Pakistan Languages and Humanities Review
www.plhr.org.pk

RESEARCH PAPER

Multiple Capitals as Predictors of Positive Mental Health in Faith Groups

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DOI http://doi.org/10.47205/plhr.2022(6-II)62

PAPER INFO

Received:
February 28, 2022
Accepted:
June 10, 2022
Online:
June 12 , 2022

Keywords:
Faith Groups,
Mental Health,
Psychological Capital,
Religiosity Capital,
Social Capital

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ABSTRACT

The current study examined the effect of multiple capitals including psychological, social and religiosity capital on positive metal health of faith groups. Moreover, the differences on study variables were investigated in faith groups. Purposive sample of Muslim, Christian, Hindu and Sikh adults (*N* = 300) were approached to collect information through Personal Social Capital Scale, Multidimensional Capitals Questionnaire and Positive Mental Health Scale. Multiple Regression analysis revealed positive effect of multiple capitals on positive mental health of faith groups. Hierarchical Regression analysis identified psychological capital as the most prominent positive predictor of positive mental health. Finally, while investigating the mean differences in faith groups on multiple capitals and positive mental health, mix findings were found. However, Christian exhibited better social-religiosity capital and positive mental health rather than Muslims, Hindus and Sikhs.

Introduction

Multidimensional capitals influence mental health in various ways. Systematic reviews of various studies shows that social capital positively predicts mental health (Hamano et al., 2010). Psychological capital is the person's mental state of development (Luthans et al., 2007) and it was found to strengthen person's mental health and improve work efficiency (You, 2016). Religious capital comprises of the degree of dominance of and connection to a specific devout culture (Finke, 2003). Religiosity capital including religious faiths and religious practices was found effective in improving mental health. Literature shows positive relationship of the multidimensional capitals and mental health, these capitals tend to improve the mental health of faith groups. Goal of the study is to enlighten the effect of these capitals in improving mental health of individuals residing in different faith groups. Study aimed to examine the multidimensional capitals as predictors of mental health in faith groups. Moreover, demographic differences (age, gender, education and faith groups) were also considered on individuals of different faith groups.

Literature Review

Literature shows the strong connection between social capital and mental health. Social capital has the potential of improving mental health and lessen the effects of mental illness. Furthermore, mental health promotion has the ability to increase social capital in a variety of ways, with societal and community-level effects. At the communal level, mental health advancement can offer assistance to form connections between wellbeing and social capital, which can impact conduct and benefit conveyance by upgrading person mental characteristics and progressing interpersonal connections. Each form of social capital is associated with psychological processes that impact mental health (De Silva et al., 2005). Bonding social capital offers feelings of stability, predictability, belonging, and comfort, all of which can be beneficial to mental wellbeing (Kawachi & Berkman, 2000).

Social capital is thought to improve mental health by allowing knowledge sharing between social groups and access to external assets, as well as expanding the circle of trust and allowing for social mobility. Previous research has found an inverse association between psychological distress and the cognitive aspect of social capital bridging. The little number of ponders on social capital and mental health are inclined to the restrictions said prior, and have delivered blended comes about. Various analysts have found that social capital features a defensive effect on mental wellbeing. All the elements of social capital, such as a sense of believe or neighborhood solidarity, are judged to act similarly, or on the off chance that a few have more control than others, is obscure. An increase in social capital promotes mental wellbeing, and mental health promotion and change (as well as effective treatment of mental disorders) lead to social capital development (Sartorius, 2003).

A positive psychological outlook, based on positive psychology literature, may improve mental health and well-being (Seligman & Csikszentmihalyi, 2000). Psychological capital (PsyCap), which is based on positive thinking, can be used as a personal resource to improve mental health. The emphasis of PsyCap is on "who you are" and "what you are becoming" (Luthans et al., 2007). Positive associations between well-being and PsyCap (Culbertson et al., 2010), as well as other essential work attitudes, behaviours, and results, were sought (Avey et al., 2010). Psychological capital (PsyCap) has been discovered to be a valuable resource for coping with stress (Wen, 2014).

