THE RELATIONSHIP BETWEEN PERCEIVED SPIRITUAL EXPERIENCE, COPING AND PSYCHOLOGICAL DYSFUNCTIONS AMONGST UNIVERSITY OF NAMIBIA MAIN CAMPUS STUDENTS

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS IN CLINICAL PSYCHOLOGY

OF

THE UNIVERSITY OF NAMIBIA

BY

Natasja Kudzai Magorokosho

200969056

September 2020

Supervisor: Dr A.E.E. Shikongo

ABSTRACT

The aim of this study was to explore the role that spiritual experience plays in coping with psychological dysfunctions (stress, anxiety and depression) amongst University of Namibia students. The target population were all full time students at the main campus, a total of 13 575. The study sampled 388 students, using the random sampling technique. Three questionnaires were administered to collect data, namely the *Socio-Demographic Questionnaire (SDQ),* the *Daily Spiritual Experience's Scale (DSES)* and *the Depression Anxiety Stress Scale (DASS).* A Pearson correlation coefficient was carried out to measure the strength and direction of the relationships that exists amongst spiritual experience, stress, anxiety and depression among University students. The key findings from the study indicated that there was no significant correlation between spiritual experience and stress. The study further did not find a significant correlation between spiritual experience and anxiety. However, the study found a significant but weak negative correlation between spiritual experience and depression. The data also showed that individuals with no spiritual experience tend to feel overwhelmed and more stressed as they hold themselves accountable for every situation.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS AND ACRONYMS

APA	American Psychology Association
CBPR	Community Based Participatory Research
DASS	Depression Anxiety Stress Scale
DSES	Daily Spiritual Experiences Scale
FBMHP	Faith Based Mental Health Promotion
SDQ	Socio-Demographic Questionnaire
SPSS	Statistical Package for Social Sciences
WHO	World Health Organization

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to my supervisor Dr Armas E.E Shikongo. He has been encouraging and supportive throughout my studies and for his guidance throughout the entire process of my growth as a post-graduate student. Your advice on both my career and research is invaluable and lasting. Thank you for sharing your knowledge with me as a supervisor and mentor.

I also wish to thank the United Methodist Women, The International Ministries with Women, Children and Youth Scholarship (IMC) Program for the financial assistance that made this journey possible.

A special thanks to my family. Words cannot express how grateful I am to my mother, Rose Magorokosho for all the sacrifices that she has made for me, as well as the prayers that continue to sustain me. I would also like to thank my friends especially Selma Uugwanga who supported me in my academic research, and encouraged me to strive towards my goal. Last but not least I wish to express my deep appreciation to my beloved husband, Munyaradzi Tambo, who was always there in times when there was no one to answer my queries.

DEDICATION

This thesis is lovingly dedicated to my mother, Rose Magorokosho, my husband Munyaradzi Tambo and my extended family for their support, encouragement, and constant love that has sustained me throughout my life.

DECLARATIONS

I, Natasja Kudzai Magorokosho, hereby declare that this study is my own work and is a true reflection of my research, and that this work, or any part thereof has not been submitted for a degree at any other institution.

Natasja Kudzai Magorokosho		*April 2020*
Name of Student	Signature	Date

CHAPTER 1: INTRODUCTION

1.1 Background of the Study

Stress, anxiety, and depression are psychological dysfunctions and have been mentioned by the World Health Organization (WHO) as significant mental health disorders (Johannessen-Henry, Deltour, Bidstrup, Dalton, & Johansen, 2013). WHO further elaborated that stress; anxiety, depression and other mood disorders share the unfortunate distinction of being the most prevalent causes of chronic illnesses (Rentala, Lau, & Chan, 2017). Among the global burden of diseases, stress, anxiety and depression are the fourth leading contributors to morbidity and mortality and it has been projected that by 2020, they will become the second leading contributors after the cardiovascular-related diseases (Rentala, Lau, & Chan, 2017).

Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration (Marcus, Yasamy, Van Ommeren, Chisholm, & Saxena, 2012).

Anxiety is considered as a state of uneasiness and it is a bodily response to a perceived danger that could be real or imaginary and triggered by an individual's thoughts, beliefs or feelings. Various studies have found that anxiety disorders are rising among students (Vitasari, Wahab, Othman & Awang, 2010). There are several empirical studies that have specifically investigated the relationship between spiritual experience and anxiety disorders. Shreve-Neiger and Edelstein (2004) state that having some type of religious affiliation/spiritual experience appears to be related to lower anxiety levels in the general population. Empirical studies have also found that there is a link between stress and

depression (Hamilton & Alloy, 2017; Hamilton &Alloy, 2016; Hamilton, Stange, Shapero, Connolly, Abramson, & Alloy, 2013); these studies report that high stress levels are correlated with depression.

Stress, on the other hand, is a consequence of, or a general response to, an action or situation that places special physical and/or psychological demands, on a person (Johannesen- Henry, Deltour, Bidstrup, Dalton, & Johansen, 2013). As such, stress involves an interaction of the person with the environment.

In general, everyone experiences these mental health disorders; however, university life is a stressful phase for many students as they go through the process of adapting to new educational and social environments (Gallagher, Mehta, Selvan, Mirza, Radia, Bharadia, & Hitch, 2014; Dessie, Ebrahin, & Awoke, 2013). They need to adjust themselves with an environment which requires compliance with new social norms and new friendships (Bhandari, 2012). Moreover, the increasing demand to perform well academically may contribute to increasing levels of stress, anxiety and depression. According to Ribeiro, Pereira, Freire, de Oliveira, Casotti and Boery (2018) as stressors accumulate; an individual's ability to cope or readjust can be strained, reducing their physical and psychological resources.

Some other empirical studies found that an individual's spiritual experience seems to be related to stress resilience and lower levels of psychological distress (Johannesen-Henry, Deltour, Bidstrup, Dalton, & Johansen, 2013).

McSherry and Jamieson (2010) define spiritual experience as the presence of a relationship with a Higher Power, a response to a deep and mysterious human yearning

for self-transcendence and surrender, a yearning to find our place and the search for the existential. Spirituality has been defined in numerous ways, this includes a belief in a Power operating in the universe that is greater than oneself, a sense of inter-connectedness with all living creatures and awareness of the purpose and meaning of life and the development of personal absolute values (Saleem, 2017). As a related concept to spirituality, religion is structured beliefs, theology, religious traditions and codes of conduct (Blazer, 2012). The concepts of spirituality and religion tend to be used interchangeably, which can be confusing, as there is a subtle difference between the two, especially when one talks of spiritual experience. The difficulty in isolating spiritual experience from religion as a valid construct has given rise to concerns about how it is measured (Bonelli & Koening, 2013). Another related concept is religiosity, which is defined as "the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living" (Worthington, Wade, Hight, Ripley, McCullough, Berry, Schmitt, Berry, Bursley, & O'Conner, 2003).

Globally, more than 300 million people suffer from depression, the leading cause of disability, and more than 260 million are living with anxiety disorders (Rentala, Lau & Chan, 2017). Many of these people live with both depression and anxiety disorders (Johannessen-Henry, Deltour, Bidstrup, Dalton, & Johansen, 2013).

Empirical studies conducted in America reported that mental health problems are on the rise among University students and that depressive disorders are the highest among University students (Luna & MacMillan, 2015). Research data indicates that spiritual experience may be an important protective factor against the onset and development of depressive symptoms (Brown, Carney, Parrish, & Klem, 2013; Daaleman & Kaufman,

2006). As noted by Rentala, Lau and Chan (2017) therapeutic practices that focus on spiritual experience, rather than religiosity, have been found to harness greater clinical utility. Thus, it is important to examine the role of spiritual experience in adaptation, coping mechanisms, managing stress, anxiety and depressive disorders, especially amongst University students. Based on the review of previous empirical studies cited above, it is evident that spiritual experience has a significant and positive role in helping individuals with spirituality to connect and better deal with various psychological disorders, with particular reference to stress, anxiety and depression.

1.2 Statement of the Problem

As aforementioned, there is a positive and significant relationship between various psychological disorders (specifically stress, anxiety and depression) and spiritual experiences. Preliminary literature review done for this study, specifically, revealed that there is a lack of empirical studies in Namibia that have investigated the link between spiritual experience and stress, anxiety and depressive disorders. This is, particularly, relevant considering that previous studies conducted in other parts of the world have shown that one of the focus areas of this study, namely depression is a growing epidemic and, therefore, an area that needs more empirical investigation to develop relevant interventions.

Previous academic studies further found that spiritual experience is an important protective factor against the onset and development of stress, anxiety and depressive symptoms (Brown, Carney, Parrish, & Klem 2013). Therefore, the present study aimed to fill in this apparent dearth of information in the Namibian context.

1.3 Hypothesis

Perceived spiritual experience has a positive reductive impact on stress, anxiety and depression amongst University of Namibia students.

1.4 Objectives of the Study

The research focused on the following specific objectives, to:

1.4.1 Assess the role and relationship amongst spiritual experience when dealing with stress, anxiety and depression amongst University of Namibia students.

1.4.2 Assess the practical implications of involving spirituality in dealing with mental health problems such as stress, anxiety and depression.

1.5 Significance of the Study

The research findings from this study could provide more insight and be useful for mental healthcare professionals and psychological wellness practitioners, since understanding spiritual experience might lead to better management of depression, anxiety and stress. Furthermore, results from this study could be of interest and use to the office of the Dean of Students, as being the agency responsible for providing counselling services to students at the University of Namibia. This is in light of the fact that spiritual experience has also been empirically linked to an increased sense of meaning, purpose, resilience, satisfaction and happiness (Pargament, Mahoney, Exline, Jones & Shafranske, 2013).

1.6 Limitations

All participants in this study were University students; therefore, generalizing results outside a University population could be a limitation of this study. Another limitation

was that the study relied on already formulated questionnaires, which are self-report in nature, and generally participants tend to report what they believe the researcher expects to see, or what reflects positively on their own abilities, knowledge, beliefs, or opinions. As such the data should be interpreted with caution (Denscombe, 2010). Therefore, participants were granted privacy when completing the questionnaire. Anonymity was also guaranteed to ensure more honest responses in order to reduce the negative effects of self-report bias.

1.7 Delimitations of the Study

This study was purposefully narrowed or delimited in several important ways. For example, despite diverse conceptualizations of spiritual experience, this concept was defined and measured using largely structured instruments. In addition, the population included only University of Namibia students, at only one campus, and from two academic levels, that is undergraduate and postgraduate students.

1.8 Definitions of Terms

Spiritual experience is defined by Plante and Sherman (2001) as a personal, meaningful self-transcendence in a search for the sacred or the "inner self." It is not necessarily rooted in or motivated by a religious institution but does relate to personal beliefs and values (Plante & Sherman 2001). It is therefore not bound to evaluation set out by the precepts of religion. Rayburn (2004) further stated that transcendence is the physical reality in order to attain contact with the superhuman, the sacred or ultimate reality with the aim of transformation is central to a spiritual experience.

Spiritual experience is conceptually defined as the presence of a relationship with a Higher Power, a response to a deep and mysterious human yearning for self-transcendence and surrender, a yearning to find our place and the search for the existential (McSherry & Jamieson, 2010). For the purpose of the present study, "spiritual experience" will be measured as the *Daily Spiritual Experiences Scale's* operational definitions measured by the Daily Spiritual Experience scale (Underwood, 2006). Low scores on the Daily Spiritual Experience Scale demonstrate a high spiritual experience.

Stress is conceptually defined as 'physical, mental, or emotional strain or tension', as well as 'a condition or feeling experienced when a person perceives that demands exceed the personal and social resources the individual is able to mobilize' (Pitt, Oprescu, Tapia, & Gray, 2017). Stress is any influence of internal and/or surrounding environment on living being which disrupt its homeostasis (Shahsavarani, Ashayeri, Lotfian, & Sattari, 2013). For the purpose of the present study, "stress" will be measured by the *Depression Anxiety Stress Scale* (Lovibond &Lovibond, 1995), where scores range from 0-21 and can differentiate between individuals with normal, mild, moderate, or severe levels of stress.

