipped to manage their thoughts and actions and cultivate a tranquil and optimistic mindset [3, 49].

1.4 Religious identity and religiosity as a protective factor in mental health

80% of gathered data on religious and spiritual studies have shown that involvement in religious practices tends to benefit the psychological, behavioural and social aspects of an individual's life [48]. Literature has shown a positive association between religious participation and general mental health outcomes such as increased life satisfaction and contentment, enhanced mental and physical health, a greater sense of purpose and meaning in life, and improved social relationships [84]. In a study conducted on an elderly population in Thailand, it was found that religious activities were positively linked to greater happiness and mental well-being [45]. Adherence to religious convictions and customs was found to have a favourable correlation with stress reduction by promoting positive attitudes and fostering a sense of optimism and hope, giving meaning to one's existence [2, 18]. People with a stronger religious identification are reported to have higher stability and an elevated level of social support from ingroup members [24]. The stronger one identifies to their religion- the lesser psychological distress is apparent [40].

Religious beliefs can prevent maladaptive behaviours and suicidal ideations, as well as provide the necessary coping strategies to deal with unavoidable life distress [17]. Studies on anxiety and religion have produced contradictory reports, some advocating the benefits of religious beliefs in treating anxiety disorders, while others drawing out the damage brought by such beliefs on fear and anxiety [75]. On the positive end of the spectrum, religious patients with depressive disorders have reported better and faster rates of remissions through the incorporation of religious coping mechanisms in their treatment [47]. Religious schizophrenic patients have demonstrated better social integration, lesser harmful behaviours, and overall diminished risk of substance abuse [58], leading to an overall healthier quality of life [15]. Both religious and spiritual support have been associated with a better recovery rate [58] and increased adherence to treatment [32]. Furthermore, a plethora of studies have demonstrated that increased religious identity leads to a lesser risk of suicide attempt and destructive behaviours [46].

Despite religious cures being commonly used in the Mauritian population in support of the treatment of mental illnesses, there is a scarcity of information on them [54]. Precursor information collected from three priests of the concerned religious groups to further delve into the common religious practices and remedies adopted in the country as a means to promote mental health and tackle mental disorders, showed that the most frequent practices shared similar characteristics across the different religious groups, i.e., from acknowledging wrongdoings to channeling more positive energy

through religious activities (see Supplementary Table S1). The practices are believed to promote well-being through acts of self-awareness, self-reflection, selflessness, and most of all adopting a forgiving and resilient state of mind.

Religious practices often stand as alternative therapies to mental illnesses, encouraging individuals to embrace religiosity as a remedy to treating mental health disorders or illnesses [33, 62]. In Mauritius, help-seeking for mental health is still not prominently embraced by the society given the conservative structure of the community, hence endorsing a more taboo-approach towards mental health support. This in turn leads to alternate strategies including religiosity. Understanding why these attributions are made and their effect on the lives of Mauritians can provide better insights into alternative approaches towards mental health for patients of faith. Hence, this study aimed to explore the salience of religiosity and its impact on mental health across the Mauritian landscape through a qualitative and quantitative approach, while also shedding light on the potential affiliation to religious cures over therapeutic and psychiatric interventions. The core dimensions investigated through this exploratory study revolved around the importance of religious identity, participation, and adherence in the Mauritian community; and the implication of the Mauritian religious identity and its use in promoting psychological well-being and dealing with mental illnesses. The findings of this study could potentially unveil the causes of aversion towards seeking psychological or psychiatric treatment; through which, inclusive strategies could be developed to enhance the availability and accessibility of such services. Ultimately, this tailored approach would encourage individuals from diverse ethnic or cultural backgrounds in Mauritius to seek appropriate support and guidance for managing their mental health.

2 Methodology

A mixed research method was used with Mauritians as exclusive respondents. Convenience sampling was used based on the availability and accessibility of participants [10], and deemed most appropriate given the sanitary protocols that were in place during the study period. Data collection was undertaken from December 2021 to March 2022 and was primarily conducted through online mediums. In an effort to ensure that mature participants and those with limited access to digital devices also had a fair chance of participating in the study, hard copies of the questionnaires were also randomly distributed across the community.

2.1 Sample characteristics and size

This study, focussing on the religious identity and religiosity of the Mauritian population and its role in mental health, targeted practitioners of religious activities aged 18 years old and above. Although no specific age band was applied, adults were primarily chosen since religious practice stems from a young age in the Mauritian culture, thus, anyone aged 18 and above would have spent at least one year within a sphere of religious culture. The primary exclusion criteria were mainly individuals who did not believe in God, 'atheists' and members of the Assemblies of God which is not formally recognized as a religion by the government [63]. With an estimated population of 1,215,822 and the proportion aged under 18 years accounting for roughly 310,000, the population size was narrowed down to 905,822 and the sample size using Slovin's formula calculated to 400. While it would have been ideal to apply a stratified sampling strategy to cater for the religion ratio, an accurate comparative analysis across the different religions was not the major objective of the study, hence generalizing people of faith was favoured.

2.2 Quantitative approach

2.2.1 Instrument design and validation

The cross-sectional study, through a self-reported questionnaire explored the following themes: religious identity, psychological well-being, and religious participation. The Multi-Religion Identity Measure (MRIM) [1] was used to explore 3 specific domains within the religion dimension namely, religious affirmation and belongingness (RAB), religious identity achievement (RIA) and adherence to religious faith and practices (RFP) with 15 items on a 7-point Likert scale. The religious practice scale (RPS) was also added to determine whether the person qualifies himself as religious, and whether the latter participates in religious activities with a report of the frequency at which this occurs. A higher score equated to higher religious participation [1]. The Friedman Well-Being Scale (FWBS) (2010) was used to provide insights into the general psychological health of the participant with 10 emotional states rated on a linear numeric scale [12]. The

quantitative instrument was pre-tested with a group of 25 individuals meeting the selection criteria as defined for this study, and validated before large scale administration. The Cronbach alpha values for the MRIM, FWBS and RPS were 0.924, 0.938 and 0.684 respectively (Supplementary Table S2), indicating a high internal consistency of the different scales used. No changes were made after the pilot testing.