Psychological capital proves to be an important source of improved mental health among individuals. The four components HERO of PcyCap helps the individuals to cope up with stressors and improve their mental conditions. Psychological capital is a positive cognitive source that positively predicts mental health. PsyCap is a construct that consists of four component tools that can predict target attainment and results by reflecting "one's optimistic assessment of circumstances and likelihood of achievement based on persuaded exertion and tirelessness" (Luthans et al., 2007). High levels of PsyCsp have been found to positively influence mental health. The link between psychological capital and individual well-being has previously been identified, implying that the production of PsyCap can aid in better well-being (Avey et al., 2011; Krasikova et al., 2015). Krasikova et al., (2015) found that psychological capiatal has a positive impact on an individual's mental health. Furthermore, researchers (Krasikova et al., 2015) discovered that PsyCap plays a predictive role in constructive mental health.

People who are tolerably or emphatically committed to a devout confidence have a more noteworthy proclivity to make positive self-concepts, self-esteem, and a more noteworthy capacity to fight off mental and enthusiastic weights, such as moderating psychopathological practices and emphatically influencing positive health (Danquah, 2018). Religiosity was emphatically related to enormous measures of mental well-being. Be that as it may, no generally prove was found for a relationship between religiosity and the anticipation of major clinical disarranges (Payne et al., 1991). Multiple psychological resources in adults refer to a certain "capital". After the rise of positive psychology some two decades before, the concept of "capital" became popular. One such important capital is social capital which is reported to have consistent direct positive effects on the mental health of adults (Seligman & Csikzentmihalyi, 2001). It is worth mentioning that the effect of social capital on mental health is not only direct but it also has indirect effects on mental health. Thus, Multidimensional Capitals Model indicates that social capital leads towards psychological capital which than influences mental health (Basset & Moore, 2013). In this pathway, the social capital effects mental health through psychological capital. Another important indirect effect of social capital is through religiosity capital. In this pathway, the social capital develops religiosity capital (Yeary et al., 2012) which then lead towards mental health (Shapiro & Sharony, 2018) as consistent evidences are available on religion-health dichotomy. Pakistan is a collectivist culture (Mustafa, 2005), in which social capital has more importance as the social structure of society also endorses development and positive use of social capital. Moreover, adults from faith groups were included in the study as religiosity capital was one of the important variables in the study which is applicable to all faith groups and secondly the residents of Pakistan belong to several faith groups including Islam, Christianity, Hinduism and Sikhism. The inclusion of religiosity capital in the present study was further extended to religious beliefs and practices. Thus, a research question what effects mental health more; religious beliefs or practices, was also taken into consideration.

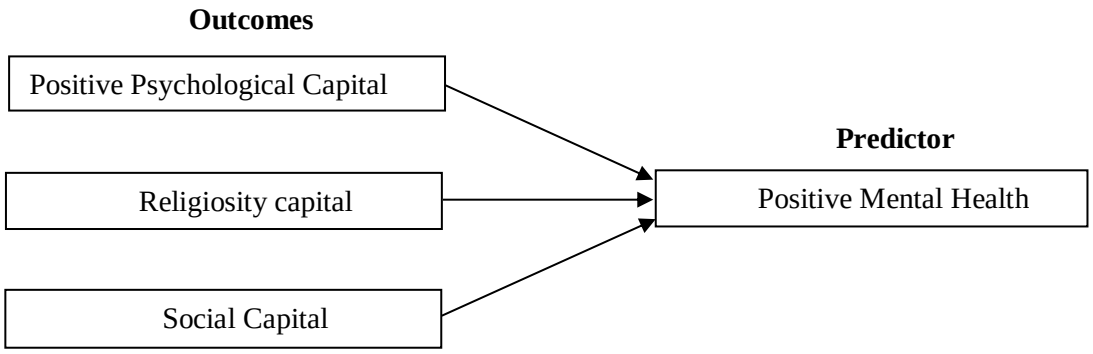

Figure 1 Conceptual Framework

Material and Methods

The present study aimed to examine the impact of multiple capitals including religiosity capital, positive psychological capital and social capital on positive mental health of faith groups in Pakistan.