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration (American Psychiatric Association, 2013). Depression can be long lasting or recurrent, substantially impairing an individual's ability to function at work or school or cope with daily life. At its most severe, depression can lead to suicide (Johannessen-Henry, Deltour, Bidstrup, Dalton, & Johansen, 2013). For the purpose of the present study, "depression" will be measured by

the *Depression Anxiety Stress Scale* (Lovibond &Lovibond, 1995), where scores range from 0-21 and can differentiate between individuals with normal, mild, moderate, or severe levels of depression.

According to Moss (2002), anxiety is the total response of a human being to threat or danger. Each experience of anxiety involves a perception of danger, thoughts about harm, and a process of physiological alarm and activation (Moss, 2002). The accompanying behaviors display an emergency effort toward "fight or flight." The American Psychiatric Association (APA) (2013) defines anxiety as "an emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure." For the purpose of the present study, “anxiety” will be measured by the *Depression Anxiety Stress Scale* (Lovibond &Lovibond, 1995), where scores range from 0-21 and can differentiate between individuals with normal, mild, moderate, or severe levels of anxiety.

CHAPTER 2: LITERATURE REVIEW

2.1 Global Overview of Religion as a Spiritual Experience

More than 80% of the global population identifies with a religious group (Hackett, 2019). A comprehensive demographic study of more than 230 countries and territories conducted by the Pew Research Center's Forum on Religion & Public Life estimates that there are 5.8 billion religiously affiliated adults and children around the globe, representing 84% of the estimated 2010 world population of 6.9 billion (Kennedy, Macnab, & Ross, 2015). According to the Pew Research (2012), the demographic study – based on analysis of more than 2,500 censuses, surveys and population registers – finds 2.2 billion Christians (32% of the world's population), 1.6 billion Muslims (23%), 1 billion Hindus (15%), nearly 500 million Buddhists (7%) and 14 million Jews (0.2%) around the world as of 2010.

According to Kennedy, Macnab and Ross (2015), as a related phenomenon with religion, the geography of spirituality, however, has been described as a complex and multidimensional construct that appears to have two distinct components: (1) an existential dimension and (2) a relational dimension (Brown, Carney, Parrish, & Klem, 2013). The existential dimension encompasses the search for meaning in life that involves a sense of connection to oneself, and to the broader environment (Adams & Bezner, 2000). Luna and MacMillan (2015) further elaborated that this sense of connection and meaning in life seems to buffer the effect of mental health problems providing individuals with an effective way of dealing with stress. On the other hand, the relational dimension of spirituality concerns an individual's relationship with God or a Higher Power (Adams & Bezner, 2000) and distribution of religious groups varies

considerably. Zinnbauer and Pargament (2005) have noted that religion was originally defined in terms of both substantive and functional dimensions. The substantive aspects of religion referred to the object of religious pursuits (such as worshipping the sacred) while the functional aspects of religion referred to the purpose of religious pursuits, such as dealing with existential issues (Zinnbauer & Pargament, 2005).

Over the past several decades, however, religion has been increasingly defined only in substantive terms, while spirituality is now conceptualized almost exclusively in functional terms. Thus, many of the functional aspects of religion, such as the pursuit of meaning, truth, wholeness, self-actualization, and interconnectivity, are now ascribed to spirituality. As alluded to earlier, it seems that the majority of world population is religious and, thus, can be described as inclined towards or seeking some form of spiritual experience in their lives. According to Snodgrass and Sorajjakool (2011), spiritual experience can help or hinder one's capacity to cope with adversity, as such, can have serious implications of unhealthy associations. For example when the individual believes that he or she has direct communication with God with little or no social accountability (e.g., "*God told me . . .*") or employ a deferral-to-God problem-solving strategy (e.g., "*It is best to just leave this problem in God's hands*"; Pargament, 1997).

Spiritual experiences have also been described as a protective factor against the development and severity of depressive symptoms (Brown, Carney, Parrish, & Klem, 2013). For example, a study conducted by Young, Wiggins-Frame and Cashwell (2007) with 300 college students indicated that spiritual experience was a moderator between negative life experiences and depressive symptoms. Studies have particularly found that

spiritual experience can be a protective factor for young adults but also for high-risk behaviors such as substance abuse (Faver & Trachete, 2005). Luna and MacMillan (2015) found an inverse relationship between spiritual experience and anxiety and depressive symptoms. The study was conducted among 1,129 undergraduate psychology and social work students; approximately 90% were minorities with 579 Latinos, 228 African-American, 126 Caucasian and 196 Caribbean. The study found that spiritual experience, believing in God's presence, age, gender and ethnicity were inversely correlated to depressive symptoms ($r2 = .90$) (Luna & MacMillan, 2015).

In the same vein, Peselow, Pi, Lopez, Besada and Ishak (2014) found that spirituality may play an essential role in the process of recovery of people with depressive disorders. A higher level of spiritual well-being is associated with less depressive symptoms (Gonzalez et al., 2014; Mills et al., 2015). Spirituality is believed to function as a valuable coping mechanism and it helps people to cope with stress from illness (Dalmida, Holstad, DiIorio, & Laderman, 2011; Gonzalez et al., 2014). A number of studies have found that spiritual well-being is significantly associated with one's health outcomes and a better quality of life (Ali, Marhemat, Sara, & Hamid, 2015; Bai & Lazenby, 2015; Lee & Salman, 2016). Based on the different empirical literature cited above which elaborate studies done in different environments yielding similar results, it is pertinent to investigate if this is also applicable in the Namibian context.

2.2 University Students Coping with Stress, Anxiety and Depression

Previously, researchers have focused more commonly on the role of spirituality and religion among University students. Various researchers have explored the concept of spiritual growth for students (Bowman & Small 2010, 2011, 2012a, 2012b; Cole &

Ahmadi, 2010; Paredes-Collins, 2014), along with the influence of institution type (Gonyea & Kuh, 2006; Morris, Smith, & Cejda, 2003; Patten & Rice, 2009; Speers, 2008). Subsequently, research has been conducted on the influence of religion and spirituality on campus climate (Bowman & Smedley, 2013; Mayhew, Bowman, & Rockenbach, 2014; Rockenbach & Mayhew, 2014; Rockenbach, Mayhew, & Bowman, 2015).

University years provide a time of academic as well as personal growth for students. Ma (2003) states that the years a student studies at University are considered to be "among the most formative", (p. 323). Many of the difficult decisions and situations facing University students entail exploring existential questions of being in the world. McGee, Nagel and Moore, (2003) detail that several issues University students may currently be facing are issues involving human suffering, issues concerning consistency and stability, concern for their safety, love and acceptance, and deciding what is true and what is not. McGee, Nagel and Moore, (2003) as stated above suggest that University students engage in spiritual experiences to seek stability for a variety of reasons. It is during this time that students may begin to examine their own religions and spiritual beliefs (Bryant, Choi, & Yasuno, 2003). To further describe this process, six stages of faith development have been described by Fowler (1984) namely: Intuitive-Projective, Mythic-Literal, Synthetic-Conventional, Individual-Reflective, Conjunctive and Universalizing. These stages represent "faith as a way of construing, interpreting, and responding to the factors of contingency, finitude, and "ultimacy" in our lives" (Fowler, 1984, p, 52). According to Fowler (1984), University students would be in the third stage of faith development, known as the synthetic-conventional faith. It is during this

stage that the individual's ability to develop hypothetical considerations and think using use abstract concepts begins to provide the foundation for faith development. Individuals in the synthetic-conventional stage are beginning to develop their own belief systems; however, they mainly seek to conform to the beliefs of individuals they relate to, such as family and peers. Because, they have not fully developed their own belief systems, "there must be a deep reflection and examination of what one believes compared to what his/her religion beliefs in order to move on to the next stage" (Fowler, 1984, p. 63). It has also been proposed that, for University students, "spiritual support may be expected to exert an influence on well-being independent of perceived social support" (Maton, 1989, p. 311). This links to previously cited findings, which have demonstrated a negative correlation between higher levels of spirituality and depressive symptoms in University students (Maton, 1989; Muller & Dennis, 2007; Turner-Musa & Lipscomb, 2007; Young, Cashwell, & Shcherbakova, 2000).

University students face stressors that differ from their peers who are not in University. Some of these stressors include academic demands, financial pressures, and separation from their usual support network. Various academic studies have been dedicated to understanding stress, its causes and consequences (Syed, Ali, & Khan, 2018; Ola, 2016). Doom and Haeffel (2013) stated that University students face intense pressure in their struggle to maintain economic stability, perform well in their academic studies, preserve their social lives, and cope with all of the ups and downs inherent in this developmental stage in their lives.

Since the mental health of students is of paramount importance, students` emotional and psychological problems are deemed significant (Taheri-Kharameh, Abdi, Koopaei,

Alizaeh, Vahidabi & Mirhoseini, 2015). Based on the report by Moallemi, Bakhshani and Raghibi, (2011) the increasing rate of referrals to student consultation departments in Universities is an indication that an increasing number of students are suffering from social, educational, and mental problems. Anxiety and depression are two important factors which endanger individuals` mental health (Taheri-Kharameh, Abdi, Koopaei, Alizaeh, Vahidabi & Mirhoseini, 2015). The negative side effects of depression, anxiety, and stress demonstrate the importance of treating their incidence among University students. For example, depression is correlated with detrimental behaviors such as smoking, poor diet, lack of exercise, poor sleep habits, and non-compliance with medical treatment recommendations (Doom & Haeffel, 2013). Individuals with anxiety disorders also report a worse quality of life than individuals without high levels of anxiety (Barrera & Norton, 2009). It can also be beneficial for institutions of higher learning to understand what aspects of life correlate with a decrease in depression, anxiety, and stress symptoms in order to encourage those behaviors in the students. For example, studies have shown that those college students who have satisfactory relationships with family and friends (social support for fellowship) are more likely to have overall life satisfaction (Ola, 2016).

Furthermore, anxiety is a psychological disorder that is associated with significant suffering and impairment in functioning. It is a blend of thoughts and feelings characterized by a sense of uncontrollability and unpredictability over potentially adverse life events (Ola, 2016). The relationship between anxiety and academic performance has been studied in a variety of laboratory and natural settings. Individuals experiencing anxiety show apprehensions that often interfere with their performance in

everyday life as well as in academic situations. Anxiety in general is expected to have a negative effect on performance. One consistent research finding shows that individuals who have a high level of anxiety perform poorly compared to those who have low anxiety on evaluative or ego-threatening tasks (Bonelli, & Koenig, 2013). In a study conducted by Syed, Ali and Khan (2018), on the relationship between anxiety and academic performance, it was reported that anxiety was significantly and negatively correlated with grades obtained by the students.

The way students perceive and experience their academic-related matters is also one of the factors that could affect the performance of the students. For instance, according to Bonelli and Koenig (2013), if an individual's experience of previous achievement is negative, then the anxiety level is higher and this leads to lower performance. Consequently, if the experience is positive, then the anxiety level is lower and this leads to a higher performance. Overall, it is important to consider motives, aptitudes, cognitive assessments of the task, and past experience when analyzing anxiety and examining how it relates to performance.

Andrews and Wilding (2004) found that 40% of a cohort of University College, London students had attended the student health clinic for psychological problems, characterized by anxiety, tension and poor concentration. Compared with the norm, the cohort as a whole also had elevated neuroticism scores. Their distress levels were found to be associated with low academic performance.

Another study on anxiety was conducted by Seligmen and Wuyek (2007) which found that highly-anxious students were significantly more likely to score lower on measures

of academic performance and peer acceptance. Longitudinal analyses revealed that highly-anxious students, compared to their less-anxious peers, scored significantly lower on measures of academic performance, aggression, and peer acceptance.

