SCIENCEFORECAST
A digital science library

Research Article
Published: 23 Feb, 2018

Journal of Psychiatry and Behavioral Health Forecast

# Religion and Depression: A Review of the Literature

*Artin Mahdanian**

*Department of Psychiatry, McGill University, Montreal, Canada*

## Abstract

**Background:** Depressive disorders are among the most important causes of disability and can be considered a major contributor to the global burden of mental illnesses. Religious beliefs and practices have roots in the history of mankind and are broadly prevalent around the world. People with chronic medical and psychiatric conditions employ religion as a healing resource. This is a review of the literature assessing religion and depression treatment.

**Materials and Methods:** MEDLINE; Embase; and PsychINFO via OvidSP were searched using text words and relevant indexing to identify studies focusing on the effects of religion and spirituality on etiology, course, therapy and prognosis of major depressive disorder. A total of 105 non-identical abstracts were identified. A PRISMA flow diagram usedto select relevant articles. This approach identified 23 articles.

**Results:** A significant number of articles (n=19 of 23) reported a positive correlation between religious behaviors and improvement of depressive symptoms to some extent. Some articles also mentioned that there is less prevalence and incidence of depression in more religious populations.

**Conclusion:** People with religious involvement are at a reduced risk for depressive disorders. Some longitudinal research suggested that religious involvement might exert a protective effect against the incidence and persistence of depressive symptoms and disorders. Clinicians involved in the treatment of depressed patients should consider the religious beliefs and practices and incorporate it into their therapy schedule.

**Keywords: Religion; Spirituality; Depression; MDD**

## Background

Depressive disorders are among the most important causes of disability and can be considered a major contributor to the global burden of mental illnesses. World health organization in his annual report of 2012 estimated that more than 350 million people of all ages suffer from depression. In the United States the lifetime prevalence of depressive disorders of any kind is estimated about 15% (10% in men and 20% in women) [1] whereas the Centre for Disease Control and Prevention in their 2012 reports approximates that at least 1 in 10 adults currently suffer from a level of depression.

Some research studies have shown that prevalence of depression can be as high as 45% in medically ill patients hospitalized in non-psychiatric wards [2,3]. There are several classifications for depression. The most common classification categorizes it as mild, moderate and severe. Typical episodes of depression lasts for at least two weeks and consists of several mental and physical symptoms including depressed mood, loss of interest, energy and enjoyment, low self-esteem, anxiety, difficulty sleeping, changes in appetite and weight, psychomotor retardation and other physical symptoms that cannot otherwise be explained (DSM-V).

Despite the general belief that depression is only a debilitating disorder, in fact, it is a deadly illness with mortality rate from suicide alone to be almost 10% resulting in over a million lives lost each year (WHO, 2012). There is also a concern that depression can have physiological effects on body and may destabilize or worsen the course of chronic medical conditions. Moreover, some research indicates that depression can decrease patient's adherence and compliance [4].

Religious beliefs and practices have roots in the history of mankind and are broadly prevalent around the world. People with chronic medical and psychiatric conditions employ religion as a widespread and useful healing and comforting resource. In fact, religious beliefs and practices can help people cope better with their physical and mental conditions, thereby reducing their likelihood of being astounded by circumstances [5,6]. Religious involvement is important to most of people around the world whether sick or well. Most polls indicate that over 75% of Americans report

OPEN ACCESS

*Correspondence:
Artin Mahdanian, Department of Psychiatry, McGill University, Montreal, Canada.
E-mail: am@globalmmentalhealth.net

Received Date: 21 Jan 2018
Accepted Date: 19 Feb 2018
Published Date: 23 Feb 2018

Citation: Mahdanian A. Religion and Depression: A Review of the Literature. J Psychiatry Behav Health Forecast. 2018; 1(1): 1003.

ISSN 2643-802X

**Table 1:** Flow chart to include and exclude.

| |
|---|
| Total articles identified (n = 105) |
| Duplicates removed (n = 45); Records (n = 60) |
| Records excluded based on title/abstract (n = 35); Records: (n = 25) |
| Full text articles assessed for eligibility (n = 2); Studies included (n = 23) |

religion as an important part of their daily life while the majority (56%) mentioned religion as very important [7].