Sample

In the present study a sample of individuals (N = 300) ranging from 18-42 years (M = 1.43, SD = 0.76) was collected from adolescents and adults residing in the families of the different faith groups. The major research question was based on the role of multiple capitals in the positive mental health. In the multiple capitals an important construct was religiosity capital which is based on the shared set of beliefs and practices across the faith groups. Thus, the members of prominent faith groups including Muslims, Christians, Sikh and Hindus were included in the study. Moreover, prior studies conducted in the indigenous context has mostly focused Muslim and Christian faith groups. However, the present study here included all the important faith groups residing in Pakistan which make it more comprehensive. Power analysis through g-power confirmed that the sample size was adequate for conducting analysis in the present study. The sample was collected from Pakistan. The 300 individuals were further divided into Muslims (n = 239, 79%), Christians (n = 30, 10%), Hindu (n = 14, 5%) and Sikh (n = 17, 6%). Greater number of girls (n = 186, 62%) as compared to boys (n = 114, 62%) participated in the study. Greater number of adolescents (n = 203, 67.7%) as compared to young adults (n = 98, 32.3%) participated in the study. Frequency of MA / MSc / BS / MBA (n = 238, 79.3%) were greater than MS / MPhil / PhD (n = 39, 13%) and BA / BSc (n = 23, 7.7%). Thus, a total sample of 300 individuals from different faith groups participated in the study. Purposive sampling technique was used in the study. The members of four faith groups including Islam, Christianity, Hinduism and Sikhs were the prominent residents of Pakistan. Moreover, only adult members of the faith groups were included in the sample. Members of the faith groups belonging to the foreign countries and Pakistani nationals of other age groups were excluded from the sample. The illiterate members of the faith groups were also excluded from the sample.

Instruments

Religiosity Capital Scale

This scale was developed by Asghar (2016). Scale was given in Urdu version. The scale was designed to measure religiosity in adults. The scale can be used for all faith groups. This scale includes 20 items and has 2 subscales including 11 items on religious practices and 9 items on religious beliefs. Religiosity capital scale is based on positively coded statements such as "I go to religious places for worship" for religious practices and "I support people from my religion in elections" for religious beliefs. This a 5-point rating scale with response categories including strongly disagree = 1, disagree = 2, neutral = 3, agree = 4 and strongly agree = 5. Minimum and maximum scores of the scale are 20 and 100 respectively. Minimum and maximum scores for religious practices are 11 and 55 respectively while 9 and 45 respectively. All the items of the scale are positively worded. Reliability of scale was 0.85 (0.81 for religious practices and 0.78 for religious beliefs). Its factorial and convergent validity was found.

Multidimensional Capital Questionnaire

This scale was developed by Malik & Riaz (2018). The scale was given in English version. This scale consists 19 items and four subscales that measures economic, human, social and psychological capital in adults. Two subscales including

social and psychological capital were used in the study, each comprises 5 items. Positive statements were used in the scale such as "I have enough money to fulfil all my needs and requirements" for social capital and "I am always optimistic about my future" for psychological capital. It is 5-point likert type scale with response categories including strongly disagree = 1, disagree = 2, neutral = 3, agree = 4 and strongly agree = 5. Minimum and maximum scores are 19 and 95 respectively. Reliability of the social and psychological scale is 0.77 and 0.80 respectively. The authors established factorial, convergent and discriminant validity.