All the above studies showed that anxiety can directly influence students' academic performance. It was reported that anxiety could affect students' academic performance in the sense that students with high anxiety level perform poorer compared to those with low anxiety.

2.3 Spiritual Experience as a Faith-based Coping Mechanism

Pargament, Mahoney, Exline, Jones and Shafranske (2013) state that spiritual experience has an effect that is above and beyond the effects of nonreligious styles of coping. Spiritual experience is defined as the presence of a relationship with a Higher Power, a response to a deep and mysterious human yearning for self-transcendence and surrender, a yearning to find our place and the search for the existential (McSherry & Jamieson, 2010). Moreover, spiritual experience has been viewed in previous research studies as "the developmental engine that propels the search for meaning, purpose, and contribution" (Rowling, 2008). Wong-McDonald (2000) discovered that when a person faces a potential stressor he/she will first exercise all of his/her resources to find a solution to it. Upon realizing that the situation is beyond their ability they then leave it in God's hands. Wong-McDonald (2000) further demonstrates that surrendering to God is strongly correlated with spiritual well-being. In this way the individual trusts his/her life and circumstances to God and no longer has to carry such burdens (Wong-McDonald, 2000).

Many people report that their spiritual experience provides them with a source of strength (Hill et al., 2003). In fact, religion is cited more than any other coping mechanism in these studies (Pargament, Keonig & Perez, 2000). Spiritual coping has been associated with lower rates of depression, better physical and mental health, and lower mortality rates. Pargament, Keonig and Perez (2000) have identified 5 key dimensions of spirituality that lead to such positive health outcomes. 1) Meaning: when a person faces an uncertain situation, spirituality provides a means for understanding and interpretation of that circumstance. 2) Control: this is similar to spiritual surrendering. 3) Comfort: religion helps to soothe the individual's fears when faced with the perplexities and disasters that happen in life. 4) Intimacy: common spiritual opinions help to draw people closer together reinforcing the research on social support. 5) Life transformation: spirituality often involves a conversion process in which one puts aside old values and ways of thinking and embraces new ones (Zinnbauer, Pargament, Cole, Rye, Butter, Belavich, Hipp, Scott, & Kadar, 1997).

Research has compared God to an attachment figure similar to a parent (Hill et al., 2003). Believers look to God as a protector and as someone who will take care of them. Thus, just like someone who experiences a secure attachment to a parent, a person who has a secure relationship with God experiences greater comfort when trying situations occur, and greater strength and confidence in everyday life (Hill et al., 2003). Such a relationship lowers depression, increases self-esteem, reduces loneliness, and promotes better social and familial relationships (Hill et al., 2003). When a person faces a major life event (e.g. surgery, illness, and natural disaster) their secure relationship with God facilitates better psychological adjustment (Hill et al., 2003).

Furthermore, because some spiritual people view life through a spiritual lens they tend to avoid vices such as gluttony, envy, lust, and pride and embrace virtues like compassion, forgiveness, gratitude, and hope (Zinnbaur et al., 1997). This may explain why some deeply spiritual individuals report having more meaning in life, a better sense of well-being, lower levels of alcohol and substance abuse, and less sexual promiscuity (Hill & Pargament, 2008). Additionally, the relationships that such people have with their congregation members, clergy, and church officials had a number of health benefits; sometimes these health benefits can last throughout the person's life as they turn to these people consistently when facing major life events (Pargament, Koeing, & Perez, 2000).

In the same vein, University students report being less anxious than their peers, spiritual persons suffering from chronic disease have more positive emotions. Among heart surgery patients, those who are more spiritual have a lower rate or mortality up to 6 months post-surgery, and family members who have lost a loved one because of homicide cope better with loss (Pargament, 2002). According to Pargament (2002) religion provides individuals with an "unambiguous sense of right and wrong, clear rules for living, a distinctive identity and the faith that their lives are sanctioned and supported by God" (p. 173). Research suggests that spiritual people have less juvenile delinquency, lower divorce rates, higher marital satisfaction, report being more satisfied with life in general, have better recovery from mental illness, are less likely to smoke, and less likely to get cancer (Snodgrass & Sorajjakool, 2011).

2.4 Spiritual Experience in Coping with and Managing Stress

Although less extensive research has been conducted on the relationship between spirituality and stress, some positive results have been found. Delgado (2007) for example, shows a negative correlation between spirituality and perceived stress, indicating that higher levels of spirituality were linked with lower levels of perceived stress. Tuck, Alleyne and Thinganjana (2006) also conducted a longitudinal study on spirituality and perceived stress and found a negative correlation between spirituality and perceived stress as well. However, both studies have some limitations with regard to the sampling. The participants in the study by Delgado (2007) were COPD patients, whereas the participants in the study by Tuck et al. (2006) were members of a religious congregation, both limiting the generalizability of the results. Labbé and Fobes (2010) for instance, showed that higher levels of spirituality are related to better coping with a stressful situation. Spirituality also seems to be related to stress resilience (Southwick, Vythilingam, & Charney, 2005) and lower levels of psychological distress (Ribeiro, Pereira, Freire, De Oliveira, Casotti, & Boery, 2018; Johannessen-Henry, Deltour, Bidstrup, Dalton, & Johansen, 2013).

2.5 Spiritual Experience in Coping with and Managing Anxiety

Having a type of religious or spiritual experience appears to be related to lower anxiety levels in the general population (Shreve-Neiger & Edelstein, 2004). Intrinsic religiosity is associated with less worry and anxiety, whereas contemplative prayer is correlated with increased security and less distress. According to Shreve-Neiger and Edelstein (2004), intrinsic religiosity refers to a lifestyle in which religion is personally appropriated and ‘lived’ from within. Extrinsic religiosity, in contrast, refers to a

lifestyle in which religion is related to social convention (Allport, 1950). There are, however, studies that find a relationship between religion and increased anxiety. Some of these seem to focus on extrinsic forms of religion (Shreve-Neiger & Edelstein, 2004; Koening, 2001; Allport, 1950; Allport, 1967).

2.6 Spiritual Experience in Coping with and Managing Depression

Depression is often characterized by feelings of hopelessness, low self-esteem, and lack of meaning or purpose in life. In addition to a range of dysphoric and psychosomatic symptoms, depression is by nature linked to spiritual experience (Rentala, Lau & Chan, 2017). Spiritual experience is that aspect of human existence that gives it its human nature. It concerns the structures of significance that give meaning and direction to a person's life and helps them deal with the hardships of existence (Bonelli & Koenig, 2013). In depression the spiritual experience component has largely been avoided due to the predominance of risk factors in the disease model, while the focus should have been on the protective factors (Rentala, Lau, & Chan, 2017).

Research evidence shows a positive association between spiritual experience and treatment outcomes for depression (Van Rensburg, Myburgh, Szabo, & Poggenpoel, 2013). Many longitudinal and cross-sectional studies have shown that spiritual experience has a positive effect against depression and significantly reduces the prevalence and incidence rates (Janse Van Rensburg, 2012; Van Rensburg et al., 2013). Literature shows that components of spiritual experience aid in the reduction of depressive symptoms and simultaneous increase in general well-being (Ola, 2016). Also, several studies have demonstrated that there is significant association of spiritual well-being with lower levels of depression, hopelessness, and suicidal ideation among

severely ill patients (Ola, 2016; Van Rensburg, Myburgh, Szabo, & Poggenpoel, 2013; Janse Van Rensburg, 2012). Failure to cope with stressors in life is one of the most important common factors for the onset and continuance of depression (Auerbach, Abela, Zhu, & Yao, 2010). If the spiritual experience component can play a role in reducing life's stress, then it can also play a defining role in preventing the development of depression or reducing depressive symptoms (Bonelli, Dew, Koenig, Rosmarin, & Vesegh, 2012). Studies also indicate that patients utilize their spiritual beliefs to overcome illness, pain and life's stress. Also those who are spiritual tend to have a more positive outlook and better quality of life (Janse Van Rensburg, 2012), thus, the potentially positive effect of spirituality as a protective mechanism against mental illness and disorders.

2.7 Theoretical Framework

Humanism is an orientation that states that human beings have natural needs and potential that demand to be developed through various means and experienced at various levels of human satisfactions. One of the humanists, namely Abraham Maslow (1908-1970) theorized that humans seek to satisfy basic needs ranging from lower level needs such as physiological needs to the higher level need for self-actualization. At this top level of self-actualization, a person develops their full potential and it is common to have "peak experiences" or "mystical experiences" of extreme ecstasy, bliss, joy, awe and wonder (Maslow, 1970). These peak experiences positively transform the individual's life in satisfying ways such as experiences of greater creativity, self-activation and wholeness (Wulff, 1997). Maslow (1970) stated that the origin of every religion (its "intrinsic core" or "universal nucleus") can be traced to a profound peak experience of a

self-actualized individual such as a prophet or mystic. Maslow (1970) viewed religious rituals and creeds codified forms of this original religious peak experience which aid individuals to experience self-actualization. However, Maslow did not view all religious experience as socially progressive. The "mystic" engages in the ideal religious experience which is highly personal, intrinsic, and idiosyncratic. As such each "discovers, develops, and retains his own religion" (Maslow, 1970). In contrast, the "legalist" is preoccupied with "all the paraphernalia of organized religion" such as buildings, rituals, dogmas and ceremonies rather than cultivating a personal and meaningful religious experience (Maslow, 1970).

An example of Maslow's (1971) law is displayed in his biographical analyses of "self-actualized". Maslow identified exemplar qualities which these self-actualizers possess in common including the ability to be reality-centered and problem-centered, have deep personal relations with others, autonomy, resistance against enculturation and having a good sense of humor (Morris, 1980).

The humanistic model of religion emphasizes that an individual's most important needs include growth, purpose, and self- actualization. Humans have innate tendencies to fulfill their potential and express their values. Religion serves as an important vehicle for fulfilling potential and expressing values.

As Maslow (1968, p. 206) stated, a human being needs a spiritually based cognitive framework ''to live by and understand by, in about the same sense that he needs sunlight, calcium or love.'' Spiritual traditions, by their very nature, fill this innate need for meaning and understanding (Frankl, 1963). For example, knowing that one is loved

unconditionally by God/Higher Power, that a caring Transcendent Being is working all things together for one's good, and that one's life has eternal significance, can yield optimism, self-confidence, and a sense of purpose and mission, etc., for the believer (Propst, 1996). Belief systems, in conjunction with the faith that animates them, have demonstrated both protective and curative properties, for example, stress, anxiety and depression have been ameliorated by employing this particular pathway as an intervention (Propst, 1996). Further, studies have demonstrated either comparable or superior outcomes as compared to standard secular interventions in treating depression with individuals for whom spirituality is a salient aspect of their personal ontology (Propst, 1996).

There are at least three basic pathways: psychological, social, and behavioral (see *Figure* 2.1 below). It is visually illustrated that there is ample evidence that there is a complex relationship between spiritual experience and mental health, because it facilitates coping and imbues negative events with meaning and purpose is related to better mental health, that is, less depression, lower stress, less anxiety, greater well-being, and more positive emotions (Koenig, 2012).