There are many coping strategies known to help people at the time of any psychological trauma or life difficulties. Family, friends, hobbies, and religion practices among the most common ones. Quantitative cohort studies suggest a relationship between religion and depression. In a systematic review it has been found that 253 of 414 observational studies (61%) have reported significant inverse relationships between religions and depression [8]. Of the 70 prospective cohort studies 39 (58%) reported that religious people were less likely to develop depression and more likely to recover from depression faster. In this systematic review, only 6% of studies found a significant positive relationship between religion and depression. In addition to these observational studies, there were at least 30 clinical trials (experimental studies), of which 19 (63%) found that depressed patients receiving religious interventions had better outcomes than those receiving only standard of care.

If religious involvement is associated with lower rates of depressive disorder and faster recovery rates then we can expect that physiological functions that can be changed by depression (immune and endocrine) might be less influenced in religious people. In fact some researches have shown such physiological effects can occur in religious people. For example, in a study of religious involvement and immune function in 112 breast cancer women, they found that religious expression was positively related to the number of circulating T-cells and helper T-cells [9].

In another study Ironson and his colleagues [10] examined the effects of change in spirituality after the HIV diagnosis on CD4 cell counts and viral loads. This study showed that participants who had more religious behaviors after the diagnosis experienced significantly less decrease in CD4 counts and less increase in the viral load during a 4-year follow-up. In this study among all baseline predictors of change in CD4 cell count and viral load, change in religiosity was the most powerful predictor. Though a good number of studies have found significantly better immune and endocrine functioning among those who are more religious, there they normally have not used an interventional technique to examine this issue.

Having said the importance of religion in the management of depressive disorders, I am now trying to give a brief review of the current research that has showed a relationship between religion and depression. When patients are asked what they usually do to cope, in some areas of the world and even some parts of the North America, more than 90% report that religious practices are very useful and calming resource, and 40% said that religion is the most important factor in their life [11].

## Materials and Methods

The following databases were searched for relevant studies by the first author and confirmed with a librarian: MEDLINE via OvidSP and PubMed (1946 to April 1, 2015); Embase Classic + Embasevia OvidSP (1947 to April 1, 2015); PsychINFOvia OvidSP (1967 to April 1, 2015). I did my best to make the search strategy and reported findings conform to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses for Observational Studies (MOOSE and PRISMA) statement [12,13]. We used text words and relevant indexing to identify studies focusing on effects of religion and spirituality on etiology, course, therapy and prognosis of mood disorders, specifically major depression disorder. The full MEDLINE strategywas applied to all databases.

A total of 105 non-identical abstracts were identified on MEDLINE, Embase and PsychINFO. All the abstracts were then reviewed, retaining all journal articles in which the effects of religious beliefs on medical and psychiatric patients with mood and affective disorders were assessed. A PRISMA flow diagram (Table 1) illustrates how studies were included and excluded.

This approach identified 23 relevant articles. Finally, I reviewed references of all the articles to make sure that no important articles have been neglected but nothing new could be identified. Finally, an assessment of study quality in these articles confirmed the eligibility. Each article was read thoroughly to collect information about patient demographics, type of mood disorder, religious practices.

## Results and Discussions

Table 2 summarizes the demographic and information of the final number of papers included in this review. A significant number of articles (n=19) reported a positive correlation between religious behaviors and improvement of depressive symptoms to some extent. Some articles even mentioned that there is less prevalence and incidence of depression in more religious populations.

In a recent study, Williams AL and his colleagues [14] conducted a cross-sectional study of 150 cancer family caregivers to evaluate the importance of religion-related variables on their depression. Though the first look at the findings was not in favor of religion on depression. They reported that the adjusted and unadjusted models, prayer was not significantly associated with caregivers' depressive symptoms or clinical disorders. However, they found that attendance at religious services was associated with depressive symptoms with an inversely linear trend. They concluded that their results indicate that social or other factors that may accompany attendance at religious services can contribute to this association, not religious beliefs and behaviors themselves.

Sun F and Hodge DR [15] assessed the same things on the 209 caregivers of Alzheimer Disease in a Latino population. They found that church attendance could moderate the relationship between subjective forms of depression through exhibiting direct effects on depression. In a similar study in Arkansas, USA, investigators reported that greater religious and clergy-base supports were associated with fewer reported depressive symptoms and less alcohol use after controlling for gender, employment, and age [16].