Personal Social Capital Scale

This scale was developed by Chen et al. (2009). This scale was specially outlined for use in survey studies to assess personally owned social capital. This scale can be used on different residents and age ranged from early to late adulthood. The scale consists of 10 blended items based on 42 subitems for assessing personally owned social capital, including bonding and bridging capitals. A five-point Likert scale was used to assess these questions with 1 = none and 5 = all. Minimum and maximum scores of scales are 42 and 210 respectively. The mean scores were 25.9 (SD = 5.2) for total social capital, 15.2 (SD = 3.0) for bonding social capital and 10.8 (SD = 3.4) for bridging social capital. The assessed Cronbach alphas were 0.87 for the overall scale, 0.85 for the bonding capital subscale, and 0.84 for the bridging capital subscale. Results of correlation and confirmatory factor analysis indicated appropriate reliability and internal consistency.

Positive Mental Health Scale

The PMH-scale was initially created by Lukat-Piron et al. (2016) in order to provide a person centered, brief and uni-dimensional instrument to assess positive mental health. PMH-scale was developed to evaluate positive mental health (Lukat et al., 2016) ranging age from 15-65 years. The scale consists of 9 Likert-type items. The scale is based on 4-point likert scale with response categories including strongly disagree = 1, disagree = 2, agree = 4 and strongly agree = 5. The descriptive statements of the scale include "All in one, I am satisfied with my life", "I feel that I am actually well equipped to deal with life and its difficulties" and other related statements. Minimum and maximum scores of the scale are 9 and 36 respectively. All the items of scales are positively coded. Cronbach alpha for this scale is reported as 0.7. Reliability of the scale is .81. Scale has good convergent and discriminant validity. The scale was used in the present study on the basis of written permission from the authors of scale through E-mail.

Ethical Considerations

Ethical principles of psychological research were followed in the present study. Firstly, the research proposed was reviewed by the departmental Board of Studies (BoS) and the BoD allowed to conduct this study with any observations regarding the violation of ethical codes of conduct. Secondly, the anonymity of the participants' identities was ensured by giving them opinion to either to disclose or not disclose their identities. Thus, mentioning their names was optional. Thirdly, not only the participants were ensured regarding the confidentiality of information but the data was kept under lock and key and not shared with any irrelevant person. Fourthly, the participants were given the right to withdraw the information at any

stage and they were requested to sign informed consent. Participants were informed (provided complete information about research) and they were asked to give consent (written willingness). Finally, the research was deception free.

Results

The present study aimed to examine the effect of multiple capitals on positive mental health of faiths groups in Pakistan.

Table 1
Psychometric Properties of Scales

Scales	M	SD	Range	Cronbach's α
Social Capital Subscale of MCQ	15.88	2.87	6-20	.80
Psychological Capital Subscale of MCQ	15.99	3.02	4-20	.83
Religious Practices Subscale of RCS	31.42	4.89	17-40	.83
Religious Beliefs Subscale of RCS	38.62	6.42	20-48	.86
Religiosity Capital Scale (RCS)	70.04	10.07	42-88	.90
Positive Mental Health Scale	28.03	5.69	9-36	.91

Note. MCQ = Multidimensionnel Capitals Questionnaire

Table 1 shows psychometric properties for the scales used in the present study. The Cronbach`s a value for index of Social Capital Subscale of MCQ, Psychological Capital Subscale of MCQ, Religious Practices Subscale of RCS, Religious Beliefs Subscale of RCS, Religiosity Capital Scale (RCS) and Positive Mental Health Scale were .80, .83, .83, .86, .90 and .91 (> .80) which indicated high reliability of all scales administered on faith groups.

Table 2
Pearson Correlation in Variables

Variables	1	2	3	4	5	6
1. Social capital	-	.66***	.45***	.45***	.51***	.57***
2. Psychological capital		-	.48***	.45***	.52***	.62***
3. Religious practices			-	.58***	.85***	54***
4. Religious beliefs				-	.91***	.51***
5. Religiosity capital					-	.59***
6. Positive mental health						-