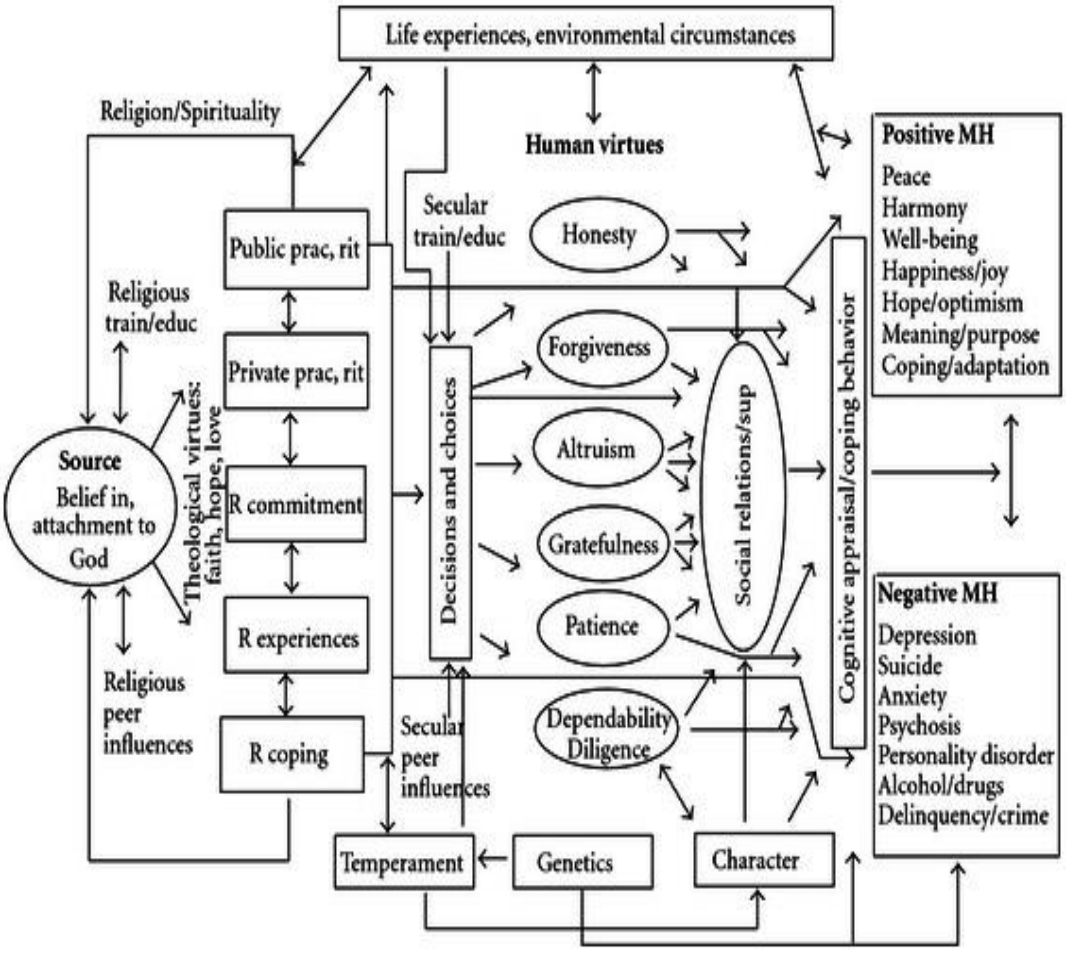

Figure 1 Theoretical model of casual pathways for mental health (MH), based on Western monotheistic religions (Christianity, Judaism, and Islam). Koenig, King, & Carson, 2012)

The figure above illustrates the relationship and role of spirituality in coping with mental problems including stress, anxiety and depression.

CHAPTER 3: RESEARCH METHODS

3.1 Research Design

The proposed study employed a quantitative research design to gather information, by a cross sectional survey, from a relatively large number of participants and allow generalization to a broader population. For the purposes of this study, a cross sectional survey design was used to explore the role and relationship amongst spiritual experience when dealing with stress, anxiety and depression amongst University of Namibia students. Furthermore, while cross-sectional surveys cannot be used to determine causal relationships, they can provide a useful springboard to further research. For instance, adding in the exploration of the practical implications of involving spirituality in dealing with mental health problems such as stress, anxiety and depression.

Denscombe (2010) postulates that one advantage of using quantitative methods is that quantitative data provide various forms of statistical calculation. The aim of a quantitative research, as opposed to a qualitative one, is to attempt to describe and report individuals' spiritual experiences in relation to stress, anxiety and depression.

According to Leedy and Ormrod (2010) quantitative research seeks explanations and makes predictions, establishes, confirms or validates relationships and develops generalizations that may contribute to theory development.

3.2 Population

The target population was all registered full time students of the University of Namibia, main campus totalling 13 575 individuals (University of Namibia Strategic & Physical Planning, 2018).

3.3 Sample

The Yamane`s formula was used to determine a representative sample for this study at 95% confidence level (Yamane, 1967).

Formula $n = N/(1+Ne^2)$

Where, *n*= sample size or participants for this research, *N*= a population size and *e*= the level of confidence. The sample consisted of 388 randomly selected participants, male and female, full time students regardless of their religious affiliation or spiritual orientation or lack thereof. All participants were from the Windhoek main campus aged 18 years and above. A simple random sampling technique was used to select participants. This technique ensures that each subgroup of the population has an equal probability of being chosen.

3.4 Research Instruments

3.4.1. Socio-Demographic Questionnaire

The self-designed socio-demographic questionnaire consists of categories of age, sex, marital status and year of study. The socio-demographic data was collected to help describe and better understand the sample selected for this study.

3.4.2. The Daily Spiritual Experiences Scale (DSES)

The DSES is a 16-item self-report instrument, developed by Underwood and Teresi (2002). It was designed to capture ordinary spiritual experiences, one's relationship with, and awareness of, the divine or transcendent, and how beliefs influence moment-to-moment features of life as understood from a spiritual or religious perspective. The

DSES was designed to be relevant for individuals with both theistic religious and nontheistic views. In the instructions, participants are instructed that a number of items use the word "God" and they should substitute another word that corresponds to the divine or holy for them if they are not comfortable with God. The questions on the DSES focus on spiritual experience in daily life. The instrument does not provide a specific timeframe for individuals, leaving this as open-ended for subjects. The first 14 items are rated on a scale of the following: "*many times a day*" (1); "*every day*" (2); "*most days"* (3); "*some days"* (4); *"once in a while"* (5); and *"never or almost never*" (6) (Underwood, 2006, p. 12). The final two items, numbers 15 and 16, are rated on a scale of the following: *"not at all close"* (1); "*somewhat close"* (2); *"very close"* (3); and *"as close as possible"* (4) (Underwood, 2006, p.12). Item number 16 on the instrument is reverse scored. The DSES is scored by totalling the scores for each of the items. Although there are no cut-off scores for the instrument, individuals with lower scores are considered to demonstrate a greater number of spiritual experiences (Underwood, 2006).

The DSES has demonstrated good psychometric properties, including high internal consistency (α = .89 to .95), test-retest reliability, and construct validity (Underwood & Teresi, 2002). Researchers have utilized this instrument within a wide scope of populations, ranging from social workers (Stewart, Koeske, & Koeske, 2006) to drug addicts (Shorkey, Uebel, & Windsor, 2007), and from elderly Jews (Kalkstein & Tower, 2009) to Indonesian Muslim youth (French, Eisenberg, Vaughan, Purwono, & Suryanti, 2008). Therefore, this instrument has demonstrated applicability across different cultures and socio-economic classes. A number of studies have confirmed both the validity and

the reliability of this instrument. For example, Underwood and Teresi (2002) reported the following forms of reliability: Pearson product-moment correlation for test-retest reliability = .85; intra-class correlation coefficient for internal reliability = .73; Cronbach's alpha estimate of internal reliability = .91-.95; and inter-rater reliability = .64-/78. More recently, Loustalot, Wyatt, Boss, May, and McDyess (2006) replicated these findings with comparable reliabilities.

3.4.3. The Depression Anxiety Stress Scale (DASS)

The Depression Anxiety Stress Scale (DASS-21) is a 21-item self-report instrument. It was designed by Lovibond and Lovibond (1995) to measure the negative emotional states of depression, anxiety, and stress. It consists of three scales each with seven items: Depression Scale (DS), Anxiety Scale (AS), and Stress Scale (SS). Items of the DASS-21 assess the severity or frequency of symptoms over the past week, and each item is answered on a 4-point Likert-type scale ranging from; Did not apply to me at all (0) to Most of the time (3). Scores range from 0 to 21 for each scale, and a total score on each scale can differentiate between individuals with normal values and those with mild, moderate, or severe levels of stress. Cronbach's alphas for the DASS-21 total score, DS, AS and SS are .90, 0.75, 0.76 and 0.77, respectively (Lovibond & Lovibond, 1995).

Various researchers have used this instrument to measure a wide scope of populations, ranging from employees absent from work due to mental health problems (Nieuwenhuijsen, de Boer, Verbeek, Blonk & van Dijk, 2003) to drug addicts (Beaufort De Weert-Van Oene, Buwalda, de Leeuw & Goudriaan, 2017), and anxiety among rural community Vietnamese woman (Tran, Tran, & Fisher, 2013). Therefore, this instrument has demonstrated applicability across different cultures and socio-economic classes.

3.5 Procedure

The participants were approached at the three campus cafeterias (The Grub, Independence and Dining Hall). The researcher introduced the nature of the research, objectives and discussed each part of the consent form with the participant before requesting the participants to complete the questionnaires. The inclusion criteria were male and female participants, above 18 years regardless of depression, anxiety and stress history. Those who consented were handed the questionnaire to complete.

3.6 Data Analysis

Data were analysed using the *Statistical Package for Social Sciences, version 25.0* SPSS) (2016). Measures of central tendency and variability analysis were specifically selected. Descriptive statistics were also employed to describe and organize the data. Pearson correlation analysis used to determine the relationship between spiritual experience and stress, anxiety and depression. In addition linear multivariate regressions were performed to describe how University of Namibia students with/ without a spiritual experience cope with stress, anxiety and depression.

3.7 Research Ethics

The researcher aimed to build a body of knowledge and gain insights into students` perspectives on spiritual experience and stress, anxiety and depression. Thus, the sample of this study was selected from a population of students from the University of Namibia. The researcher obtained an ethical clearance certificate provided in Appendix A. Participants were informed about the aims and objectives of the study prior to completion of the questionnaire. It was, further, explained to them that by expressing their beliefs, they would assist the researcher in gaining an understanding and building

knowledge on the subject at hand. No other benefits were promised to the participants. The participants were also made aware of their option to withdraw from the study without consequences. A consent form (*Appendix B*) was developed and provided to potential participants at the University of Namibia.

CHAPTER 4: PRESENTATION OF DATA

4.1 Demographic Data

Figure 2 Gender

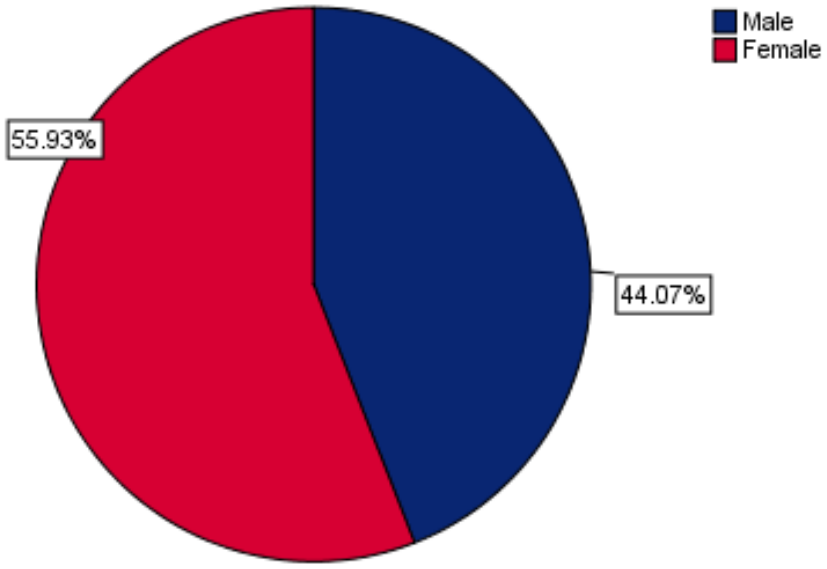

Figure 2: Pie chart showing gender distributions of participant's female (55.93%) and male (44.07%).