Koenig [17] has got a very nice review describing the impacts of depression on medical patients and relationship between religious involvement and depression, specifically the potential role of religious cognitive-behavioral therapy in the treatment of depression in chronic illnesses. The Duke University is conducting a large RCT on this and their preliminary pilot studies suggest that religious CBT ought to be particularly effective in those persons with situational depression related to disabling medical illness, particularly in those who are religious.

**Table 2:** Summary of the articles included in the review.

| |
|---|
| 1: Williams AL, Dixon J, Feinn R, McCorkle R. Cancer family caregiver depression: are religion-related variables important? Psychooncology. 2014 Aug 11. doi: 10.1002/pon.3647. |
| 2: Sun F, Hodge DR. Latino Alzheimer's disease caregivers and depression: using the stress coping model to examine the effects of spirituality and religion. J ApplGerontol. 2014 Apr; 33(3): 291-315. |
| 3: Montgomery BE, Stewart KE, Bryant KJ, Ounpraseuth ST. Dimensions of religion, depression symptomatology, and substance use among rural African American cocaine users. J EthnSubst Abuse. 2014; 13(1): 72-90. |
| 4: Koenig HG. Depression in chronic illness: does religion help? J Christ Nurs. 2014 Jan-Mar; 31(1): 40-6. |
| 5: Rasic D, Asbridge M, Kisely S, Langille D. Longitudinal associations of importance of religion and frequency of service attendance with depression risk among adolescents in Nova Scotia. Can J Psychiatry. 2013 May;58(5):291-9. |
| 6: Lamba G, Ellison JM. Religion/Spirituality and depression. Am J Psychiatry. 2012 Apr; 169(4): 433. |
| 7: Hayward RD, Owen AD, Koenig HG, Steffens DC, Payne ME. Religion and the presence and severity of depression in older adults. Am J Geriatr Psychiatry. 2012 Feb; 20(2): 188-92. |
| 8: Blazer D. Religion/spirituality and depression: what can we learn from empirical studies? Am J Psychiatry. 2012 Jan; 169(1): 10-2. |
| 9: Hayward RD, Owen AD, Koenig HG, Steffens DC, Payne ME. Longitudinal relationships of religion with posttreatment depression severity in older psychiatric patients: evidence of direct and indirect effects. Depress Res Treat. 2012; 2012: 745970. doi: 10.1155/2012/745970. Epub 2012 Feb 22. |
| 10: Rasic D, Kisely S, Langille DB. Protective associations of importance of religion and frequency of service attendance with depression risk, suicidal behaviours and substance use in adolescents in Nova Scotia, Canada. J Affect Disord. 2011 Aug; 132(3): 389-95. doi: 10.1016/j.jad.2011.03.007. |
| 11: Stanley MA, Bush AL, Camp ME, Jameson JP, Phillips LL, Barber CR, Zeno D, Lomax JW, Cully JA. Older adults' preferences for religion/spirituality in treatment for anxiety and depression. Aging Ment Health. 2011 Apr; 15(3): 334-43. |
| 12: Phillips LL, Paukert AL, Stanley MA, Kunik ME. Incorporating religion and spirituality to improve care for anxiety and depression in older adults. Geriatrics. 2009 Aug;64(8):15-8. |
| 13: Paukert AL, Phillips L, Cully JA, Loboprabhu SM, Lomax JW, Stanley MA. Integration of religion into cognitive-behavioral therapy for geriatric anxiety and depression. J PsychiatrPract. 2009 Mar; 15(2): 103-12. doi: 10.1097/01.pra.0000348363.88676.4d. |
| 14: Peitl MV, Peitl V, Pavlovic E. Influence of religion on sexual self-perception and sexual satisfaction in patients suffering from schizophrenia and depression. Int J Psychiatry Med. 2009; 39(2): 155-67. |
| 15: Dew RE, Daniel SS, Goldston DB, Koenig HG. Religion, spirituality, and depression in adolescent psychiatric outpatients. J NervMent Dis. 2008 Mar; 196(3): 247-51. |
| 16: Koenig HG. Religion and remission of depression in medical inpatients with heart failure/pulmonary disease. J NervMent Dis. 2007May;195(5): 389-95. |
| 17: Koenig HG. Religion and depression in older medical inpatients. Am J Geriatr Psychiatry. 2007 Apr; 15(4): 282-91. |
| 18: Gur M, Miller L, Warner V, Wickramaratne P, Weissman M. Maternal depression and the intergenerational transmission of religion. J NervMent Dis. 2005 May; 193(5): 338-45. |
| 19: Nelson CJ, Rosenfeld B, Breitbart W, Galietta M. Spirituality, religion, and depression in the terminally ill. Psychosomatics. 2002 May-Jun; 43(3): 213-20. |
| 20: Braam AW, Van den Eeden P, Prince MJ, Beekman AT, Kivelä SL, Lawlor BA, Birkhofer A, Fuhrer R, Lobo A, Magnusson H, Mann AH, Meller I, Roelands M, Skoog I, Turrina C, Copeland JR. Religion as a cross-cultural determinant of depression in elderly Europeans: results from the EURODEP collaboration. Psychol Med. 2001 Jul; 31(5): 803-14. |
| 21: McCullough ME, Larson DB. Religion and depression: a review of the literature. Twin Res. 1999 Jun;2(2):126-36. |
| 22: Commerford MC, Reznikoff M. Relationship of religion and perceived social support to self-esteem and depression in nursing home residents. J Psychol. 1996 Jan; 130(1): 35-50. |
| 23: Andreasen NJ. The role of religion in depression. J Relig Health. 1972 Apr;11(2):153-66. doi: 10.1007/BF01533217. PubMed PMID: 24414684. |