2.2.2 Data analysis

The quantitative data was analysed using SPSS software with statistical significance capped at $p < 0.05$. Descriptive data was presented through frequencies and percentages of the individual sublevels within the variables being investigated. Normality of data was assumed at $p > 0.05$; and tested prior to inferential analyses. Correlations were drawn between combinations of religious identity, practice, and belongingness with psychological well-being; and potential relationships between specific demographic characteristics such as age and level of educational attainment with religious identity were drawn using Chi-square measures. Regression analyses were also performed to determine the potential predictability of well-being using the different dimensions of the MRIM scale, namely, RAB, RIA and RFP.

2.3 Qualitative approach

2.3.1 Interview protocol

The qualitative assessment consisted of 16 pre-set questions formulated after an extensive review of literature and based on a general understanding of the contextual religious practices in Mauritius. Given the sanitary protocols in the country, convenience sampling was used based on the availability and accessibility of participants [10], as it was deemed to be the safest and most cost-effective approach. 12 participants purposively selected and independent from the quantitative segment were interviewed: 4 from each religious group, 2 from each gender. They were all above 35 years, the age band determined empirically by previous studies where people identified more strongly to their religion as from their late thirties [9]. Both online and face to face interviews were conducted depending on the participants' preferences.

The inclusion criteria for this qualitative arm were predominantly being a believer and involvement in religious practice. To ensure neutrality and avoid any preconceived bias, only candidates with no prior relationship to the interviewer were selected. The participants were given the option of choosing between online and face-to-face interviews. The semi-structured questions were subject to reformulation in the native language depending on the level of education and understanding of the participants to extract as much details as possible, all while ensuring that their rights were respected as outlined through the consent form.

2.3.2 Data coding and extraction

The interviews were transcribed verbatim and translated into English in conditions where the participants preferred answering in a different language than English, i.e., either Creole or French. The themes explored were the importance of one's religious history, the different doctrines implemented by Mauritians, nurturing mental health within each religion, importance given to one's religious identity, implementation, and integration of religious remedies in mental healthcare treatment. Hence, the following clusters were thematically extracted from the transcripts, (i) definition of religious identity; (ii) indoctrination to religious groups; (iii) mental health and religion; (iv) importance of religious identity, and (v) role of religious identity in mental health. Data was then condensed and explored according to the broader categories as per the extracts obtained from the respective participants. The principal investigator clustered the key terms from the respective transcripts according to the themes identified and these were validated by an independent researcher co-opted by the co-investigator.

2.3.3 Preliminary participatory data collection

Prior to the quantitative and qualitative instrument designs, a better understanding of religion in the local context was sought through informal participatory data collection from representatives of each of the religious groups. The respective priests were prompted on 5 major elements through a semi-structured list consisting of 16 pre-set questions, which would help define the scope of the study, i.e., (i) The doctrines of religion in Mauritius; (ii) Religious identity; (iii) Mental health and religion; (iv) Religious 'remedies' in the local context; and (v) Integration of religion in mental healthcare

treatment. The merits of mixing formal and informal data collection enabled the identification of the main themes for the inclusion in the main study while ensuring that the broader concept of religiosity and mental health was prospected through a more neutral lens rather than a self-reported opiniated tool. This method was critical to the improvement of the internal validity of the study instruments as well as to ensure objectivity throughout the study [55].

2.4 Ethical consideration

Prior to participating in this research, participants were required to sign a consent form after clear information pertaining to their rights about participation and withdrawal from the study at any given time was provided. The information sheet also covered aspects of data management and confidentiality as per the established guidelines. Ethical requirements were reviewed, and the study approved by the Postgraduate Dissertation Committee (PDC), School of Health Sciences, University of Technology, Mauritius [PGDC2021.1109-02].

3 Results

3.1 Quantitative results

3.1.1 Demographics

276 responses (response rate: 70%) were collected with the following participant distribution: 172 Hindus, 43 Muslims, 39 Roman Catholics, 14 Christians, 1 Buddhist and 2 from a different religious group. Only 0.02% of the sample reported to be non-religious. A large gender-based disparity in participation was not observed (male versus female; 46% versus 54%). Most respondents were from the age range of 26 to 35 (n = 46) and 51 to 60 (n = 36). All participants had attained at least a secondary level education and only 29 reported being unemployed. 67% of participants were either married or in a relationship (n = 185), while 30% were single (n = 83) (See Supplementary Table S3).

3.2 Religious identity and practice across the Mauritian population

Muslims (84%) were more likely to qualify themselves as religious and reported higher participation in ceremonies and rituals compared to Hindus (66%) and Catholics (41%). Focusing on the developmental spectrum, a significant although weak association was observed between age and religious practice [$\chi^2(36) = 53.6$, $p < 0.05$, Cramer's $V = 0.180$] and pride taken from one's religion and its accomplishments [$\chi^2(36) = 52.9$, $p < 0.05$, Cramer's $V = 0.179$]. Regression analysis confirmed age as a predictor of religious beliefs and lifestyle; with 10% of the variance explained through the model [$F(1, 274) = 30.6$, $p < 0.001$]. No significant relationship was identified between demographic variables such as educational attainment [$\chi^2(18) = 18.9$, $p > 0.05$], gender [$\chi^2(6) = 6.03$, $p > 0.05$] and marital status [$\chi^2(36) = 42.0$, $p > 0.05$] against the religious practice scores.

The 3 major religious groups reported high mean scores on the MRIM scale, indicating elevated religious affirmation ($\mu^{Hindu} = 5.97$, $\mu^{RC} = 5.94$, $\mu^{Islam} = 6.50$), religious identity ($\mu^{Hindu} = 5.51$, $\mu^{RC} = 5.35$, $\mu^{Islam} = 5.74$) and religious faith and practices ($\mu^{Hindu} = 5.86$, $\mu^{RC} = 5.91$, $\mu^{Islam} = 6.47$) within the Mauritian population. No significant associations were observed between level of education [$\chi^2(180) = 156$, $p > 0.05$], age [$\chi^2(360) = 316$, $p > 0.05$] and employment status [$\chi^2(180) = 143$, $p > 0.05$] with religious identity; while marital status was modestly associated with religious belongingness [$\chi^2(162) = 212$, $p < 0.05$, Cramer's $V = 0.358$] and religious practice [$\chi^2(162) = 234$, $p < 0.05$, Cramer's $V = 0.376$]. Furthermore, religious participation was strongly associated to religious affirmation [$\chi^2(162) = 361$, $p < 0.05$, Cramer's $V = 0.467$] and religious identification [$\chi^2(360) = 616$, $p < 0.05$, Cramer's $V = 0.610$].