Figure 3 Age Cohorts

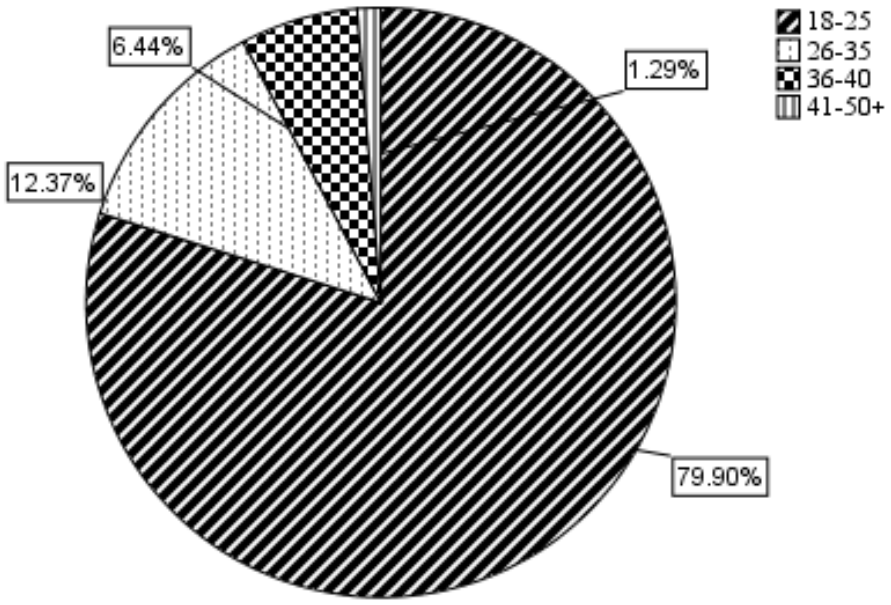

Figure 3: Pie chart showing the age distribution of the participants.

The highest age range is 18-25 (79.90%), followed by 26-35 (12.37%), followed by 36-40 (6.44%) and lowest is 41-50+ (1.29%).

Table 1 Means and Standard Deviation of the age of participants

	n	M	SD
Age cohorts			
18-25	310	22	1.64
26-35	48	29	1.26
36-40	25	37	1.17
41-50+	5	42	4.02

Table 1 above indicates that the mean age of the participants who fall in the 18-25 age cohorts was 22 years with a standard deviation of 1.64. The mean age for participants in

the age cohort 26-35 was 29 with a standard deviation of 1.26. The mean age for participants in the age category was 36-40 was 37 with a standard deviation of 1.17. While the last age cohort was 41-50+ the mean age was 42 with a standard deviation.

Figure 4 Year of Study

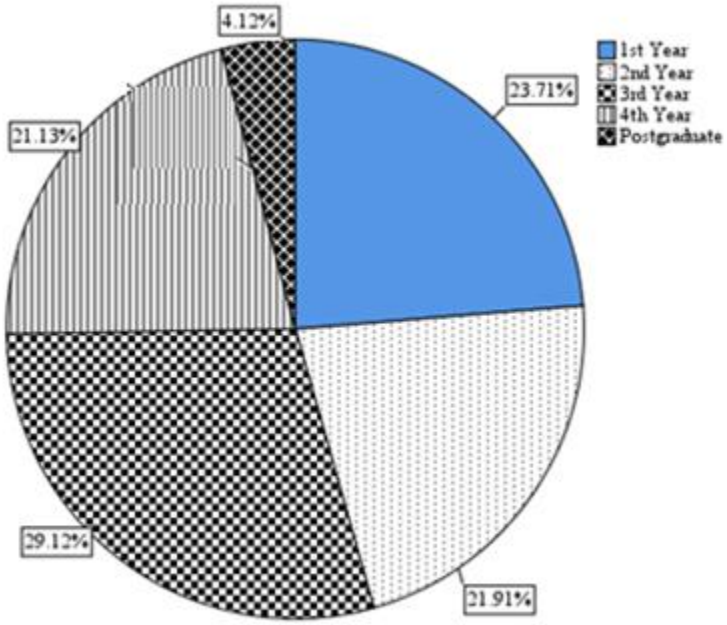

Figure 4: Pie chart showing the distribution of participants by year of study

The majority were 3rd year, 113 (29.12%), followed by 1st year, 91(23.71%), followed by 2nd year, 85 (21.91%), followed by 4th year, 83 (21.13%) and the lowest was post-graduate 16 (4.12%).

Table 2 Mean and Standard deviation of participant's responses on Total Global scales

	N	Min	Ma	Mean	S D
Daily Spiritual Experience Scale (DSES)					
	388	33	59	45.69	4.44
Depression, Anxiety and Stress Scale (DASS)					
Stress scale	388	9	21	15	1.92
Anxiety scale	388	10	20	15	1.91
Depression scale	388	9	20	15	1.90

Table 2 above illustrates the mean and standard deviation of the participant's responses to the DSES and the DASS. The DSES had a mean of 45.69 (SD = 4.4), under the stress scale the mean was 15 (SD = 1.92), the anxiety scale had a mean of 15 (SD=1.91) and the depression scale had a mean of 15 (SD=1.90).

4.2 Empirical Data

Table 3 Prevalence of depression, anxiety and stress amongst UNAM students

Scale	Category	Percentage	Frequency
DASS (Depression)	Normal	26.%	102
	Mild	32%	124
	Moderate	41.5%	162
	Severe	0.5%	10
DASS (Anxiety)	Normal	88.7%	342
	Mild	7%	28
	Moderate	4%	17
	Severe	0.3%	1
DASS (Stress)	Normal	87%	333
	Mild	10%	42
	Moderate	2%	8
	Severe	1%	5

Table 3 above shows results on the prevalence of the depression, anxiety and stress amongst the research participants as measured by the DASS-21 questionnaire, 26% reported no depression, 32% reported mild depression, 41.5% reported moderate depression and 0.5% reported severe depression. 88.7% of participants reported no feelings of anxiety, 7% reported mild anxiety, 4% reported moderate anxiety and 0.3% reported severe anxiety. 87% of the participants reported no feelings of stress, 10% reported mild feelings of stress, 2% reported moderate feelings of stress and 1% reported severe feelings of stress.

Table 4 Correlation of spiritual experience and stress, anxiety and depression

		DSES total score
Stress scale	Pearson Correlation	0.014
	Sig. (2-tailed)	0.783
	N	388
Anxiety scale	Pearson Correlation	0.039
	Sig. (2-tailed)	0.445
	N	388
Depression scale	Pearson Correlation	-0.105*
	Sig. (2-tailed)	0.038
	N	388

*. Correlation is significant at the 0.05 level (2-tailed).

Table 4 above of Pearson correlation coefficients show that there was no significant correlation between spiritual experience and anxiety (r=0.039, n=388, p<0.05, 2 tailed). The table further shows that there was no significant relationship between spiritual experience and stress (r= 0.014, n=388, p<0.05, 2 tailed). However, there was a significant but weak negative correlation between spiritual experience and depression (r= -0.105, n=388, p<0.05, 2 tailed).

CHAPTER 5: DISCUSSION OF RESULTS AND RESEARCH FINDINGS

5.1 Demographic Data

In the randomly collected sample, there is a significantly higher number of females compared to males (p = 0.0005), this finding corresponds with the significantly higher number of females registered at the University of Namibia compared to males.

The majority of the participants are in the age group 18-25years; this is the average age of University students across the globe (Valero & Van Reenen, 2016). Lastly, the majority of the students are undergraduates as the University has a primary focus on teaching and is still developing the research component.

5.1.1 Prevalence of the stress, anxiety and depression amongst UNAM students

A significant majority (74%) of the individuals reported feelings of depression; this corresponds to several studies (Rentala, Lau & Chan, 2017, Johannessen-Henry, Deltour, Bidstrup, Dalton, & Johansen, 2013) that reported a growing epidemic of depression amongst university students. This growing epidemic has been attributed to some of the stressors that University students face that differ from their peers who are not in university these include academic demands, financial pressures, and separation from their usual support network (Luna & MacMillan, 2015). This is a significant problem and there is currently no data on the levels of depression amongst University students in Namibia (until this report), as such, no programs have been established to mitigate the effects of depression at the University of Namibia.

A total of 12% of the participants are anxious, similar results have been reported by Syed, Ali, & Khan (2018) who also reported anxiety as a growing epidemic. Unfortunately, there are currently no programs and minimal efforts in place at the

University of Namibia to measure anxiety and raise awareness of these mental health issues. However, there are programs outside the University which are offered by the Ministry of health and social services such as mental health awareness (Bartholomew, 2016). A total of 87% of the participants reported no feelings of stress, 10% reported mild feelings of stress, 2% reported moderate feelings of stress and 1% reported severe feelings of stress. A total of 13% of the participants are under different levels of stress, which is concerning given the increasing reports of mental illness across different settings (Vitasari, Wahab, Othman & Awang, 2010). A culture of speaking out could be encouraged to help individuals deal with mental health issues

5.2 Empirical Data

5.2.1 *Objective 1: Examine the relationship between spiritual experience and stress, anxiety and depression amongst University of Namibia students*

Despite a growing body of empirical literature documenting a positive correlation between spiritual experience and mental health problems (Gonzalez et al., 2014; Mills et al., 2015), there has never been a study within the Namibian context which explored the relationship between spiritual experience and mental health problems.

A Pearson correlation coefficient was carried out to measure the strength and direction (positive or negative) of the relationships that exists amongst spiritual experience and stress, anxiety and depression among University students. There was no significant correlation between spiritual experience and stress (r= 0.014, n=388, p<0.05, two tailed). This result deviates from previous findings that have reported a significant inverse relationship between spiritual experience and stress. Delgado (2007) for example, shows a negative correlation between spirituality and perceived stress, indicating that higher levels of spirituality were linked with lower levels of perceived stress. Tuck, Alleyne and Thinganjana (2006) also conducted a longitudinal study on spirituality and perceived stress and found a negative correlation between spirituality and perceived stress as well. However, both studies have some limitations with regard to the sampling. The participants in the study by Delgado (2007) were COPD patients, whereas the participants in the study by Tuck et al. (2006) were members of a religious congregation, both limiting the generalizability of the results and the studies were not conducted in Namibia. Therefore, these factors could be the reason for deviation. In as

much as the findings were not significant statistically, a number of participants suffer from stress and there is a need to find ways of managing stress.

There was no significant correlation between spiritual experience and anxiety (r=0.039, n=388, p<0.05, two tailed) as illustrated in *Table 4* above. This result differs from previous findings, for example, Ola (2016) found that with regard to correlation between spirituality, depression, anxiety and stress there was significant inverse correlation for male and female students. In addition Maslow indicated that the failure to have needs met at various stages of the hierarchy could lead to mental health issues. Individuals who do not feel loved or belonging may experience anxiety. The difference with this study could be as a result of the difference in the majority cohort of the participants which was 18-25 sample size and that the studies were conducted in a different setting. However, although the findings were not statistically significant, a number of participants suffer from anxiety and there is a need to find ways of managing anxiety.

Table 4 further indicated that there was a significant but weak negative correlation between spiritual experience and depression (r= -0.105, n=388, p<0.05, two tailed). This result is inconsistent with Van Rensburg, Myburgh, Szabo, and Poggenpoel, (2013) who found a positive correlation between spiritual experience and treatment outcomes for depression. Other longitudinal and cross-sectional studies concur that spiritual experience has a positive effect against depression and significantly reduces the prevalence and incidence rates (Janse Van Rensburg, 2012; Van Rensburg et al. 2013).

Spiritual experience may help people to cope better with stressful life circumstances, give meaning and hope, and surround depressed persons with a supportive community. However in some populations or individuals like the University of Namibia, there is an

inverse relationship between spiritual experience and depression this could be caused by an individuals spiritual beliefs which may increase guilt and lead to discouragement as people fail to live up to the high standards of their spiritual life (Bonelli, Dew, Koenig, Rosmarin, & Vasegh, 2012). Furthermore, those unable to live according to these standards may face rejection from their faith community, resulting in social isolation.

