

Depression: Biological, Psychosocial, and Spiritual Dimensions and Treatment

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Abstract

Depression is one of the most pervasive disorders and a leading cause of disability worldwide. Clinical depression consists of a group of disorders with various causes. Consequently, the treatment profile is also diversified. Scientific research confirms a strong presence of biological, psychosocial, and environmental factors that contribute to the development of major depression. Does depression lead to certain medical illnesses? What are possible risks and protective factors? What are current treatment options? What is the impact of stigma in preventing individuals from seeking treatment? Do religious beliefs and spiritual values play a role in depression? Since the Bahá'í Faith teaches the unity and harmony of science and religion, what insights do the Bahá'í teachings offer regarding this disease that are particularly valuable?¹

Introduction

There is a pitch of unhappiness so great that the goods of nature may be entirely forgotten, and all sentiment of their existence vanish from the mental field. —William James 1923

From ancient times, depression, also known as melancholia, has been recorded to have affected people from all walks of life, some of whom were renowned in their fields of erudition, including medicine. From shamans' ritual ceremonies to the present time of molecular biology and neurosciences, humankind has been engaged in a search for a lasting remedy to bring joy and conquer depression and other psychiatric disorders. Aristotle wrote, "Why is it that all men who are outstanding in philosophy, poetry or the arts are melancholic and some to such an extent that they are infected by the disease arising from the black bile?" He indicated that among them were Plato and Socrates (cited in Goodwin and Jamison 333). Closer to our time in history, prominent figures who have suffered from mood disorders include Charles Darwin, Abraham Lincoln, Ernest Hemingway, Virginia Woolf, Winston Churchill, William James, Sören Kierkegaard and Sylvia Plath (Whybrow et al. 18).

There have been other people, some ordinary and some great—philosophers, writers, poets, musicians, scientists, and even prophets—who suffered the anguish of emotional pain. When human suffering is transformed through spiritual insight and intrinsic values, the result might be great accomplishments in the service of society.

Joy and sadness are part of human emotions and are very common in daily life. Not every sadness is a sign of clinical depression. For example, sadness may occur in response to a life crisis, a failure, or a disappointment, and normally does not impair daily activities. Clinical—or major—depression, on the other hand, is essentially a painful emotional state that often begins with a subjective feeling of persistent loss of interest accompanied by anxiety and sadness.

There are variations in the onset, intensity, and duration of depressive disorder. Sometimes the intensity of clinical depression can reach such a pitch that it results in an inability to function; a disturbance in

¹ This article on depression is not intended to provide guidance for diagnosis and treatment. Therefore, individuals who need professional advice should consult their physician or other competent mental health professional.

one's quality of life; and a profound sense of guilt, hopelessness, and helplessness. In major depression there is a feeling of emptiness and despair. Suicidal ideas are common. Concentration and cognitive functions are adversely affected. As the depression deepens, biological symptoms including changes in sleep patterns, appetite, physical, and mental fatigue, as well as a general loss of pleasure in life intensify.

The evolution of major depression involves a relapsing and remitting pattern in most patients. After the first episodes, the occurrence of a next episode is greater than 40% over a two-year period. Following two episodes, the risk of recurrence within the following five years rises to almost 75% unless effective treatment is administered (Katon).

Prevalence of Depression

Depression is one of the most pervasive and serious emotional disorders. According to the World Health Organization (WHO), depression is now the fourth leading cause of disability in the world, and it has been estimated that by 2020 this illness will rank as the second leading cause of disability. (Kessler and Bromet). Through its adverse affect on one's physical, psychological, and spiritual wellbeing, depression impairs daily functioning and disrupts quality of life. Depression is associated with negative health outcomes including cardiac diseases, suicide, and decreased life expectancy. Any measure that would mitigate its detrimental effects on mental health and wellbeing is important (Baetz et al.).

The prevalence of major depression varies from one country to another and across cultures. Epidemiological population studies conducted across nations reflect the extent of the variability of the prevalence rate of depression. For example, in a lifetime prevalence study of major depression, the estimates ranged from 1.0% (Czech Republic) to 16.9% (U.S.), with midpoints at 8.3% (Canada) and 9.0% (Chile) (Kessler and Bromet). Likewise, the severity of clinical symptoms, their duration, and their response to treatment vary from person to person.

Another WHO survey of primary care patients revealed a wide variation of prevalence of depression in 14 countries, ranging from 1.6% to 26.3%. The differences of prevalence reflect the level of functional impairment as a basis for diagnosis. However, the variability can also be attributed to subjectivity of expressing symptoms by the patients and their evaluating physicians. In view of the strong stigma and shame attached to mental illness in some countries, statistical information collected in surveys on depression and suicide that include those countries may not represent the reality of the number of individuals affected. Nevertheless, the presence of "clinically significant distress or impairment" is a very important factor in the clinical diagnosis of depression (Bentley et al. 983).