Multiple regression analyses were used to test if the MRIM subscales of religious identity and belongingness significantly impacted the scores of religious practices. The results showed that a prediction model with religious identification and adherence explained 22.5% of the variance within the dependent variable, i.e., religious practice [$F(3, 272) = 26.3$, $p < 0.001$]. The influence of religious identity and adherence subscales on religious practice were also assessed; with a reported 58.9% of the variance in religious customs explained by the subscales. However, only religious identity significantly predicted religious involvement [$\beta = 0.742$, $p < 0.001$].

3.3 Exploring the relationship between mental well-being and religiosity

No significant differences were recorded across the different religious groups and wellbeing. The mean scores of the FWBS indicated positive total well-being of the participants, exceeding the average means presented by Friedman's compilation of clinical findings, supporting the general sense of well-being across the participants of faith in Mauritius (Table 1). Significant associations between age and joyfulness [χ^2 (96) = 158, $p < 0.05$, Cramer's V = 0.309] and educational attainment and emotional stability [χ^2 (123) = 160, $p < 0.05$, Cramer's V = 0.439], employment status and self-confidence [χ^2 (48) = 76.2, $p < 0.05$, Cramer's V = 0.303] were noted, potentially drawing towards the additional role of socio-economic stability and maturing of the participants towards well-being.

A significant although weak relationship was identified between the RPS scores and happiness [χ^2 (48) = 73.86, $p < 0.05$, Cramer's V = 0.211] in contrast to emotional stability which showed a stronger association [χ^2 (246) = 296.15, $p < 0.05$, Cramer's V = 0.432]. Further examination revealed strong positive links between the 3 dimensions of religious identity and well-being; such that religious identity achievement, religious affirmation and belongingness, and adherence to religious faith and practices were all related to well-being in descending order of reported strength [RIA [χ^2 (1680) = 2228 $p < 0.05$, Cramer's V = 0.537]; RAB[χ^2 (1620) = 2041, $p < 0.05$, Cramer's V = 0.523], and RFP [χ^2 (1620) = 1757, $p < 0.05$, Cramer's V = 0.487] (See Supplementary Table S4). This was further complemented with the potential predictability of well-being using MRIM sub-scales, results which significantly demonstrated the net cumulative predictability of effect of the dependent variable, i.e., FWBS using RIA, RAB, and RFP, with an explained variance of 8.4% [F (3, 272) = 9.70, $p < 0.001$]. However, only religious identity achievement significantly impacted total well-being [$\beta = 0.250$, $p < 0.05$], emotional stability [$\beta = 2.334$, $p < 0.05$] and self-confidence [$\beta = 0.645$, $p < 0.05$]. None of the variables predicted joyfulness and happiness.

3.4 Qualitative outputs

3.4.1 The role of religion in mental health

Religious practices and the doctrines differed according to the religion as well as within specific religious groups (Table 2). All participants had a general awareness of what mental illness entailed and advocated that even though mental illnesses cannot be prevented, the associated negative symptoms can be mitigated through religious practices. Nonetheless, when asked about how to deal with symptoms of schizophrenia, most participants attributed the sickness to negative aura or demonic beliefs. 13 out of 16 respondents reported that the best solution to treat mental illnesses were both psychotherapy and religion; as seeking advice from both a counsellor and a priest could offer a more holistic treatment programme and promote adherence. The majority of Catholic participants posited that adhering to the Catholic doctrines is the best way to deal with mental illnesses as the power of God can heal everyone. One participant stated that "*if you believe in God, you can even move mountains*!" They reasoned that while a psychiatrist would be able to provide professional help, he would not pray for you nor offer unconditional love. That duty can only be performed by an ordained priest.

Table 1 FWBS scores within the Mauritian sample

FWBS scale	Mean values reported			
	Hindus	Roman Catholics	Muslims	Friedman's reported means
Self-Confidence	15.81	15.41	15.60	12.20
Emotional Stability	37.91	38.74	39.84	30.70
Joyfulness	15.81	16.59	16.95	13.90
Happiness	7.97	8.79	8.77	7.50
Total Well-Being	77.50	79.54	81.16	64.30

Table 2 Participants' pespective on religion and practice

	Hinduism	Roman Catholicism	Islam
Defining Religion	Religion offers a proper guide through life, thereby offering a healthy way to live in harmony with oneself and in society, straying away from negativism. Religion is a refuge and an essential part of one's identity. Prayers performed in temples or at home are often recited in one's religious language; Hindi/Tamil/Telugu in Hinduism, French/Creole in Roman Catholicism and Urdu/Arabic in Islam		
Language and religion	Prayers performed in temples or at home are often recited in one's religious language		
	Hindi/Tamil/Telugu	French/Creole	Urdu/Arabic
Doctrines	Believe in the concept of Karma, trusting that karmic retribution is a way to keep devotees on the 'right' path. They have to engage in prayers, fasting and mantra recitals	Believe in the strict adherence to the doctrines of Catholicism as preached by the Papacy, such as forgiveness. Compliance to the religious path can eventually lead to enlightenment, giving devotees strength to surpass any obstacle in life	Believe in the strict adherence to the Quran's preaching and being grateful to God for everything they have been given in life
Religious rituals	Participants had individualised ways of venerating their religious views in the manner they each deemed appropriate. The goal was to honour God daily	The practices and prayers were well-enumerated and practiced by the sampled participants. The day had to start with specific rituals/prayers, giving grace to God	
View of mental disorders	All participants had a general awareness of what mental illness entailed but attributed symptoms such as hallucinations to negative aura or demonic possessions		
Schizophrenia and religion	The preferred solution for people with this ailment would be to seek help from both a priest and a doctor/psychiatrist, as the person might be 'mentally impaired', and a priest might not necessarily be able to deal with the symptoms as the latter will not have the required expertise	All participants agreed that it is best to resort to religious remedies, such as exorcism and confession, from a priest rather than to go for medical or psychiatric advice. They believe that the symptoms of schizophrenia are linked to evil or negative energies, which can only be mitigated using religious coping strategies	3 participants reported that this sickness might be due to supernatural occurrences, such as "evil eyes" or "negative energies", as such it is more important to go see an Islamic priest (M*awlanah*), rather than seek psychiatric advice