Maslow (1968) stated that the failure to have needs met at various stages of the hierarchy could lead to illness, particularly psychiatric illness or mental health issues. Individuals who do not feel love or belonging may experience depression. Lack of esteem or the inability to self-actualize may also contribute to depression.

5.2.2 Objective 2: Explore the practical implications of involving spirituality in dealing with mental health problems such as stress, anxiety and depression

The second objective of the study was to explore the practical implications of involving spirituality in dealing with mental health problems such as stress, anxiety and depression. A significant proportion (74%) of participants as indicated in table 3 reported feelings of depression. Although the findings from the correlation analysis of spiritual experience, anxiety and stress were not statistically significant, a total of 13% of the participants are under different levels of stress, 11.3% of the participants are anxious among University of Namibia students. However, interpretation of clinical research outcomes should not be based solely on the presence or absence of statistically significant differences.

Of note a growing body of evidence is showing beneficial outcomes of spiritual approaches to mental health problems, for instance stress, anxiety and depression (Rentala, Lau, & Chan, 2017; Pillay, Ramlall, & Burns, 2016). The current study only

found a link between spiritual experience and depression. However there is a need to understand spirituality which can be seen as a unique human dimension, making life sacred and meaningful, being an essential part of the physician-patient-relationship and the recovery process (Hefti, 2011). According to Patel and Shikongo (2006) with the growing realization of the importance of spirituality, through empirical evidence of the positive links between mental (and physical) health and spirituality, with public interest as indicated by the plethora of popular psycho-spiritual literature that espouses the principles of spiritual lifestyles and the public need, it would seem that the discipline of psychology needs to respond in a more proactive and contextually relevant manner.

Individuals suffering from mental illness, in this case depression, emphasize that understanding one's problems in spiritual terms can be a powerful alternative to a biological or psychological framework. As Maslow (1970, p. 206) stated that a human being needs a spiritually based cognitive framework ''to live by and understand, in about the same sense that he needs sunlight, calcium or love.'' Spiritual traditions, by their very nature, fill this innate need for meaning and understanding (Frankl, 1963).

Pargament, Keonig and Perez (2000) identified 5 key dimensions of spirituality that lead to positive mental health outcomes. 1) Meaning: when a person faces an uncertain situation spirituality provides a means for understanding and interpreting that circumstance. 2) Control: this is similar to spiritual surrendering. 3) Comfort: religion helps to sooth the individual's fears when faced with the perplexities and disasters that happen in life. 4) Intimacy: common spiritual opinions help to draw people closer together reinforcing the research on social support. 5) Life transformation: spirituality often involves a conversion process in which one puts aside old values and ways of

thinking and embraces new ones (Zinnbauer, Pargament, Cole, Rye, Butter, Belavich, Hipp, Scott, & Kadar, 1997).

The mental health treatment needs of University students are largely unmet. Community-based interventions hold promise for raising awareness and promoting mental health awareness (Austin & Claiborne, 2011). Community-based interventions involve either collaborations with community-based agencies or attempts to change individual behaviors by reaching people in their normal community settings. They can also aim to target community values and attitudes (i.e., stigma) (Bruce, Smith, Miranda, Hoagwood, & Wells, 2002). These interventions typically employ principles of community based participatory research (CBPR), a methodology in which mental health professionals, researchers, and community members are equal partners throughout intervention planning, development, and implementation (Israel, Eng, Schulz, & Parker, 2005; Wallerstein & Duran, 2010).

Peterson, Atwood and Yates (2002) elaborated that CBPR begins with a research topic of importance to the community, with the aim of combining knowledge and action for social change to improve community [health].” From this perspective, the research process should involve University students from the onset to identify and frame the research issues and health problems that should be studied, design the study measures and methods, participate in and/or lead implementation, and participate in evaluating and interpreting the findings (Peterson, Atwood & Yates, 2002). One typical way to achieve a more participatory approach is to convene a community advisory board consisting of Dean of students and Students representative committee.

A CBPR approach, along with careful formative research, should lead to identification of issues related to cultural values and to spiritual sensitivity, as well as to the type of intervention and level of church involvement that would be most appropriate for a given population and health issue. In addition, using CBPR can increase empowerment and community ownership of the health program and thus lead to greater participation and long-term sustainability. CBPR methods ensure a “do with” rather than “do to” approach to research that is vital for building trust and community empowerment (Wallerstein & Duran, 2010).

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The findings from this study demonstrate that there is no relationship amongst spiritual experience, stress and anxiety. There was however an inverse relationship between spiritual experience and depression amongst University of Namibia students. A significant proportion (74%) of the participants in this study reported feelings of depression. Therefore, there is a need to find ways of managing depression in the University setting. This study shows literature on the implementation of spiritual practices when an individual is suffering from any form impact mental health issue such as depression amongst students. Thus, this study can lend support to the growing body of work indicating that we should take seriously this rising burden. Lastly, spiritual experience is a vital issue that requires research attention as it can potentially reduce stress, anxiety, depression and encourage optimal mental health.

6.2 Limitations

The limitation to this study was that the sample of this study consisted of only University educated participants, drawn from one largely uniform setting. Perhaps a sample drawn from various campuses (settings) and more varied education backgrounds would improve the generalizability of the results.

6.3 Recommendations

6.3.1. Faith-based Mental Health Promotion (FBMHP)

Based on the findings of this study, the following recommendations seem relevant, namely the academic institutions need to consider providing open-minded counselling services where spiritual oriented students can use their faith to deal and cope with various psycho-spiritual challenges. This could be done by providing resources that enable the students to develop their spirituality even if the institution itself does not endorse a particular religion (e.g. providing access to Bible studies, building relationships with local clergyman and churches, providing more resources for faith-based organizations). This can further be done by employing counsellors who are trained to help students utilize their spirituality to promote positive mental health and who are cross-culturally and religiously sensitive. Additionally, to incorporate diversity training that emphasizes religious sensitivity and highlight the positive influence that spiritual experience would play in coping with various mental health problems.

There is a significant inverse correlation between spiritual experience and depression; therefore, there is a need to promote interventions such as Faith-Based Mental Health Promotion (FBMHP). The FBMHP has received growing attention from researchers and clinicians as a way to implement culturally sensitive, community-based health programs (Campbell et al., 2007). FBMHP is further designed to provide measurable benefits to community members through education, screening, and mental health treatment (DeHaven, Hunter, Wilder, Walton, & Berry, 2004).

6.3.2. Therapeutic Pastoral Counseling Services

Other relevant psycho-spiritual services would be the inclusion of pastoral counseling in the therapeutic services offered at the University. A significant proportion (75%) of the participants reported feelings of depression, 12% of the participants suffer from anxiety and 13% suffer from stress and could benefit from counselling. Pastoral counseling, as the literature points out, is the "healing, sustaining, guiding/shepherding and reconciling" (Clinebell 1966, 1984) undertaken by professionals who use spiritual resources as well as psychological understanding for healing and growth. The role of a pastor is more than just preaching. It holds elements such as comfort, direction and support at all times of the congregation's path (Aten, Topping, Denney, & Bayne, 2010). The pastor is one who has great influence that impacts the church, the family and the community at large.

6.4 Future Research

The results provide some relevant empirical evidence to support the link between spiritual experience and stress, anxiety and depression; however, more research is needed to further elucidate the subjective nature of the relationships. The research method selected for the present study was largely quantitative; therefore, future research should use a mixed method approach, which brings in a qualitative angle to get an in-depth understanding. Although the data collection instrument was appropriate gathering the relevant information to help explain how people experience the higher power/God; it is limited in explaining how people use this experience to cope with life's hardships. Thus, future research might consider using other instruments to evaluate spirituality as the central coping mechanism in academic and non-academic settings.

7. REFERENCES

Adams, T.B., & Bezner, J.R. (2000). Conceptualization and measurement of the spiritual and psychological dimensions of wellness in a college population. *Journal of American College Health*, *48,* 165- 173.

Ali, J., Marhemat, F., Sara, J., & Hamid, H. (2015). The relationship between spiritual well-being and quality of life among elderly people**.** *Holistic Nursing Practice*, *29(3)*, 128–135.

Allport, G. (1950). *The Individual and his Religion*. New York: McMillan.

Allport, G., & Ross, J.M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology, (5),* 432-443.

Austin, S.A., & Claiborne, N. (2011).Faith Wellness Collaboration: A Community-Based Approach to Address Type II Diabetes Disparities in an African-American Community. *Soc Work Health Care*, *50*(5):360–375.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Auerbach, R. P., Abela, J. R. Z., Zhu, X., & Yao. S. (2010). "Understanding the role of

coping in the development of depressive symptoms: symptom specificity, gender differences, and cross-cultural applicability," *British Journal of Clinical Psychology*, (49)4,547–561.

Aten, J., Topping, S., Denney, R., & Bayne, T. (2010). Collaborating with African American churches to overcome disaster mental health disparities: What mental health professional can learn from Hurricane Katrina. Professional Psychology: *Research and Practice*, 41,167–173.

Bai, M., & Lazenby, M. (2015). A systematic review of associations between spiritual wellbeing and quality of life at the scale and factor levels in studies among patients with cancer. *Journal of Palliative Medicine*, *18(3)*, 286–298.

Bartholomew, T. T. (2016). Mental Health in Namibia: Connecting Discourses on Psychological Distress, Western Treatments and Traditional Healing. *Psychology and Developing Societies*, 28(1), 101–125.

Beaufort I, N., De Weert-Van Oene G, H., Buwalda V, A, J., de Leeuw J, R, J., & Goudriaan A, E. (2017): The Depression, Anxiety and Stress Scale (DASS-21) as a Screener for Depression in Substance Use Disorder Inpatients: A Pilot Study. *Eur Addict Res, 23*, 260-268.

Blazer, D. (2012). Religion/spiritual experience and depression: What can we learn from empirical studies? *American Journal of Psychiatry*, *169 (1)*, 10–12.

Bhandari, P. (2012).Stress and health related quality of life of Nepalese students

studying in South Korea: a cross-sectional study. *BMC Psychology*, *10*, 26–35.

Bonelli, R. M., & Koenig, H.G. (2013). Mental disorders, religion and spiritual experience 1990 to 2010: *A systematic evidence-based review. Journal of Religion and Health, 52(2),* 657–73.

Bonelli, R., Dew, R. E., Koenig, H. G., Rosmarin, D. H., & Vasegh, S. (2012). Religious and spiritual factors in depression: review and integration of the research. *Depression research and treatment*, 2012, 962860.

Bowman, N. A., & Small, J. L. (2010). Do college students who identify with a privileged religion experience greater spiritual development? Exploring individual and institutional dynamics. *Research in Higher Education, 51,* 595-614.

Bowman, N. A., & Small, J. L. (2012a). Exploring a hidden form of minority status: College students' religious affiliation and well-being. *Journal of College Student Development, 53,* 491-509.

Bowman, N., & Small, J. (2012b). The experiences and spiritual growth of religiously privileged and religiously marginalized college students. In N. A. Bowman (Ed.) *Spirituality in College Students' Lives: Translating Research into Practice* (pp. 19-34). New York, NY: Taylor and Francis.

Bowman, N., & Toms Smedley, C. (2013). The forgotten minority: Examining religious affiliation and university satisfaction. *Higher Education, 65*, 745-760.

Brown, D. R., Carney, J. S., Parrish, M. S., & Klem, J. L. (2013). Assessing spiritual experience: The relationship between spiritual experience and mental health. *Journal of Spiritual experience in Mental Health, 15,* 107–122.

Bruce, M.L., Smith, W., Miranda, J., Hoagwood, K. & Wells, K.B. (2002). Community-based interventions. *Ment Health Serv Res*, 4(4):205–214.