A cohort study in Canadian high schools with 2-year follow-up to examine the association between self-reported religious importance or religious ceremony attendance and depression during adolescence [18] found that the girls who were not depressed at baseline and who attended religious services had much lower odds of later depression and boys who were depressed at baseline who attended religious services had lower odds of being still depressed at follow-up. Moreover, depression at baseline predicted lower religious behavior among boys. In all, religious behavior independently could predict lower depression at follow-up among girls while the same association among boys was bidirectional. Another prospective study in adult population off spring of depressed and non-depressed parents. A 10-20 years follow-up assessments were performed and the results have shown that offspring who reported that religion was very important to them had about one-fourth the risk of experiencing major depression and in those offspring of depressed parents who reported high importance of religion had about one-tenth the risk of depression [19].

In a cross-sectional analysis in the Southeastern United States, they compared 476 psychiatric in-patients and 167 non-depressed controls [20]. They found that presence of depression was related to less frequent worship attendance, more frequent private religious practice and moderate subjective religiosity. Among the depressed group, less severe depression was related to more frequent worship attendance, less religiousness, and having a born-again experience. These results were only partially explained by the effects of social support and stress buffering.

In a study at University of Michigan [21], psychiatric patients were assessed before study for depression and again after 3 months. Measures taken before study treatment included religiousness (subjective idea of religiosity, private prayer, worship attendance, and religious media use), social support, and perceived stress. They evaluated the depression severity using Montgomery-Asberg Depression Rating Scale (MADRS). They also found that subjective religiousness and religious services attendance was directly related to better initial MADRS, and indirectly related to better post-treatment MADRS via the pathway of lower stress, more social support, and more private prayer. Private prayer was directly related to better post-treatment MADRS.

Another cross-sectional self-reported survey in Nova Scotia, Canada to examine the relationships of measures of personal importance of religion and frequency of attendance at religious services among high school students [22]. They reported that among female students, higher personal importance of religion was associated with decreased odds of depression, suicidal ideation, drinking and marijuana use, while more religious attendance was protective for substance use behaviors and suicidal ideation. In males, both measures of religiosity were associated with decreased substance use. In all, similar to many other reports, they concluded protective associations of measures religiosity in Canadian adolescents.

Peitl et al [23] evaluated the influence of religion on sexual self-perception and sexual satisfaction on 100 patients suffering from schizophrenia, 100 patients suffering from depression and 100 healthy controls. Their results showed that Roman-Catholic schizophrenic patients experience greater sexual satisfaction than Eastern-Orthodox or atheist patients. In depressed patients there were no significant differences regarding sexual satisfaction. They concluded that religious views have a positive impact on sexual functioning and sexual self-perception of patients suffering from depression and schizophrenia and also healthy individuals.