4 Discussion

4.1 Nurturing a religious identity in Mauritius

Only 5 participants qualified themselves as non-religious out of the 276 responses, contradicting the modern trends of the Western culture, stating that religion is slowly losing its value [17]. A weak association was seen between age and religious practice [$\chi^2(36) = 53.6$, $p < 0.05$, Cramer's $V = 0.180$], as Mauritian youngsters are nurtured with religious values and ceremonies from birth, thereby indicating the role of religion in forming the Mauritian identity. This contrasts with Western cultures, whereby individuals are more prone to explore different religious dogmas when reaching adulthood [39]. In a multi-religious country like Mauritius, the religious freedom provides the opportunity to discover and participate in different types of religious rituals such as Maha Shivaratree (Hindu), Easter celebrations (Roman Catholicism), Eid-Ul-Fitr (Islam festival) as from a young age, permitting the phase of exploration to happen incessantly across one's lifespan, thereby forging a stronger religious identity. Such phenomenon are common occurrences in multi-cultural countries, whereby the acceptance of diversity and cultural preservation is key to promoting religious values centred around those specific communities [37]. This also aligns with inputs from Phalet et al. [65] which highlights the importance of parental religious socialization through practice and community engagement as part of cultural maintenance, strengthening religious identity. With increasing frequency and severity of hardships in life, interviewees have reported feeling closer to God [44, 53, 72], thus, increasing their religious beliefs and commitment as they grow older and experience the world. This would explain why age partly predicted one's religious values and lifestyle.

4.2 Religious participation in Mauritius

Muslim participants in this sample reported a higher religious participation (84%) compared to Hindus (66%) and Roman Catholics (41%), data which could be explained by the fact that most Muslim children in Mauritius attend *Madrassa* (Islamic school) where they are taught the doctrines of Islam and teachings of the Qur'an. According to Mungly [59], the establishment of Madrassa happened since the integration of early Muslim communities in the country, providing free Islamic education for the majority of Muslim children [30]. To date, Karnataka, in south India, counts 960 Islamic schools, indicating the importance of Islamic education [79]. Religion is believed to be the essence of the Islamic identity, hence, as from childhood, a Muslim is bestowed with the necessary knowledge to adhere to the Islamic ideologies [25]. Additionally, despite the strong influence of western ideologies on youngsters nowadays, Voas' and Fleischmann's review [89] showed that new generations are not necessarily less religious than their ancestors, even though they might engage in religious practices slightly differently, they still fervently adhere to their religious beliefs. Studies carried out in Western communities have shown that women tend to be more religious than men and have increased religious participation [52]. However, in this sample, no disparities were observed between men and women, irrespective of their marital status, as both gender can engage equally in religious activities as dictated by the religious doctrines in Mauritius, explaining why gender and relationship status did not affect the frequency of religious participation.

Language is a powerful instrument used in the dissemination of cultural values and in promoting one's identity to a specific religious group [6]. How people communicate to conceptualise and share their religious ideologies over generations, shape their identity [60]. Across the globe, devotees of all religious groups generally display their faith through oral reverence in their respective religious language [70]. Such instances can be seen in Mauritian places of worship, such as Mawlanas calling "Azan" in Arabic through Mosques, 'Pandits' conducting prayers in Sanskrit or Hindu language in temples; and prayers and hymns are recited in French or Creole in Catholic churches. Additionally, in Mauritian schools, religious diversity and cultural exchange are promoted through the celebration of different religious events and the inclusion of different language classes (Hindu, Urdu, Creole, Tamil, Telugu) in government primary and secondary schools. Moreover, there are Catholic and Islamic colleges across the country which incorporate religious studies as part of their curriculum, ensuring the holistic integration of religion into the academic journey [82]. Undeniably, religion is embedded in the Mauritian educational system, thereby offering a rationale for the continuous religious participation in adulthood, despite higher educational attainment. In a typical Mauritian family, the elderly are committed to the transmission of religious values and traditions across generations; ensuring

the continuation and affirmation of religious identity in adulthood [87]. As confirmed through the qualitative findings, interviewees were incepted a profound knowledge of religious ideologies, in both school and family settings, forming a "Hindu" or "Muslim" or "Catholic" religious identity as from a young age; resonating with the transmission of religious values [16]. Consequently, this high level of engagement in religious activities leads to a higher feeling of in-group belongingness and stronger identification to one's religious identity.

4.3 The significance of religion for mental health in Mauritius

Participants from the interviews hinted that they felt significantly more confident and contented when engaging in religious practices, in line with the quantitative data as reported through the FWBS and RPS, indicating higher psychological well-being with religious participation, aligning with similar findings collected over the years in various parts of the world [2, 42, 45, 84, 85]. Additionally, religious identity could significantly predict total well-being, emotional stability, and self-confidence, corroborating findings on: achieving greater stability and psychological health increases religious identification [2, 68]; and a higher self-esteem in a society that places emphasis on religious identity [74]. Religious belongingness (RAB) has been associated with higher psychological well-being of Mauritians, which is in line with Schumaker's [72] and Neeleman and Lewis' [61]; stating that religious engagement can alleviate emotional conflicts and promote social engagement respectively. Irrefutably, as reported in Koenig's [48] and Jokela's [40] studies, religious identification and participation have positive effects on psychological, behavioural and social constructs in life; contributing towards good mental health.

4.4 Promoting mental health through religious practice

While the practices engaged by Hindus are not homogeneous across participants, they all believe fervently in the deities and hold the view that devotees should honour God by attending prayer sessions delivered through the temples regularly, fasting and participating in the main religious ceremonies. The fasting period allows them to be rid of bad karma and accept what cannot be changed, such as unavoidable life challenges [22]. Two participants referred to the use of yoga and Ayurveda in helping heal one's psychological ailments as per instructed in the Rig and Atharva Vedas [14], supporting the belief that yogic techniques relieve accumulated stress [5]. They also believed that mental health can be promoted by holding noble thoughts, which can be achieved by reciting mantras regularly and giving the mind enough strength to heal itself in the process. The premise that acting morally will ultimately decide one's fate and can bring consolation when facing obstacles in life, comforted them and gave them confidence to persevere in life, confirming Lehtonen's views [50] on the inducing power of religious values.