Carmody, J., Reed, G., Kristeller, J., & Merriam, P. (2008). Mindfulness, spirituality, and health-related symptoms. *Journal of Psychosomatic Research, 64,* 393-403.

Clinebell, J. H. (1984). *Basic types of pastoral care & counseling: Resources for the ministry of healing and growth*. Nashville: Abingdon.

Clinebell, J. H. (1966). *Basic types of pastoral care & counseling: Resources for the ministry of healing and growth*. Nashville: Abingdon.

Cole, D., & Ahmadi, S. (2010). Reconsidering campus diversity: An examination of Muslim students' experiences. *Journal of Higher Education, 81,* 121-139.

Dessie, Y., Ebrahin, J., Awoke, T. (2013).Mental distress among university students in Ethiopia: a cross-sectional survey. *Pan African Medical Journal*, 15,95–9.

Dalmida, S. G., Holstad, M. M., DiIorio, C., & Laderman, G. (2011). Spiritual well-

being and health-related quality of life among African–American women with HIV/AIDS. *Applied Research in Quality of Life, 6(2),* 139–157.

Delgado, C. (2007). Sense of coherence, spirituality, stress and quality of life in chronic illness. *Journal of Nursing Scholarship, 39*, 229-234.

Delgado, C. (2007). Sense of coherence, spirituality, stress and quality of life in chronic illness. *Journal of Nursing Scholarship, 39*, 229-234.

Doom, J.R., & Haeffel, G.J. (2013).Teasing apart the effects of cognition, stress, and depression on health. *Journal of .Health Behavior.37,* 610–619.

Frankl, V.E. (1963). *Man's search for meaning: an introduction to logo therapy*. Oxford, England: Washington Square Press.

French, D. C., Eisenberg, N., Vaughan, J., Purwono, U., & Suryanti, T. A. (2008). Religious involvement and the social competence and adjustment of Indonesian Muslim adolescents. *Developmental Psychology, 44(2),* 597-611.

Galen, L. W., & Kloet, J. D. (2011). "Mental well-being in the religious and the non-religious: evidence for a curvilinear relationship". *Mental Health, Religion & Culture. 14 (7),* 673–689.

Gallagher, C.T., Mehta, A.N., Selvan, R., Mirza, I.B., Radia, P., Bharadia, N.S., & Hitch, G. (2014). Perceived stress levels among undergraduate pharmacy

students in the UK. *Curr Pharm Teach Learn*, 6(3), 437–41.

Gonzalez, P., Castañeda, S. F., Dale, J., Medeiros, E. A., Buelna, C., Nuñez, A., & Talavera, G.A. (2014). Spiritual well-being and depressive symptoms among cancer survivors. *Supportive Care in Cancer, 22(9),* 2393–2400.

Hackett, C. (2019). How Religious Composition Around the World Differs between Younger and Older Populations. *Socius*.

Hamilton, J. L., Stange, J. P., Shapero, B. G., Connolly, S. L., Abramson, L. Y., Alloy, L. B. (2013). Cognitive vulnerabilities as predictors of stress generation in early adolescence: Pathway to depressive symptoms. *Journal of Abnormal Child Psychology, 41*, 1027–1039.

Hamilton, J. L., Alloy, L. B. (2016). Atypical reactivity of heart rate variability to stress and depression across development: Systematic review of the literature and directions for future research. *Clinical Psychology Review, 50,* 67–79.

Hamilton, J. L., & Alloy, L. B. (2017). Physiological Markers of Interpersonal Stress Generation in Depression. *Clinical Psychological Science, 5(6),* 911–929.

Hefti, R. (2011). Integrating Religion and Spirituality into Mental Health Care, Psychiatry and Psychotherapy. *Religions*, 2, 611–627.

Hill, P. C., & Pargament, K. L. (2003). Advances in the conceptualization and

measurement of religion and spirituality. Implications for physical and mental health research. *American Psychologist, 58(1),* 64-74.

Israel, B, A., Eng, E., Schulz, A.J., & Parker, E.A. (2005). *Methods in Community-Based Participatory Research for Health.* Jossey-Bass; San Francisco.

Johannessen-Henry, C. T., Deltour, I., Bidstrup, P. E., Dalton, S. O., & Johansen, C. (2013). Associations between faith, distress and mental adjustment- A Danish survivorship study. *Acta Oncologica, 52,* 364-371.

Kalkstein, S., & Tower, R. B. (2009). The Daily Spiritual Experiences Scale and well-being: Demographic comparisons and scale validation with older Jewish adults and a diverse Internet sample. *Journal of Religious Health. 48, 402–417*

Kennedy, G. A., Macnab, F. A., & Ross, J. J. (2015). The effectiveness of spiritual/religious interventions in psychotherapy and counselling: a review of the recent literature. *Melbourne: PACFA.*

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. New York, NY, US: Oxford University Press.

Koenig, H.G. (2008). Concerns about measuring "spirituality" in research. *Journal of Nerv Mental Disorders. 196,* 349–355.

Koenig, H.G. (2001). Religion and medicine II: Religion, mental health, and related

behaviours. *International Journal of Psychiatry in Medicine*, 31, 97-109.

Koenig, H.G., King, D.E., & Carson, V.B. (2012). *Handbook of Religion and Health*. 2nd edition. New York, NY, USA: Oxford University Press

Koenig, H. G. (2012). Religion, spirituality, and health: the research and clinical implications. *ISRN psychiatry*, 2012, 278730.

Labbé, E. E., & Fobes, A. (2010). Evaluating the interplay between spirituality, personality and stress. *Applied Psychophysiology and Biofeedback, 35,* 141-146.

Lee, Y. H., & Salman, A. (2016). Evaluation of using the Chinese version of the Spirituality Index of Well-Being (SIWB) Scale in Taiwanese elders. *Applied Nursing Research*, 32206–32211.

Loustalot, F. V., Wyatt, S. B., Boss, B., & May, W., McDyess, T. (2006). Psychometric examination of the Daily Spiritual Experiences Scale. *Journal of Cultural Diversity*, 13(3), 162-167.

Luna, N., & MacMillan, T. (2015). The relationship between spiritual experience and depressive symptom severity, psychosocial functioning impairment, and quality of life: Examining the impact of age, gender, and ethnic differences. *Mental Health, Religion & Culture, 18(6),* 513-525.

Ma, S.Y. (2003). The Christian college experience and the development of spirituality

among students. *Christian Higher Education, 2*, 321-339.

Marcus, M., Yasamy, M.T., Van Ommeren, M., Chisholm, D., & Saxena, S. (2012). Depression A Global Public Health Concern. *WHO Department of Mental Health and Substance Abuse*, 1, 6-8.

Maslow, A. (1970). *Religions, Values, and Peak-Experiences*. New York: Viking Press.

Maslow, A. H. (1971). *The Farther Reaches of Human Nature*. New York: Esalen Books.

Mayhew, M. J., Bowman, N., & Rockenbach, A. B. (2014). Silencing whom? Linking campus climates for religious, spiritual, and worldview diversity to student worldviews. *The Journal of Higher Education, 85*, 219-242.

McGee, M., Nagel, L., & Moore, M. K. (2003). A study of university classroom strategies aimed at increasing spiritual health. *College Student Journal, 37*, 583-594.

McSherry, W. & Jamieson, S. (2010). 'An online survey of nurses' perception of spirituality and spiritual care, *Journal of Clinical Nursing, 20*, 1757–1767.

Mills, P., Wilson, K., Iqbal, N., Iqbal, F., Alvarez, M., Pung, M., & Redwine, L. (2015). Depressive symptoms and spiritual wellbeing in asymptomatic heart failure patients. *Journal of Behavioral Medicine, 38(3),* 407–415.

Moallemi, S., Bakhshani, N. M., & Raghibi, M. (2011). On the relationship between mental health, spiritual intelligence and dysfunctional attitudes in students of Systan and Baluchestan University, Southeast of Iran. *Journal of fundamentals of Mental Health, 12(4),* 702-709.

Morris, J. E. (1980). Humanistic psychology and religion: Steps toward reconciliation. *Journal of Religion and Health, 19(2),* 92-102.

Morris, J. M., Smith, A. B., & Cejda, B. D. (2003). Spiritual Integration as a predictor of persistence at Christian institutions of higher education. *Christian Higher Education, 2,* 341-351.

Moss, D. (2002). Psychological perspectives: Anxiety disorders: Identification and intervention. In B. Horowitz (Ed.), Communication apprehension: Origins and management (pp. 74-113). San Diego, CA: Singular/ Thomson Learning.

Murray, Evan D.; Cunningham, Miles G.; Price, Bruce H. (September 2011). "The Role of Psychotic Disorders in Religious History Considered". *Journal of Neuropsychiatry and Clinical Neurosciences, 24(4),* 410–426.

Nieuwenhuijsen, K., de Boer, A. G., Verbeek, J. H., Blonk, R. W., & van Dijk, F. J. (2003). The Depression Anxiety Stress Scales (DASS): detecting anxiety disorder and depression in employees absent from work because of mental health

problems. *Occupational and environmental medicine, 60 Suppl 1(Suppl 1),* 77–82.

Ola, M. (2016). Impact of Spirituality on Depression, Anxiety and Stress of Students Preparing for Competitive Exams, *International Journal of Indian Psychology, 3(3), 11*.

Paredes-Collins, K. (2014). Campus climate for diversity as a predictor of spiritual development at Christian colleges. *Religion & Education, 41,* 171- 193.

Oncologica, 52, 364-371.

Pargament K.I (1997). *The psychology of religion and coping: Theory, research, practice*. New York: Guilford.

Pargament, K. I., Mahoney, A., Exline, J., Jones, J., & Shafranske, E. P. (2013). Envisioning an integra-tive paradigm for the psychology of religion and spirituality. In K. I. Pargament (Ed.) *APA hand-book of psychology, religion, and spirituality: Vol. 1. Context, theory, and research* (pp. 3–19). Washington, DC: American Psychological Association.

Patel, C., & Shikongo, A. (2006). Handling Spirituality/Religion in Professional Training: Experiences of a Sample of Muslim Psychology Students. *Journal of Religion and Health, 45,* 93-112.

Patten, T. A., & Rice, N. D. (2009). Religious minorities and persistence at a systemic religiously affiliated university. *Christian Higher Education, 8(1)*, 42-53.

Peselow, E., Pi, S., Lopez, E., Besada, A., & Ishak, W. W. (2014). The impact of spirituality before and after treatment of major depressive disorder. *Innovations in Clinical Neuroscience, 11(3/4)*, 17-23.

Peterson, J., Atwood, J.R, Yates, B. (2002). Key elements for church-based health promotion programs: outcome-based literature review. *Public Health Nurs*. 19(6), 401–11.

Pew Research. (2012).The global religious landscape (2012, December). Retrieved from *http://www.pewforum.org/2012/12/18/global-religious-landscape-exec/*.

Piotrowski, N. P., & Hollar, D. P. (2014). Stress. *Magill's Medical Guide (Online Edition)*.

Pitt, A., Oprescu, F., Tapia, G., & Gray, M. (2017). An exploratory study of students' weekly stress levels and sources of stress during the semester. *Active Learning in Higher Education*, 19(1), 61-75.

Plante, T.G., & Sherman, A.C. (2001). *Research on faith and health.* New approaches to old questions. In: T.G. Plante & A.C. Sherman (eds.), Faith and health: Psychological perspectives (New York: Guilford), p. 13.

Propst, L. R. (1996). Cognitive-behavioral therapy and the religious person. In E. P. Shafranske (Ed.). *Religion and the clinical practice of psychology* (pp. 391-407).Washington, DC: American Psychological Association.

Pillay, N., Ramlall, S., & Burns, J.K. (2016). Spirituality, depression and quality of life in medical students in KwaZulu-Natal. *South African Journal of Psychiatry, 22*(1), a731.