A study testing the hypothesis that maternal depression decreases rates of the intergenerational transmission of religiosity from mother to offspring and attenuates the beneficial qualities of religiosity in offspring [24]. Their results showed that maternal depression decreases the intergenerational transmission of religion. They also showed that in the presence of maternal depression, offspring were more likely to have MDD at 10-year follow-up. Finally, it was revealed that in the absence of maternal depression, offspring were less likely to have major depression at 10-year follow-up when mother-offspring were concordant on attendance. Therefore, in the presence of maternal depression, transmission of religious attendance is no longer associated with decreased likelihood of offspring major depression whereas transmission of religious importance is associated with increased likelihood of offspring depression.

One of the studies assessed adults' preferences for religion/spirituality in treatment for anxiety and depression [25]. In this study, most participants (77-83%) preferred including religion/spirituality in treatment of anxiety and depression. The participants who thought it was important to include religion in therapy mentioned more positive religious-based coping, greater strength of religious faith, and greater collaborative and less self-directed problem-solving styles than participants who did not think it was important.

An examination of the relationship religiosity and perceived social support for depression and self-esteem in 83 nursing home residents indicated that perceived social support from family, public religious activity, and length of stay in the home were related to self-esteem. Health status and having a choice in selecting the nursing home were negatively related to depression. Fundamental religiosity and the resident's perceived social support from friends were not significantly related to depression or self-esteem.

Moreover, Koenig [3] also showed in another study that after controlling for demographic and physical health factors, depressed patients were more likely to indicate no religious affiliation, more likely to indicate spiritual but not religious, and less likely to pray or read scripture. He concluded that older medically ill hospitalized patients with depression are less religiously involved than non-depressed or those with less severe depression.

The impact of religious involvement on remission time of depression was examined in medical inpatients with heart failure and/or chronic pulmonary disease [2]. This study concluded that patients who were involved in group-related religious activities experienced a shorter time to remission. A cross-cultural study [26] demonstrated that depression rates were lower among regular church-attenders and fewer depressive symptoms were found among the female elderly in countries with high rates of regular church-attendance. They concluded that religious practice is associated with less depressive symptoms in elderly Europeans, both on the individual and the national level.

Dew et al [27] examined the relationship between multiple facets of religion/spirituality and depression in treatment-seeking adolescents. Their results suggested that after controlling for other factors depression was related to feeling abandoned or punished by God, feeling unsupported by one's religious community, and lack of forgiveness. In addition, Nelson and colleagues [28] also concluded that the beneficial aspects of religion may be primarily those that relate to spiritual well-being rather than to religious practices per se.

Finally a very nice review article by Paukert et al [29] showed that among psychotherapies used in the treatment of anxiety and depression in older adults, cognitive behavioral therapy incorporated with religion may have the strongest acceptability and effectiveness. The studies they looked at indicated that improvement in depressive and anxiety symptoms occurs earlier in treatment when CBT incorporates religion.

Tanya Marie Luhrmann in her nice paper [30] argues against designation of health-giving properties of religious to pure social support and she strongly believed that there is another mechanism with positive relationship to supernatural. She says that such a mechanism is proposal that builds upon anthropological accounts of symbolic healing and depends on the learned cultivation of the imagination and the capacity to make what is imagined more real. Researched have mentioned that the reason religion can lead to such outcomes may be due to social support, operationalized social networks, more supportive social relationships, increased healthy behaviors, emotional coping efforts, and in general giving a sense of meaning and coherence.

She built her paper upon the anthropological model of "symbolic healing". More specifically, she argues that the capacity to make this relationship and to experience its effects rests on a learned cultivation of the imagination that is to say to make what is imagined more real. Her paper in fact offers a theory of the way that prayer may enable this imaginal process. Symbolic healing has four features: experiences of the healer and healed are generalized with culture-specific symbols, a suffering patients comes to a healer who persuades him that the problem can be defined in terms of the myth, the healer attaches the patient's emotions to transactional symbols particularized from the general myth, and the healer manipulates the transactional symbols to help the patient transact his/her own emotions. She believes that the most important role of the prayer is to help make what is imagined more real and its central act is paying attention to internal experience-thoughts, images, and awareness of your body.