Catholic participants stated that "talking it out" can be a cathartic experience through religious confession with a priest, supporting the claims that the use of sacraments promotes catharsis, thereby appeasing the alienation and guilt brought upon by one's wrongdoings [36, 91, 94], and allowing closure. The Catholic participants all believed that the church offers a lot of activities that promotes social inclusion and psychological well-being that can be helpful in promoting their mental health. Additionally, participants mentioned how listening to Catholic hymns can help them modulate their state of mind radically to a more positive way of thinking. Most Catholic participants reported that mental illnesses can be cured by seeking the counsel of a Catholic priest and the church. While it might seem to border the extremes of religion, Carl Jung himself mentioned how Catholicism has a rich array of techniques that facilitates psychological growth [76]. Therefore, it is not entirely surprising that the average Catholic will seek a religious guide for support when mentally ill.

Religious practices were well-defined and enumerated by all the participants. They all mostly engage in the same rituals on a daily basis. All Muslim reported practicing their 5 ritual prayers, *Salat* every day at specified times, similar to the rituals enumerated in Islam globally [83]. A lesser-known ritual that was pointed out by one participant is the "*wudu*" which refers to the water cleansing, an important practice executed prior to engaging in any Islamic prayer. Most participants believed that adhering to the Islam way gave participants the ability to focus and stimulate their productivity, while developing a sense of altruism, and concomittantly promoting a better state of mind. They have also reported that being true to their faith allowed them to keep their composure and stay positive when faced with stress, in line with findings from Lamoshi [49].

4.5 Integration of religion and psychotherapy

Grover and colleagues' [24] claimed that organic causes of mental illness need to be properly explained, before recommending the adoption of religious remedies. Since most participants believed that properly adhering to the religious path could eventually help them avoid or even cure psychotic disorders, a general lack of awareness of psychotic disorders and their symptoms in the Mauritian population is evident. Given this lack of understanding and sensitisation towards the role of religion and religiosity in mental health, this could explain why Mauritians are often more prone to turn to religion for explanation rather than seek scientific or medical help [31].

Priests from the three studied religions must normally undergo intensive training before being anointed. Muslim priests *(Mawlanas)* undergo training to counsel disciples and to be knowledgeable about the Qu'ran and their respective religious laws in order to reach out to their respective disciples, as confirmed by Iqbal [34]. Similarly, Catholic priests also need to undergo years of study and gain pastoral experience, followed by ordination to be able to practice as ordained priests [19]. They are often termed as "spiritual guides" by the interviewees. On the other hand, the knowledge imparted by Hindu priests (*Pandits*) were portrayed as being more theological and religious than offering therapeutic assistance. *Pandits* usually have to undergo 8 years of study in the scriptures of Vedas and language to master the religious hymns and develop an expert knowledge with reference to the structures of Hinduism. They offer remedies by interpreting astrological scriptures, which often require prayers to invoke the nine planets, instead of offering counselling [86]. This could offer further justification for Mauritians' disposition to adhere to religious dogmas and rituals when suffering from mental illnesses, rather than seeking psychiatric advice.

Both Hindus and Muslims believed that merging psychology to religious doctrines can be more beneficial for patients diagnosed with mental illnesses. They assumed that having a proper guide in life, i.e., religion, and a prescribed treatment from a professional will work in tandem to assist with the gradual recovery of the patient. In congruence with this finding, adapted-religious psychotherapy has been linked to an overall increased psychological functioning of patients as compared to those receiving non-religious therapies [13]. People with stronger religious identification have been reported to comply more to treatment incorporating religious components [90]. However, very few clinicians receive the adequate training to incorporate religious principles into therapy and treatment programmes [71]; a pertinent prevailign condition in Mauritius.

Contrastingly, Catholics from the study mostly believed that religion is the sole answer to all problems that arise in life, further indicating the need to train priests in early disorder diagnosis and referral pathways. As per the qualitative inputs from the religious representative, Catholic priests are trained to help people with mental disorders such as addiction and other pertinent issues within the family and marital unit, as confirmed by Woodruff [92], positing that pastoral counselling requires clergymen to undergo professional training beyond the boundaries of religious doctrines. Participants strongly believed that the spirituality and religiosity complemented the counselling skills of the priests, potentially indicating why they would rather opt for religious remedies to treat mental health problems, instead of seeking help from therapists. This view fits White's and Jung's (1952) conclusion that the tenet of Catholicism promotes mental well-being. The synergy between professional/medical and religious help seeking cannot be ignored. Traditional psychotherapy might strengthen the empathic and social bonds between the patient and the therapist while the warm and welcoming approach of a Catholic priest can improve adherence to the therapeutic treatment [21, 57].

5 Conclusion

Religious values and practices are woven into the lives of Mauritians. Religion has a great influence on mental health in Mauritius. This study challenges western ideologies about the importance of religious identity for the typical Mauritian as these philosophies does not suit the Mauritian culture. Religion is the essence of the Mauritian identity, and the integrated daily religious practices nurture mental health, while enabling the average Mauritian to deal with life stressors and negativism. Understanding how religion can influence a person's mental health can be an instrumental auxilliary step towards the mental health care services in the country. The influence of religion cannot be taken lightly, as endorsed by the pool of qualitative and quantitative findings; and reiterating the fact that a Mauritian cannot be fully understood without grasping the essence of his religion. The implication of religious identification and

participation can offer crucial support in the field of mental health, promoting a psychologically healthier society, and driving holistic approaches towards mental health therapies.

5.1 Limitations

Comparative investigations were not carried out due to the sensitive nature of the topic, despite compelling information that could have been extracted on the disparities between the different religious groups studied. The research also did not account for the subgroups of Hindus and the marginalised religions such as Buddhism, which could have provided a comprehensive outlook on the topic in the local context. A large-scale study using a cluster sampling strategy could increase the outreach to the smaller religious strata and provide a more comprehensive outlook on the inclusion of religion as part of mental health protective factors in the Mauritian landscape. The age bracket between across the different age groups slightly differed and this could potentially indicate the influence of generational gaps which were not investigated in this study. Lastly, responses from non-religious participants could also have been collected to carry out comparative analyses against believers of this sample and to offer coping strategies for mental illnesses outside of religion.

Author contributions KV: conceptualization, methodology, investigation, software, formal analysis, writing—original draft; M.P: validation, methodology, writing—review and editing; J.S: conceptualization, validation, writing—review and editing. All authors read and approved the final manuscript.

Funding This research publication was funded by the University of Technology, Mauritius.