***$p < .001$.

Table 2 indicates correlations between variables. Results show that social capital has positive correlation with psychological capital ($r = .66$, $p < .001$), religious practices ($r = .45$, $p < .001$), religious beliefs ($r = .45$, $p < .001$), religiosity capital ($r = .51$, $p < .001$) and positive mental health ($r = .57$, $p < .001$). Psychological capital has positive correlation with religious practices ($r = .48$, $p < .001$), religious beliefs ($r = .45$, $p < .001$), religiosity capital ($r = .52$, $p < .001$) and positive mental health ($r = .62$, $p < .001$). Religious practices have positive correlation with religious beliefs ($r = .58$, $p < .001$), religiosity capital ($r = .85$, $p < .001$) and positive mental health ($r = .54$, $p < .001$). Religious beliefs have positive correlation with religiosity capital ($r = .91$, $p < .001$) and positive mental health ($r = .51$, $p < .001$). Religiosity capital has positive correlation with positive mental health ($r = .59$, $p < .001$).

Table 3
Hierarchical Regression Showing Effect Multiple Capitals on the Positive Mental Health of Faith Groups

Variable	*B*	95%CI	*SE B*	β	R^2	ΔR^2
Step 1					.39	.39***
Constant	9.15***	[6.42, 11.87]	1.38			
Psychological capital	1.18***	[1.01, 1.35]	0.09	.63***		
Step 2					.48	.09***
Constant	0.65	[-2.75, 4.24]	1.73			
Psychological capital	0.83***	[0.64, 1.01]	0.09	.44***		
Religiosity capital	0.20***	[0.14, 0.26]	0.03	.36***		
Step 3					.50	.02**
Constant	-0.47	[-3.89, 2.95]	1.73			
Psychological capital	0.64***	[0.43, 0.86]	0.10	.34***		
Religiosity capital	0.18***	[0.13, 0.24]	0.02	.32***		
Social capital	0.35***	[0.13, 0.57]	0.11	.18**		

**$p < .01$. ***$p < .001$.

Table 3 shows the impact of multiple capitals as predictors and positive mental health as outcome variable. In Step 1, the R^2 value of .63 revealed that the psychological capital explained 63% variance in the positive mental health of faith groups with F (1, 298) = 193.08, $p < .001$. The findings revealed that psychological capital positively predicted positive mental health of faith groups (β = .63, $p < .001$). In Step 2, the R^2 value of .48 revealed that psychological capital and religiosity capital explained 48% variance in the positive mental health with F (2, 297) = 140.19, $p < .001$. The findings revealed that psychological capital (β = .44, $p < .001$) and religiosity capital positively predicted positive mental health of faith groups (β = .36, $p < .001$). In Step 3, the R^2 value of .50 revealed that psychological capital, religiosity capital and social capital explained 50% variance in the positive mental health with F (3, 296) = 99.53, $p < .001$. The findings revealed that psychological capital (β = .34, $p < .001$), religiosity capital (β = .32, $p < .001$) and social capital positively predicted positive mental health of faith groups (β = .18, $p < .01$). The ΔR^2 value of .09 revealed 9% change in the variance of model 1 and model 2 with ΔF (1, 297) = 53.37, $p < .001$. The ΔR^2 value of .02 revealed 2% change in the variance of model 2 and model 3 with ΔF (1, 296) = 9.85, $p < .01$. Findings revealed that psychological capital is the superlative predictor of positive mental health. Religiosity capital is the second important predictor of positive mental health in faith groups of Pakistan.

Table 4
Hierarchical Regression Showing Effect of Religious Practices and Beliefs on Positive Mental Health of Faith Groups

Variable	*B*	95%CI	*SE B*	β	R^2	ΔR^2
Step 1					.28	
Constant	8.41***	[4.85, 11.97]	1.81			
Religious practices	0.62***	[.51, .74]	0.06	.54***		
Step 2					.35	.07***
Constant	4.41*	[.70, 8.14]	1.89			
Religious practices	0.42***	[.29, .55]	0.07	.36***		
Religious beliefs	0.27***	[.17, .37]	0.05	.30***		