More than 350 million people in the world are affected by depression (WHO 2012), with women impacted at twice the rate of men. The reasons women outnumber men in this regard are discussed later, under "Clinical Symptoms of Depression." According to the World Mental Health Survey conducted in 17 countries, on average, one in 20 people reported having had a depressive episode during the previous year (Marcus et al.).

Etiology of Depression

The etiology of depression is complex because it actually consists of a multifaceted group of depressive disorders. Due to the multifactorial nature of major depression, there is no one simple definitive and universal cause for the disorder. Major depression has been attributed to a number of causative factors including psychological, genetic, environmental, and biological causes. On the molecular level, major depression is believed to be associated with imbalances of neurotransmitters, dysregulation of inflammatory pathways, increased oxidative dysfunction, and hypothalamic-pituitary-adrenal (HPA) disturbances. These imbalances and the dysregulation of neurobiological pathways are influenced by our lifestyle as well as by environmental, genetic, and psychosocial factors including diet, sleep, exercise, and interpersonal relationships (Lopresti et al.).

Among the psychosocial factors that may trigger or precipitate the development of major depression are life stress and crisis. It has been estimated that 75% of patients with major depression experience stressful life events prior to the onset of their depression. Interpersonal and psychosocial stressors affect the brain and neurophysiological activities and may lead to symptoms of depression. Besides psychosocial stressors, genetic vulnerabilities also contribute to neurophysiological alteration of brain function leading to clinical symptoms of depression (Akiskal 116–17).

Among the biological factors that contribute to depression in later life are vascular lesions in the subcortical areas of the brain. One important feature of vascular depression is impairment of the executive function of the brain along with depression. Executive dysfunction is characterized by “disturbance in planning, sequencing, organizing and extracting information,” which may result in cognitive aberration (Blazer 15).

In psychoanalytic theory, depression is interpreted as the result of aggression turned inward or against the self. Another interpretation of depression is loss of an idealized love object, person, or relationship. Cognitive behavioral therapy views depression through the lens of cognitive deficit as the central part of depressive disorder. Based on cognitive theory, depression is the result of negative thinking, self-deprecation, cognitive distortion, or misperception of external life situations. Depressed patients become oversensitive to rejection, and in the state of depression they see everything as negative and gloomy. But one may argue that depression is at the root of cognitive dysfunction and is not its by-product. Another aspect of the cognitive and behavioral concept of depression is that of learned helplessness, which leads to vulnerability to failure and social rejection, which further increase the symptoms of depression. Yet another theory of depression is based on a biological model. As mentioned above, according to this hypothesis, depression is caused by neurotransmitter dysregulation or endocrinological dysfunction (Whybrow et al. 33).

Research findings in developing countries suggest that maternal depression may be a risk factor in young children (Rahman et al.). Further studies have shown that maternal depression can be associated with underweight and stunted growth in early childhood. The mechanism for this association between maternal depression and inadequate growth of children is not clear. However, it is suggested that early diagnosis, treatment and prevention of maternal depression may reduce the impairment of physical growth of children in developing countries (Surkan et al.).

Clinical Symptoms of Depression

Before describing the symptoms of depression, it is important to know that depression is not a single clinical entity. It is comprised of a group of depressive disorders, most of which are included in the following:

- Major depressive disorder or major depression
- Depressive episode of bipolar disorder or bipolar depression
- Unipolar depression
- Dysthymic or persistent depressive disorder
- Seasonal affective disorder or seasonal depression
- Psychotic depression

The intensity of depression may be characterized as mild, moderate, or severe. It is not possible to describe each category of depression in this article. Instead, an overview of general symptoms of depression and related issues are outlined with special reference to major depression.

Major depression is a severe and incapacitating type of emotional disorder that can manifest itself as part of bipolar disorder, unipolar depression, or major depressive disorder. A mild and chronic form of

depression is also known as dysthymic mood disorder. Reactive or transient depressive mood can occur in response to certain life crises, on the occasion of anniversaries that evoke sad or traumatic memories, during the premenstrual period, or during the first weeks after child birth, also known as maternal blues or post-partum depression. This last condition is not considered to be a clinical depression unless it becomes prolonged (Akiskal 1124).

In major depression, symptoms are “out of proportion to any concurrent stressors or situation; being unresponsive to reassurance or support; being sustained for weeks, months and sometimes years; having a pervasive effect on the person, such that judgment is seriously influenced by the mood.” (Akiskal 1125). According to the 2013 edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, in major depressive disorder the following symptoms are present for at least a two-week period: depressed mood most of the day for nearly every day; decreased interest or pleasure in life; weight loss or sometimes weight gain; insomnia or hypersomnia almost every day; psychomotor agitation or retardation; fatigue or loss of energy; feeling of worthlessness; decline in concentration; recurrent thoughts of death; and suicidal ideation, attempt, or suicide (94–98).