Data availability The data that support the findings of this study will be made available from the corresponding author and consent of all the authors upon request.

Declarations

Ethics approval and consent to participate The study was conducted in accordance with the Declaration of Helsinki, and approved by the Postgraduate Dissertation Committee, School of Health Sciences, University of Technology, Mauritius [PGDC2021.1109-02].

Informed consent Informed consent was obtained from all subjects involved in the study.

Competing interests The authors declare no competing interests.

References

1. Abu-Rayya HM, Abu-Rayya MH, Khalil M. The multi-religion identity measure: a new scale for use with diverse religions. J Muslim Mental Health. 2009;4(2):124–38. https://doi.org/10.1080/15564900903245683.
2. Ahmed S, Amer MM. Counseling muslims: handbook of mental health issues and interventions. Milton Park: Routledge; 2011.
3. Al-Jawziyyah IQ, Al-Khattab N. Patience and gratitude. 4th ed. London: Ta-Ha Publishers; 1997.
4. American Psychiatric Association. Diagnostic and statistical manual of mental disorders DSM-IV. 4th ed. Washington DC: American Psychiatric Association; 1994.
5. Avasthi A, Kate N, Grover S. Indianization of psychiatry utilizing indian mental concepts. Indian J Psychiatry. 2013;55(2):S136–44. https://doi.org/10.4103/0019-5545.105508.
6. Balraj BM, Singh S, Abd Manan MH. The relationship between language and religion. Int J Acad Res Bus Soc Sci. 2020;10(11):1217–24.
7. Behere P, Das A, Yadav R, Behere A. Religion and mental health. Indian J Psychiatry. 2013;55(6):187. https://doi.org/10.4103/0019-5545.105526.
8. Benda BB, Toombs NJ. Religiosity and violence. J Crim Just. 2000;28(6):483–96. https://doi.org/10.1016/s0047-2352(00)00064-7.
9. Bengtson VL, Silverstein M, Putney NM, Harris SC. Does religiousness increase with age? Age changes and generational differences over 35 years. J Sci Study Relig. 2015;54(2):363–79. https://doi.org/10.1111/jssr.12183.

10. Bhome S, Jha N, Chandwani V, Desai S, Iyer S, Prabhudesai A, Koshti SD. Research methodology. Kolhapur: Himalaya Publishing House; 2013.
11. Bowlby J, Ainsworth MD. Maternal care and mental health. In: Brown LB, editor. Religion, personality, and mental health (recent research in psychology) (softcover reprint of the original 1st ed. 1994 ed.). Cham: Springer; 1966.
12. Caldwell-Harris CL, Wilson AL, LoTempio E, Beit-Hallahmi B. Exploring the atheist personality: well-being, awe, and magical thinking in atheists, Buddhists, and Christians. Ment Health Relig Cult. 2010;14(7):659–72. https://doi.org/10.1080/13674676.2010.509847.
13. Captari LE, Hook JN, Hoyt W, Davis DE, McElroy-Heltzel SE, Worthington EL. Integrating clients' religion and spirituality within psychotherapy: a comprehensive meta-analysis. J Clin Psychol. 2018;74(11):1938–51. https://doi.org/10.1002/jclp.22681.
14. Chaturvedi SK. Religious, spiritual, and cultural aspects of psychiatric ethics in hinduism. Oxford Handb Online. 2015. https://doi.org/10.1093/oxfordhb/9780198732365.013.46.
15. Cohen CI, Jimenez C, Mittal S. The role of religion in the well-being of older adults with Schizophrenia. Psychiatr Serv. 2010;61(9):917–22. https://doi.org/10.1176/ps.2010.61.9.917.
16. Copen CE, Silverstein M. The transmission of religious beliefs across generations: Do grandparents matter?. Journal of Comparative Family Studies. 2008;39(1):59–71. https://doi.org/10.3138/jcfs.39.1.59.
17. Crockett A, Voas D. Generations of decline: religious change in 20th-century Britain. J Sci Study Relig. 2006;45(4):567–84. https://doi.org/10.1111/j.1468-5906.2006.00328.x.
18. Dein S, Cook C, Powell A, Eagger S. Religion, spirituality, and mental health. Psychiatrist. 2010;34(2):63–4. https://doi.org/10.1192/pb.bp.109.025924.
19. Dowd M. Catholic priest requirements. Chron. 2018. https://work.chron.com/catholic-priest-requirements-4196.html. Accessed 11 Sept 2022.
20. Etengoff C, Rodriguez EM. Religious identity. Encycl Child Adolesc Dev. 2020. https://doi.org/10.1002/9781119171492.wecad458.
21. Farrow M. The dangers of spiritualizing your psychological problems. Catholic News Agency. 2023. https://www.catholicnewsagency.com/news/34126/the-dangers-of-spiritualizing-your-psychological-problems. Accessed 9 Mar 2022.
22. Gautum S. Mental health in ancient india and its relevance to modern psychiatry. Indian J Psychiatry. 1999;41(1):5–18.
23. Greenfield EA, Marks NF. Religious social identity as an explanatory factor for associations between more frequent formal religious participation and psychological well-being. Int J Psychol Relig. 2007;17(3):245–59. https://doi.org/10.1080/10508610701402309.
24. Grover S, Davuluri T, Chakrabarti S. Religion, spirituality, and schizophrenia: a review. Indian J Psychol Med. 2014;36(2):119–24. https://doi.org/10.4103/0253-7176.130962.
25. Hassan R. On being religious: patterns of religious commitment in Muslim societies. Muslim World. 2005;97:437.
26. Hogg M, Vaughan G. Social psychology. 8th ed. London: Pearson Education; 2017.
27. Holdcroft B. What is religiosity. J Cathol Educ. 2006. https://doi.org/10.15365/joce.1001082013.
28. Hollup O. Islamic revivalism and political opposition among minority muslimsin Mauritius. Ethnology. 1996;35(4):285. https://doi.org/10.2307/3773871.
29. Horton R. A definition of religion, and its uses. J Roy Anthropol Inst Great Br Irel. 1960;90(2):201. https://doi.org/10.2307/2844344.
30. Hosanee Z. Muslims in Mauritius. Academia. 2017. https://www.academia.edu/34517002/Muslims_in_Mauritius.
31. Huang CLC, Shang CY, Shieh MS, Lin HN, Su JCJ. The interactions between religion, religiosity, religious delusion/hallucination, and treatment-seeking behavior among schizophrenic patients in Taiwan. Psychiatry Res. 2011;187(3):347–53. https://doi.org/10.1016/j.psychres.2010.07.014.
32. Huguelet P, Binyet-Vogel S, Gonzalez C, Favre S, McQuillan A. Follow- up study of 67 first episode schizophrenic patients and their involvement in religious activities. Eur Psychiatry. 1997;12(6):279–83. https://doi.org/10.1016/s0924-9338(97)84786-4.
33. Hursahye MT. Is Mauritius doing enough to tackle mental health? YUVA Mauritius. 2021. https://yuvamauritius.com/2021/11/24/is-mauritius-doing-enough-to-tackle-mental-health/
34. Iqbal AM. The educational background of imams and its contribution to their recognition as religious leaders: the case of indonesian muslim community in the Netherlands. Islam Realitas. 2017;3(1):21. https://doi.org/10.30983/islam_realitas.v3i1.209.
35. Jacobi CJ, Cowden RG, Vaidyanathan B. Associations of changes in religiosity with flourishing during the COVID-19 pandemic: a study of faith communities in the United States. Front Psychol. 2022. https://doi.org/10.3389/fpsyg.2022.805785.
36. Jacobs J. Religious ritual and mental health. In: Schumaker JE, editor. Religion and mental health. New York: Oxford University Press; 1992. p. 291–9.
37. Jayadi K, Abduh A, Basri M. A meta-analysis of multicultural education paradigm in Indonesia. Heliyon. 2022. https://doi.org/10.1016/j.heliyon.2022.e08828.
38. Jensen JL, Manwaring KF, Gill RA, Sudweeks RS, Davies RS, Olsen JA, Phillips AJ, Bybee SM. Religious affiliation and religiosity and their impact on scientific beliefs in the United States. Bioscience. 2019;69(4):292–304. https://doi.org/10.1093/biosci/biz014.
39. Jia F, Alisat S, Algrim K, Pratt MW. Development of religious identity and commitment during emerging adulthood: a mixed-methods longitudinal study. Emerg Adulthood. 2020;9(3):259–64. https://doi.org/10.1177/2167696820949799.
40. Jokela M. Religiosity, psychological distress, and well-being: evaluating familial confounding with multicohort sibling data. Am J Epidemiol. 2021;191(4):584–90. https://doi.org/10.1093/aje/kwab276.
41. Kang C. Hinduism and mental health: engaging British Hindus. Ment Health Relig Cult. 2010;13(6):587–93. https://doi.org/10.1080/13674676.2010.488427.
42. Kehoe NC. Religion and mental health from the catholic perspective. In: Koenig HG, editor. Handbook of Religion and mental health. Cambridge: Academia Press; 1998. p. 211–23.
43. Kelly CM. The church in Mauritius. Irish Quart Rev. 1947;36(144):469–75.
44. Keyes CLM, Reitzes DC. The role of religious identity in the mental healthof older working and retired adults. Aging Ment Health. 2007;11(4):434–43. https://doi.org/10.1080/13607860601086371.
45. Klangrit S, Perrodin DD, Siripaprapakon Y, Choudhry FR, Intaranggkul T, Pratoomkaew S, Khemsiri K, Saengrung K, Vachirayano W. Religion and mental health among older adults in Thailand: a national survey study. Ment Health Rev J. 2021;26(4):380–91. https://doi.org/10.1108/mhrj-06-2020-0039.