Rayburn, C.A. (2004). Religion, spirituality, and health. *American Psychologist*. 59, 52-53.

Rentala, S., Lau, B. P. H., & Chan, L. C. (2017). Association between spiritual experience and depression among depressive disorder patients in India. *Journal of Spiritual experience in Mental Health, 19 (4)*, 318-330.

Rockenbach, A. B., & Mayhew, M. J. (2014). The campus spiritual climate: Predictors of satisfaction among students with diverse worldviews. *Journal of College Student Development, 55,* 41-62.

Rockenbach, A. N., Mayhew, M. J., & Bowman, N. A. (2015). Perceptions of the campus climate for nonreligious students. *Journal of College Student Development, 56*, 181-186.

Ribeiro, Í.J.S., Pereira, R., Freire, I.V., de Oliveira, B.G., Casotti, C.A. & Boery, E.N.

(2018). Stress and Quality of Life among University Students: A Systematic Literature Review, *Health Professions Education, 4(2),* 70-77.

Shahsavarani, A. M., Ashayeri, H., Lotfian, M., & Sattari, K. (2013). The effects of Stress on Visual Selective Attention: The Moderating Role of Personality Factors. *Journal of American Science,* 9(6s): 1-16

Shorkey, C., Uebel, M., & Windsor, L. C. (2007). Measuring dimensions of spirituality in chemical dependence treatment and recovery: Research and practice. *International Journal of Mental Health and Addiction, 6, 286-305.*

Snodgrass, J., & Sorajjakool, S. (2011). Spiritual experience in older adulthood: Existential meaning, productivity, and life events. *Pastoral Psychology, 60(1),* 85-94.

Southwick, S. M., Vythilingam, M., & Charney, D. S. (2005). The psychobiology of depression and resilience to stress: Implications for prevention and treatment. *Annual Review of Clinical Psychology, 1,* 255-291.

Speers, S. (2008). The secular thesis revisited: Religious life on the secular college campus today. *Journal of College and Character, 10*, 1-11.

Stewart, C., Koeske, G. F., & Koeske, R. D. (2006) Personal religiousness and

spirituality associated with social work practitioners' use of religious-based intervention practices. *Journal of Religion & Spirituality in Social Work: Social Thought, 25(1),* 69-85.

Syed, A., Ali, S.S. & Khan, M. (2018).Frequency of depression, anxiety and stress among the undergraduate physiotherapy students. *Pak J Med Sci, 34(2),* 468-471.

Taheri-Kharameh. Z., Abdi, M., Omidi Koopaei, R., Alizadeh, M., Vahidabi, V., & Mirhoseini. H. (2016). Investigating the Relationship between Communication and collaboration of Nurses with Physicians from Nurses` Point of view in Neyshabur Hospitals. *Health Spiritual Med Ethics, 3 (1),* 30-35.

Tran, T., Tran, T., & Fisher, J. (2013). Validation of the depression anxiety stress scales (DASS) 21 as a screening instrument for depression and anxiety in a rural community-based cohort of northern Vietnamese women. *BMC psychiatry*. 13. 24.

Tuck, I., Alleyne, R., & Thinganjana, W. (2006). Spirituality and stress management in healthy adults. *Journal of Holistic Nursing, 24,* 245-255.

Valero, A., & Van Reenen, J. (2016). *The economic impact of Universities: Evidence from across the globe (No. w22501).* National Bureau of Economic Research.

Van Rensburg, A. J., Myburgh, C., & Szabo, C.P. (2013). Poggenpoel M. The role of spirituality in specialist psychiatry: A review of the medical literature. *African Journal of Psychiatry, 16 (4*), 247–55.

Vitasari, P., Wahab, M.N.A., Othman, A., & Awang, M.G. (2010). A research for identifying study anxiety sources among University students. *International Education Studies, 3(2),* 189-196.

Worthington, E. L., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., Berry, J. W., Schmitt, M. M., Berry, J. T., Bursley, K. H., & O'Conner, L. (2003). The religious commitment inventory-10: Development, refinement, and validation of a brief scale for research and counseling. *Journal of Counseling Psychology, 50,* 84-96.

Worthington, E. L. (1988). Understanding the values of religious clients: A model and its application to counseling. *Journal of Counseling Psychology, 35,*166-174.

Zinnbauer, B. J., & Pargament, K. I. (2005). Religiousness and spirituality. In R. Paloutzian & C.Park (Eds.), *Handbook of the psychology of religion and spirituality* (21-42). New York: Guilford Press.

APPENDICES

APPENDIX A

Ethical Clearance Certificate & Permission Letter

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: FHSS /555/2020 **Date: 6 February, 2020**

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: An Examination Of The Relationship Between Spiritual Experience And Stress, Anxiety And Depression Of Students At The University Of Namibia Main Campus: A Comparative Approach

Researcher: Natasja Kudzai Magorokosho

Student Number: 200969056

Supervisor: Dr. A Shikongo

Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
(d) The ADREC retains the right to:

(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
(ii) Request for an ethical compliance report at any point during the course of the research.

HREC wishes you the best in your research.

Dr. J.E de Villiers : UREC Chairperson

Ms. P. Claassen: UREC Secretary

CENTRE FOR POSTGRADUATE STUDIES

University of Namibia, Private Bag 13301, Windhoek, Namibia
340 Mandume Ndemufayo Avenue, Pioneers Park
☎ +264 61 206 3275/4662; Fax +264 61 206 3290; URL: http//www.unam.edu.na

UNAM
UNIVERSITY OF NAMIBIA

RESEARCH PERMISSION LETTER

Student Name: Natasja Kudzai Magorokosho

Student number: 200969056

Programme: MASTER OF ARTS IN (CLINICAL PSYCHOLOGY)

Approved research title: AN EXAMINATION OF THE RELATIONSHIP BETWEEN SPIRITUAL EXPERIENCE AND STRESS, ANXIETY AND DEPRESSION OF STUDENTS AT THE UNIVERSITY OF NAMIBIA

TO WHOM IT MAY CONCERN

I hereby confirm that the above mentioned student is registered at the University of Namibia for the programme indicated. The proposed study met all the requirements as stipulated in the University guidelines and has been approved by the relevant committees.

Permission is hereby granted to carry out the research as described in the approved proposal.

Best Regards

27 September 2019

Prof. Marius Hedimbi

Director: Centre for Postgraduate Studies

Tel: +264 61 2063275

E-mail: directorpgs@unam.na

Centre for Postgraduate Studies
Office of the Director
2019 -09- 27
University of Namibia
UNAM

APPENDIX B

Consent Form &Demographic Questionnaire

INFORMED CONSENT

Dear Participant,

I am a master student under the direction of Dr. A. E.E Shikongo in the Department of Psychology at the University of Namibia – Main Campus. I invite you to participate in a research study, entitled **AN EXAMINATION OF THE RELATIONSHIP BETWEEN SPIRITUAL EXPERIENCE AND STRESS, ANXIETY AND DEPRESSION OF STUDENTS AT THE UNIVERSITY OF NAMIBIA MAIN CAMPUS**

BENEFITS: If you choose to participate in this study, results will provide important information to professionals working in the area of mental health.

CONDITIONS OF PARTICIPATION: Your participation will involve completing two questionnaires and will take about +-15 minutes. Your involvement in the study is voluntary. Furthermore, you may discontinue participation at any time without penalty.

CONFIDENTIALITY: This questionnaire is anonymous. The results of this study might be published, but your name will not be linked to responses in publications that are released from this project. Therefore, there is no need for you to provide your student number. In fact, the published results will be presented in summary form only. All information you provide will remain confidential. If you have understood the information discussed with you and you agree to participate in the study may you provide your signature in spaces provided below.

Signature:……

Date……...

Thanks for your consideration!

Sincerely,

Natasja Magorokosho
Department of Human Sciences: Psychology
University of Namibia, 0814973639

Socio-Demographic Questionnaire (SDQ)

Many people tend to resort to their religion/ spirituality as a way to cope with life problems. In order to learn more about ways that different people cope with depression, anxiety and stress. The information you provide will be used to gain more information about people in general and will not be used to identify you in any way. Please respond to all items.

Instructions: *Please **tick** in the appropriate box for each item***:**

1. Gender: ☐ Male ☐ Female

2. Age category:
   - ☐ 18-25
   - ☐ 26-35
   - ☐ 36-40
   - ☐ 41-50+

3. Marital status:
   - ☐ Married
   - ☐ Single
   - ☐ Divorced
   - ☐ Widow/ Widower

4. Year of study:
   - ☐ 1st Year
   - ☐ 2nd Year
   - ☐ 3rd Year
   - ☐ 4th Year
   - ☐ Postgraduate

APPENDIX C

Depression Anxiety Stress Scale (DASS-21)
Developed by Lovibond & Lovibond (1995

DASS 21				
Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There is no right or wrong answers. Do not spend too much time on any statement. The rating scale is as follows: 0 Did not apply to me at all 1 Applied to me to some degree, or some of the time 2 Applied to me to a considerable degree, or a good part of time 3 Applied to me very much, or most of the time				
1. I found it hard to wind down/ relax	0	1	2	3
2. I was aware of dryness of my mouth	0	1	2	3
3. I couldn't seem to experience any positive feeling at all	0	1	2	3
4. I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5. I found it difficult to work up the initiative to do things	0	1	2	3
6. I tended to over-react to situations	0	1	2	3
7. I experienced trembling (e.g., in the hands)	0	1	2	3
8. I felt that I was using a lot of nervous energy	0	1	2	3
9. I was worried about situations in which I might panic and make a fool of myself	0	1	2	3

10. I felt that I had nothing to look forward to	0	1	2	3
11. I found myself getting agitated / irritated	0	1	2	3
12. I found it difficult to relax	0	1	2	3
13. I felt down-hearted and blue	0	1	2	3
14. I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15. I felt I was close to panic	0	1	2	3
16. I was unable to become enthusiastic about anything	0	1	2	3
17. I felt I wasn't worth much as a person	0	1	2	3
18. I felt that I was rather touchy	0	1	2	3
19. I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20. I felt scared without any good reason	0	1	2	3
21. I felt that life was meaningless	0	1	2	3

APPENDIX E

Daily Spiritual Experience Scale (DSES)

Developed by Underwood & Teresi (2002)

The list that follows includes items you may or may not experience. Please consider how often you directly have this experience, and try to disregard whether you feel you should or should not have these experiences. A number of items use the word 'God.' If this word is not a comfortable one for you, please substitute another word that calls to mind the divine or holy for you

Many times, a day	Every day	Some days	Once in a while	Never
1	2	3	4	5

Please **circle** the appropriate number (only one) for each statement:

1. I feel God's presence.	1	2	3	4	5
2. I experience a connection to all of life.	1	2	3	4	5
3. During worship, or at other times when connecting with God, I feel joy which lifts me out of my daily concerns.	1	2	3	4	5
4. I find strength in my religion or spirituality.	1	2	3	4	5
5. I find comfort in my religion or spirituality.	1	2	3	4	5
6. I feel deep inner peace or harmony.	1	2	3	4	5

7. I ask for God's help in the midst of daily activities.	1	2	3	4	5
8. I feel guided by God in the midst of daily activities.	1	2	3	4	5
9. I feel God's love for me, directly.	1	2	3	4	5
10. I feel God's love for me, through others.	1	2	3	4	5
11. I am spiritually touched by the beauty of creation.	1	2	3	4	5
12. I feel thankful for my blessings.	1	2	3	4	5
13. I feel a selfless caring for others.	1	2	3	4	5
14. I accept others even when they do things I think are wrong.	1	2	3	4	5
15. I desire to be closer to God or in union with the divine	1	2	3	4	5

16. In general, how close do you feel to God?	Not at all	Somewhat close	Very close	As close as possible
	1	2	3	4

NB: For those who indicated **NEVER (5)** in the above statements please indicate how you normally cope with depression, anxiety and stress in the space provided below:

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……