The person praying has to learn to use his imagination to experience God as present. The capacity of the praying to shift attention away from the everyday is basic to dissociation, hypnosis and trance. The name for mental capacity common to trance, hypnosis, dissociation in which the individual becomes caught up in ideas or images or fascinations, is absorption. In fact, absorption is the capacity to become focused in a non-instrumental way on the mind's object. It is a cognitive, attentional process. None of these can really work unless patients are able to experience their interactions with God as real.

In fact spiritual healing uses the mind to heal the body. Luhrmann believes that in order to make this process effective, the patients must allow what they imagine to feel as if it is real, external, not "just" in their minds. It says that there is a learning process prior to the action of symbolic healing. There are two mechanisms for this: first,

imagination-rich prayer in effect helps to increase the vividness of the imagination and helps to feel God more present; second, the repeated experience of imaginal conversational interaction with a God understood as loving may allow Him to be experienced as a soothing self-object.

## Conclusion

I reviewed data from approximately 23 published studies that examined the association of religion/spirituality with depressive symptoms or disorders. In these studies, religion was measured as religious affiliation; general religious involvement; organizational religious involvement; prayer or private religious involvement; religious motivation; or religious beliefs. In all, people with no religious affiliation are at an elevated risk of depression compared to those who are religiously affiliated. People with high levels of general religious involvement, organizational religious involvement, and intrinsic religious motivation are at a reduced risk for depressive disorders.

Although these associations tend to be consistent, they are modest and are substantially reduced in multivariate research. Very little longitudinal research suggests that some forms of religious involvement might exert a protective effect against the incidence and persistence of depressive symptoms and disorders. It is, therefore, suggested that clinicians involved in the treatment of depressed patients should consider their religious beliefs and incorporate it into their therapy schedule.