46. Koenig HG, McCullough ME, Larson DB. Handbook of religion and health. 1st ed. Oxford: Oxford University Press; 2001.
47. Koenig HG. Medicine, religion and health: where science and spirituality meet. 1st ed. West Conshohocken: Templeton Foundation Press; 2008.
48. Koenig HG. Religion, spirituality, and health: the research and clinical implications. ISRN Psychiatry. 2012;2012:1–33. https://doi.org/10.5402/2012/278730.
49. Lamoshi AY. Religion as a resilience tool to manage stress in adolescents: islamic approach. Glob J Hum Soc Sci. 2015;15(3):1.
50. Lehtonen T. Belief in karma: the belief-inducing power of a collection of ideas and practices with a long history. Religions. 2022;14(1):52. https://doi.org/10.3390/rel14010052.
51. Levin J, Kimble MA, McFadden SH. Aging, spirituality, and religion: a handbook. Minneapolis: Fortress Press; 2003.
52. Li YI, Woodberry R, Liu H, Guo G. Why are women more religious than men? Do risk preferences and genetic risk predispositions explain the gender gap? J Sci Study Relig. 2020;59(2):289–310. https://doi.org/10.1111/jssr.12657.
53. Loewenthal K. Religion, culture and mental health. 1st ed. Cambridge: Cambridge University Press; 2009.
54. Mahomoodally MF, Mootoosamy A, Wambugu S. Traditional therapies used to manage diabetes and related complications in mauritius: a comparative ethnoreligious study. Evid Based Complement Altern Med. 2016;2016:1–25. https://doi.org/10.1155/2016/4523828.
55. Marsland N, Wilson I, Abeyasekera S, Kleih U. Combining quantitative (formal) and qualitative (informal) survey methods. Socioeconomic methodologies for natural resources research. Chatham: Natural Resources Institute; 2001.
56. Masci D. Why Millennials are less religious than older Americans. 2020.https://www.pewresearch.org/short-reads/2016/01/08/qa-why-millennials-are-less-religious-than-older-americans/.
57. McHale M. Catholic priests as counselors: an examination of challenges faced and successful techniques. Verbum. 2004;1:3.
58. Mohr S, Brandt PY, Borras L, Gilliéron C, Huguelet P. Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia. Am J Psychiatry. 2006;163(11):1952–9. https://doi.org/10.1176/ajp.2006.163.11.1952.
59. Mungly JN. Case study of main potential improvements to Madrassah education in Mauritius, Port Louis: unpublished. 2011.
60. Mustafi M. Religion and linguistic culture. JUSTICIA. 2019;7:118.
61. Neeleman J, Lewis G. Religious identity and comfort beliefs in three groups of psychiatric patients and a group of medical controls. Int J Soc Psychiatry. 1994;40(2):124–34. https://doi.org/10.1177/002076409404000204.
62. Ng-Tseung C, Verkuyten M. Religious and national group identification in adolescence: a study among three religious groups in Mauritius. Int J Psychol. 2013;48:846–57.
63. Office of International Religious Freedom. International Religious Freedom Report. 2021.
64. Oppong SH. Religion and Identity. Am Int J Contemp Res. 2013;3(6):10–6.
65. Phalet K, Maliepaard M, Fleischmann F, et al. The making and unmaking of religious boundaries. CMS. 2013;1:123–45. https://doi.org/10.5117/CMS2013.1.PHAL.
66. Peek L. Becoming muslim: the development of a religious identity. Sociol Relig. 2005;66(3):215. https://doi.org/10.2307/4153097.
67. Rasic DT, Belik SL, Elias B, Katz LY, Enns M, Sareen J. Spirituality, religion and suicidal behavior in a nationally representative sample. J Affect Disord. 2009;114(1–3):32–40. https://doi.org/10.1016/j.jad.2008.08.007.
68. Ross CE. Religion and psychological distress. J Sci Study Relig. 1990;29(2):236. https://doi.org/10.2307/1387431.
69. Sabry W, Vohra A. Role of Islam in the management of psychiatric disorders. Indian J Psychiatry. 2013;55(6):205. https://doi.org/10.4103/0019-5545.105534.
70. Saraswathi S. Is there a link between language and religion? Deccan Herald. 2020. https://www.deccanherald.com/opinion/is-there-a-link-between-language-and-religion-798745.html.
71. Schafer RM, Handal PJ, Brawer PA, Ubinger M. Training and education in religion/spirituality within APA-accredited clinical psychology programs: 8 years later. J Relig Health. 2009;50(2):232–9. https://doi.org/10.1007/s10943-009-9272-8.
72. Schumaker JF. Religion and mental health. In: Sherwood H, editor. Religion: why faith is becoming more and more popular. London: The Guardian; 1992.
73. Scroope C. Core concepts. Cultural atlas. 2017. https://culturalatlas.sbs.com.au/mauritian-culture/mauritian-culture-core-concepts.
74. Searles R. Religious people have higher self-esteem but only in some countries, study shows. HuffPost. 2012.https://www.huffpost.com/entry/religion-happiness_n_1219295
75. Shreve-Neiger AK, Edelstein BA. Religion and anxiety: a critical review of the literature. Clin Psychol Rev. 2004;24(4):379–97. https://doi.org/10.1016/j.cpr.2004.02.003.
76. Spiegelman JM. Psychotherapists and the clergy: fifty years later. J Relig Health. 1984;23(1):19–32. https://doi.org/10.1007/bf00999897.
77. Statistics Mauritius. Housing and population census. Government of Mauritius 2020. 2020. https://statsmauritius.govmu.org/Pages/Statistics/ESI/CJS/CJS_Yr20.aspx. Accessed 19 Sept 2021.
78. Schwadel P. The effects of education on Americans' religious practices, beliefs, and affiliations. Rev Relig Res. 2011;53(2):161–82. https://doi.org/10.1007/s13644-011-0007-4.
79. Talha IKP, Labeed S, Thouseef AMY. A study on Madrasa education system of Karnataka. Int J Educ Plann Adm. 2015;5(1):31–9.
80. Tepper L, Rogers SA, Coleman EM, Malony HN. The prevalence of religious coping among persons with persistent mental illness. Psychiatr Serv. 2001;52(5):660–5. https://doi.org/10.1176/appi.ps.52.5.660.
81. Thakkar H. Theory of Karma. South African Gujarati Maha Parishad. 1989.
82. United States Department of State. (rep.). International Religious Freedom Report for 2019. 2020. https://www.state.gov/wp-74-content/uploads/2020/06/MAURITIUS-2019-INTERNATIONAL-RELIGIOUS-FREEDOM-REPORT.pdf. Accessed 24 Jan 2022.
83. United religions initiative. Islam: basic beliefs. 2022.https://www.uri.org/kids/world-religions/muslim-beliefs.
84. VanderWeele TJ. Physical activity and physical and mental well-being in church settings. Am J Public Health. 2017;107(7):1023–4. https://doi.org/10.2105/ajph.2017.303843.
85. VanderWeele TJ. Religious communities and human flourishing. Curr Dir Psychol Sci. 2017;26(5):476–81. https://doi.org/10.1177/0963721417721526.
86. Verma M. The education of hindu priests in the diaspora: assessing the value of community of practice theory. Teach Teach Educ. 2010;26(1):11–21. https://doi.org/10.1016/j.tate.2009.08.003.