***$p < .001$.

Table 4 shows the impact of religious practices and beliefs as predictors and positive mental health as outcome variable. In Step 1, the R^2 value of .28 revealed that the religious practices explained 28% variance in the positive mental health of faith groups with F (1, 298) = 120.60, $p < .001$. The findings revealed that religious practices positively predicted positive mental health of faith groups ($\beta = .54$, $p < .001$). In Step 2, the R^2 value of .35 revealed that intrapersonal and interpersonal religiosity explained 35% variance in the positive mental health with F (2, 297) = 79.79, $p < .001$. The findings revealed that religious practices ($\beta = .36$, $p < .001$) and religious beliefs positively predicted positive mental health of faith groups ($\beta = .30$, $p < .001$). The ΔR^2 value of .07 revealed 7% change in the variance of model 1 and model 2 with ΔF (1, 297) = 28.04, $p < .001$. Findings revealed that religious practices are the superlative predictor of positive mental health.

Table 5
Mean, Standard Deviation and F-Values for Faith Groups on Variables

	Muslim		Christian		Hindu		Sikh					
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*	η^2	Post-Hoc
Social capital	15.61	2.86	17.47	2.61	15.64	3.10	17.17	2.16	5.18	.002	.05	1<2>3<4
Psychological capital	15.80	3.12	17.20	2.12	15.79	3.24	16.71	2.28	2.29	.079	.02	-
Religious practices	30.80	4.65	34.64	4.27	32.42	6.80	33.23	5.17	6.79	.000	.06	1<2>3<4
Religious beliefs	30.38	6.61	40.50	4.51	39.85	6.24	37.59	6.49	1.29	.278	.01	-
Religiosity capital	69.21	10.04	75.13	8.24	72.28	11.44	70.82	10.18	3.44	.017	.03	1<2>3>4
Positive mental health	27.59	5.75	30.57	4.53	28.71	5.62	29.41	5.72	2.97	.032	.03	1<2>3<4

Table 5 shows mean, standard deviation and F-values for faith groups on variables. Results indicated significant mean differences on social capital with F (3, 246) = 5.18, $p < .01$. The findings show that Christian scored higher on social capital (M = 17.47, SD = 2.61) as compared to Sikh (M = 17.17, SD = 2.16), Hindu (M = 15.64, SD = 3.10) and Muslim (M = 15.61, SD = 2.86). Results indicated non-significant mean differences on psychological capital with F (3, 246) = 2.29, $p > .05$. Results indicated significant mean differences on religious practices with F (3, 246) = 6.79, $p < .001$. The findings show that Christian scored higher on religious practices (M = 17.20, SD = 2.12) as compared to Sikh (M = 16.71, SD = 2.28), Muslim (M = 15.80, SD = 3.12) and Hindu (M = 15.79, SD = 3.24). Results indicated non-significant mean differences on religious beliefs with F (3, 246) = 1.29, $p > .05$. Results indicated significant mean differences on religiosity capital with F (3, 246) = 3.44, $p < .05$. The findings show that Christian scored higher on religiosity capital (M = 75.13, SD = 8.24) as compared to Hindu (M = 72.28, SD = 11.44), Sikh (M = 7082, SD = 10.18) and Muslim (M = 69.21, SD = 10.04). Results indicated significant mean differences on positive mental health with F (3, 246) = 2.97, $p < .05$. The values of η^2 revealed small effect size for all variables (< .20). Post-Hoc comparisons further between group mean differences on social capital, religious practices, religiosity capital and positive mental health.

Discussion

The present study is based on the impact of multidimensional capital on mental health of faith groups. Different capitals including psychological capital, social capital and religiosity capital were present in the current study. Religiosity capital is categorized in religious beliefs and religious practices which positively

predicts mental health of individuals. In an effort to test these hypotheses, the study was conducted in Pakistan in faith groups including Muslims, Sikh, Hindu and Christian. Moreover, mediation of psychological capital and religiosity capital was found between social capital and positive mental health.