## References


1. Steffens DC, Skoog I, Norton MC, Hart AD, Tschanz JT, Plassman BL, et al. Prevalence of depression and its treatment in an elderly population: the Cache County study. Arch Gen Psychiatry. 2000; 57: 601-607.
2. Koenig HG. Religion and remission of depression in medical inpatients with heart failure/pulmonary disease. The Journal of nervous and mental disease. 2007; 195: 389-395.
3. Koenig HG. Religion and depression in older medical inpatients. The American journal of geriatric psychiatry: official journal of the American Association for Geriatric Psychiatry. 2007; 15: 282-291.
4. DiMatteo MR, Lepper HS, Croghan TW. Depression is a risk factor for noncompliance with medical treatment: meta-analysis of the effects of anxiety and depression on patient adherence. Arch Intern Med. 2000; 160: 2101-2107.
5. Koenig HG. Religion and medicine III: developing a theoretical model. International journal of psychiatry in medicine. 2001; 31: 199-216.
6. Koenig HG. Religion and medicine II: religion, mental health, and related behaviors. International journal of psychiatry in medicine. 2001; 31: 97-109.
7. Newport DJ, Baldessarini RJ, Knight BT, Fernandez SV, Morris NJ, Viguera AC, et al. Comparison of women with confirmed versus presumably misdiagnosed bipolar disorder. J Clin Psychiatry. 2012; 73: 242-246.
8. Koenig HG, King DE, Carson VB. Depression. Handbook of religion and health 2nd ed. New York, NY2012.
9. Sephton SE, Koopman C, Schaal M, Thoresen C, Spiegel D. Spiritual expression and immune status in women with metastatic breast cancer: an exploratory study. Breast J. 2001; 7: 345-353.
10. Ironson G, Stuetzle R, Fletcher MA. An increase in religiousness/spirituality occurs after HIV diagnosis and predicts slower disease progression over 4 years in people with HIV. J Gen Intern Med. 2006; 21: S62-68.
11. Koenig HG. Religious attitudes and practices of hospitalized medically ill older adults. Int J Geriatr Psychiatry. 1998; 13: 213-224.
12. Stroup DF, Berlin JA, Morton SC, Olkin I, Williamson GD, Rennie D, et al. Meta-analysis of observational studies in epidemiology: a proposal for reporting. Meta-analysis Of Observational Studies in Epidemiology (MOOSE) group. JAMA. 2000; 283: 2008-2012.
13. Liberati A, Altman DG, Tetzlaff J, Mulrow C, Gotzsche PC, Ioannidis JP, et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate healthcare interventions: explanation and elaboration. BMJ. 2009; 339: b2700.
14. Williams AL, Dixon J, Feinn R, McCorkle R. Cancer family caregiver depression: are religion-related variables important? Psycho-oncology. 2015; 24: 825-831.
15. Sun F, Hodge DR. Latino Alzheimer's disease caregivers and depression: using the stress coping model to examine the effects of spirituality and religion. Journal of applied gerontology: the official journal of the Southern Gerontological Society. 2014; 33: 291-315.
16. Montgomery BE, Stewart KE, Bryant KJ, Ounpraseuth ST. Dimensions of religion, depression symptomatology, and substance use among rural African American cocaine users. Journal of ethnicity in substance abuse. 2014; 13: 72-90.
17. Koenig HG. Depression in chronic illness: does religion help? Journal of Christian nursing: a quarterly publication of Nurses Christian Fellowship. 2014; 31: 40-46.
18. Rasic D, Asbridge M, Kisely S, Langille D. Longitudinal associations of importance of religion and frequency of service attendance with depression risk among adolescents in Nova Scotia. Canadian journal of psychiatry Revue canadienne de psychiatrie. 2013; 58: 291-299.
19. Miller L, Wickramaratne P, Gameroff MJ, Sage M, Tenke CE, Weissman MM. Religiosity and major depression in adults at high risk: a ten-year prospective study. The American journal of psychiatry. 2012; 169: 89-94.
20. Hayward RD, Owen AD, Koenig HG, Steffens DC, Payne ME. Religion and the presence and severity of depression in older adults. The American journal of geriatric psychiatry: official journal of the American Association for Geriatric Psychiatry. 2012; 20: 188-192.
21. Hayward RD, Owen AD, Koenig HG, Steffens DC, Payne ME. Longitudinal relationships of religion with posttreatment depression severity in older psychiatric patients: evidence of direct and indirect effects. Depression research and treatment. 2012; 2012: 745970.
22. Rasic D, Kisely S, Langille DB. Protective associations of importance of religion and frequency of service attendance with depression risk, suicidal behaviours and substance use in adolescents in Nova Scotia, Canada. Journal of affective disorders. 2011; 132: 389-395.
23. Peitl MV, Peitl V, Pavlovic E. Influence of religion on sexual self-perception and sexual satisfaction in patients suffering from schizophrenia and depression. International journal of psychiatry in medicine. 2009; 39: 155-167.
24. Gur M, Miller L, Warner V, Wickramaratne P, Weissman M. Maternal depression and the intergenerational transmission of religion. The Journal of nervous and mental disease. 2005; 193: 338-345.
25. Stanley MA, Bush AL, Camp ME, Jameson JP, Phillips LL, Barber CR, et al. Older adults' preferences for religion/spirituality in treatment for anxiety and depression. Aging & mental health. 2011; 15: 334-343.
26. Braam AW, Van den Eeden P, Prince MJ, Beekman AT, Kivela SL, Lawlor BA, et al. Religion as a cross-cultural determinant of depression in elderly Europeans: results from the EURODEP collaboration. Psychological medicine. 2001; 31: 803-814.
27. Dew RE, Daniel SS, Goldston DB, Koenig HG. Religion, spirituality, and depression in adolescent psychiatric outpatients. The Journal of nervous and mental disease. 2008; 196: 247-251.

28. Nelson CJ, Rosenfeld B, Breitbart W, Galietta M. Spirituality, religion, and depression in the terminally ill. Psychosomatics. 2002; 43: 213-220.

29. Paukert AL, Phillips L, Cully JA, Loboprabhu SM, Lomax JW, Stanley MA. Integration of religion into cognitive-behavioral therapy for geriatric anxiety and depression. Journal of psychiatric practice. 2009; 15: 103-112.

30. Luhrmann TM. Making God real and making God good: some mechanisms through which prayer may contribute to healing. Transcult Psychiatry. 2013; 50: 707-725.