87. Vermeer P. Religion and family life: an overview of current research and suggestions for future research. Religions. 2014;5(2):402–21. https://doi.org/10.3390/rel5020402.
88. Villani D, Sorgente A, Iannello P, Antonietti A. The role of spirituality and religiosity in subjective well-being of individuals with different religious status. Front Psychol. 2019. https://doi.org/10.3389/fpsyg.2019.01525.
89. Voas D, Fleischmann F. Islam moves west: religious change in the first and second generations. Ann Rev Sociol. 2012;38(1):525–45. https://doi.org/10.1146/annurev-soc-071811-145455.
90. Walker KR, Scheidegger TH, End L, Amundsen M. The Misunderstood Pastoral Counselor: Knowledge and Religiosity as Factors Affecting a Client's Choice. VISTAS Online. 2012;1:62.
91. White V. God and the unconscious. London: Harvill; 1952.
92. Woodruff CR. Pastoral counselling: An American perspective. Br J Guid Couns. 2002;30(1):93–101. https://doi.org/10.1080/03069888022010654 6.
93. Woodyard C. Exploring the therapeutic effects of yoga and its ability to increase quality of life. Int J Yoga. 2011;4(2):49–54. https://doi.org/10.4103/0973-6131.85485.
94. Worthen V. Psychotherapy and catholic confession. J Relig Health. 1974;13(4):275–84. https://doi.org/10.1007/bf01534226.
95. Xygalatas D, Kotherová S, Maňo P, Kundt R, Cigán J, Klocová EK, Lang M. Big gods in small places: the random allocation game in Mauritius. Relig Brain Behav. 2017;8(2):243–61. https://doi.org/10.1080/2153599x.2016.1267033.
96. Ysseldyk R, Matheson K, Anisman H. Religiosity as identity: toward an understanding of religion from a social identity perspective. Pers Soc Psychol Rev. 2010;14(1):60–71. https://doi.org/10.1177/1088868309349693.