The hypothesis "Social capital is likely to positively predict positive mental health of faith groups in Pakistan" was confirmed in the study. The results indicate that social capital has an effect on mental health at the ecological level. Promoting social capital will help the individuals to improve their mental health (Hamano et al., 2010). A negative relationship between social capital and mental illness was found, as were composite measures of social capital and ordinary mental disorders. It is difficult to understand that which component of social capital causes better health, but investigates appear that social capital leads to positive mental wellbeing. Social mental ponders has appeared that people who distinguish with different bunches have way better somatic and mental wellbeing results (Cruwys et al., 2013; Jones & Jetten, 2011) and alter way better to basic life occasions (Iyer et al, 2009). There are scarcity of Social Capital mediations examining the impact on mental wellbeing results. This ponder appeared that both SC scores and mental wellbeing results progressed over time but there was small prove of advantage compared to control bunches within the long term (Flores et al., 2017).

The hypothesis " Positive psychological capital is likely to positively predict positive mental health of faith groups in Pakistan" was supported in the study. Researches has shown that positive mental health is closely associated with Psychological Capital as well as various components of Psychological Capital (Culbertson et al., 2010). It was observed that psychological capital will mitigate the effects of stress on mental well-being. In this way, psychological capital was found to be positively correlated with mental well-being (Nafees & Jahan, 2017). Positive psychological capital brings quality of life in people of faith groups that leads to improved mental health. Study indicated that psychological capital and its dimensions such as hope, optimism, resilience and efficacy resulted in positive mental health. A strong positive relationship between PsyCap and mental health (Munawer et al., 2021). PsyCap features a critical positive impact on fulfillment with life and critical negative impacts on discouragement and uneasiness (Turliuc & Candel, 2021). The Psychological capital is essentially connected with its criterions such as self-esteem, locus of control, positive influence and so on. Psycap has an awesome impact on mental health.

The hypothesis "Religiosity capital to positively predict mental health of faith groups in Pakistan" was supported in the study. Religion capital is seen to be a conceivable supporter to mental wellbeing quality (Baier & Wright, 2001). Agreeing to the larger part of well-conducted researches, Higher degrees of devout inclusion are emphatically related with lists of mental well-being (life fulfillment, bliss, positive influence, and higher resolve), counting diminished misery, self-destructive contemplations and behavior, and drug use (Moreira et al., 2006). Different researches highlight the Importance of religiosity capital and positive mental health. Religiosity capital is considered as vital adaptive component for overseeing upsetting situations in life (Weber & Pargament, 2014).

A potential association between religiosity capital and enhanced mental health is emerging from scientific study. Diverse confidence conventions have

comparative wellbeing results, but spiritual, religious, and psychological characteristics differ. Positive and negative personality qualities are important determinants of positive health (and particularly mental health) in all faith traditions, and devout intercessions ought to proceed to be utilized in clinical hone to make strides mental wellbeing (Johnstone et al., 2012). The majority of research identified a link between religiosity and other good mental health variables such optimism and trust, self-regard, feeling of meaning and reason in life, self-determination, and social aid. Religion has been shown to have the capacity to influence, mitigate, or enhance resilience in relation to harmful behaviors, hence improving good health and general welfare among adolescents, young people, and adults (Francis et al., 2019). Religion and spirituality can promote mental health through positive religious coping, community and support, and positive beliefs (Weber & Pargament 2014).

The hypothesis "religious practices are likely to positively predict positive mental health in faith groups" was supported in the study. Religious practices can offer assistance one's mental wellbeing as customary participation at a put of adore interfaces a person into a community of individuals who can give fabric, ethical, enthusiastic, and social back, all of which can cultivate great mental health (Whitley, 2017). According to research, certain religious practices may even affect the brain in a way that improves mental health, (Rettner, 2015). Religious practices considerably contribute to physical and mental wellbeing. Customary religious practices reduce sadness, advances self-esteem, and builds familial and conjugal bliss. Devout revere too increments life span, moves forward an individual's chances of recuperating from sickness, and reduces the rate of numerous infections. Religious practices, both organizational and non-organizational devout association, were found to be noteworthy indicators of an assortment of mental wellbeing results (You et al., 2019)

The hypothesis "religious beliefs are likely to positively predict positive mental health in faith groups" was supported in the study. Individuals who follow a religious belief system have been shown to benefit from a variety of psychological benefits (Mosley, 2019). Religious beliefs and psychological well-being were found to have a strong link. Religious views appear to be a predictor of resilience, while resilience appears to be a predictor of depression. (Evangelos, 2018). Mental capital and social capital emphatically affected mental wellbeing, and the interaction impact of psychological capital and social capital was emphatically critical on mental wellbeing (Ciby et al., 2020). Picking up a mindfulness of social capital can really move forward social capital since it gives opportunity for reflection and the coming about reprioritization and arrangements of values. For case, when we are more completely mindful of the significance of making a difference, sharing, and caring practices our lifeworld unpretentiously changes, making a penchant for these sorts of practices in our way of life (Claridge, 2019). Social capital is the important and strong association to other which is as fundamental a human require as protection and clothing. Association with strong companions, neighbors and/or family does three vital things: it decreases push and gives consolation it increments your strength and it increments your openings for development which are imperative components of mental capital. PsyCap has a significant positive effect on satisfaction with life (Turliuc & Candel, 2021). Psychological capital is positively correlated with positive mental health (Nafees & Jahan, 2017).

Religious norms help individuals within groups to build social capital (Woolcock & Narayan, 2000). Religiosity capital is considered as a potential

supporter to the quality of mental wellbeing (Baier & Wright, 2001). The larger part of well-conducted considers found that higher levels of devout inclusion are emphatically related with pointers of mental well-being (life fulfillment, bliss, positive influence, and higher assurance) and with less discouragement, self-destructive contemplations and behavior, alcohol use (Moreira et al., 2006).

Implications

1. Pakistan is a collectivist culture in which positive coexistence, constructive relationships and interpersonal bonding are integral tenants of the society. These all-positive characteristics are combined to form "social capital". Another salient feature of Pakistani society is that Pakistan is a "highly religious" society (Gallup, 2012). Thus, social and religiosity capital are important inbuilt characteristics of adults residing in Pakistan. It is important to note that these two factors are consistent positive predictors of mental health.

2. Besides these two capitals of positive psychology, psychological capital is another decisive factor in predicting mental health. The findings of the present empirical investigation confirmed the positive impact of social, religious and psychological capitals on mental wellbeing of faith groups including Muslims, Christians, Hindus and Sikhs. The social capital has both direct and indirect effect on mental wellbeing as in the light of the findings, religiosity capital and psychological capital enhances the impact of social capital on mental wellbeing.

3. Social and religiosity capitals are the part of social structure in Pakistan. These can be effectively used to improve mental health of faith groups. Thus, the adults should be educated to distinguish qualitative and quantitative social capital. Quantitative social capital (large number of relationships) is itself a stressor.

4. On the contrary, qualitative social capital (having limited but constructive relationships) is more desirable. Thus, adults should develop and effectively use qualitative social capital which will contribute to their mental health. The is the case of religiosity capital. Members of faith groups should be educated about the positive use of religiosity to improve their mental health.

5. An important and applied insight derived from the study is that "religious practices were more supervisor predictor of mental health as compared to religious beliefs". This is what our "religious" or "so called religious" people need to learn. If a faith group has good beliefs but bad practices, a mentally healthy society cannot be ensured. This is why, George Bernard Shaw once said about Islam and Muslims "best religion, worst people".

Conclusions

Present study investigated the effect of multiple capitals on positive mental health in faith groups in Pakistan in adults. The findings of the study concluded the effect of social, psychological and religiosity capital on mental health in faith groups including Muslims, Christian, Hindu and Sikh. Results showed that individuals that

rated high on multiple capitals also scored high on positive mental health. According to the results social capital, psychological capital and religiosity capital positively predicts mental health in faith groups. Religious practices and religious beliefs are also associated with positive mental health. Overall study shed light on the effect different capitals on the mental health of individuals from different faith groups.

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