In milder depression, the patient may complain more of somatic and physical pain rather than expressing the mournful moods of severe depression. In some cultures, patients may find it more acceptable and less stigmatizing to complain of physical symptoms such as headache or pain in the chest or abdomen. Culturally these symptoms are taken more seriously especially in men, who in some countries are not expected to complain of anxiety and sad mood or to cry because these are perceived as signs of weakness. Unfortunately, such a cultural attitude may cause individuals to mask or deny their emotional feelings, fearing the stigma of mental illness, and avoid proper treatment. When depression is not clinically diagnosed it may progressively worsen and end in tragic consequences.

Cognitive function, particularly concentration and decision-making, are adversely affected by depression. Akiskal reported a case of a middle-aged woman who was tormented by severe and unjustified guilt because as a child she had not repaid 5 cents she had borrowed from a classmate. Sometimes such cognitive inflexibility may result in a delusional way of thinking (1128).

Depression slows down or significantly decreases mental— cognition, perception, psychomotor and behavioral— as well as physical activities. The patient feels pessimistic, unmotivated, and disinterested, with a deep sense of helplessness and despair. Sometimes symptoms are associated with paranoia and delusions or hallucinations.

Among the psychological factors most frequently associated with late-life depression are cognitive distortions. Such distortions include unrealistic expectations and the tendency to overgeneralize or overreact to an adversity, which predispose elderly individuals to depression. For example, the failure of a relative to visit an elderly person may be perceived as no one caring for him or her. On the other hand, the accumulated wisdom of an elderly person may serve as a protective factor in such circumstances. This is because with wisdom, one can deal with uncertainty (Blazer).

With regard to higher prevalence of depression in women and the type of symptoms they experience, researchers have explored a number of contributing factors. These include a longer life span of women as compared to men as well as women’s biological life cycle, hormonal differences, and psychosocial factors. There are also some differences in the way women experience depression as compared to men. “While women with depression are more likely to have feelings of sadness, worthlessness, and excessive guilt, men are more likely to be very tired, irritable, lose interest in once pleasurable activities, and have difficulty sleeping” . As mentioned above, women are more vulnerable to depression at certain times, such as during pre-menstruation and after childbirth. Men are more likely to turn to alcohol and substance abuse than women when they are depressed and are less likely to talk about how they feel with family and friends, burying those feelings by working harder. Although there is a higher prevalence of suicidal attempts by women in the United States, many more men die as a result of

attempting suicide (National Institute of Mental Health, *Depression* 7). These differences may vary across cultures.

Anxiety disorders are the most common psychiatric disorders worldwide and are most frequently associated with mood disorders (Hidaka 207). It is debated whether anxiety disorder precedes depression or is concurrently present, but it is also possible that the illness may begin with depression and be followed by anxiety. The overall impression is that the lifetime prevalence of generalized anxiety disorder and major depressive disorder constitutes a significant mental health burden (Moffit et al. 651).

Grief is a type of reactive depression in response to an important loss or separation, such as death, divorce, or breakdown in a love relationship. It is an emotional response to bereavement and is universal in life experience. It is natural to experience sorrow and sadness, and often guilt, with the loss of a loved one, but such grief is self-limiting and usually does not evolve into depressive disorder unless the grieving process becomes severe and complicated. Therefore, it is important to closely observe its development. Whereas it was previously believed by many that grief should not last longer than two months after a loss, the new classification of *DSM-5* does not specify a time period for grief to be resolved. Some bereaved patients are at higher risk for depression, substance misuse, and suicide (Bentley et al. 989).

Seasonal depression or seasonal affective disorder (SAD) is characterized by mood changes that are related to the circadian rhythm. Typically, in the northern hemisphere, this kind of depression begins in autumn and continues through winter, disappearing in spring and summer. Patients with SAD have an inherent vulnerability to light deprivation, hence the onset of the illness in autumn or winter, when daylight hours decline, and relief in spring and summer, when exposure to light is greater. Depression in these patients is experienced differently; appetite, especially for carbohydrates, increases, leading to weight gain during the autumn and winter. Sleep patterns are shifted, with sufferers sleeping later at night and waking later in the morning; hours required for sleep also increase. Depressed mood is experienced with lingering fatigue, a veritable energy crisis. Concentration and motivation decrease, resulting in loss in productivity.

With depression comes an inability to feel the joy and pleasure of life and to be interested in what used to be a happy or enjoyable experience. Depression that worsens to such a degree that patients are unable to experience the natural joy of being with loved ones and are overcome by a sense of indifference and emptiness may lead to hopelessness and despair. However, all these dark and mournful clouds of depression may dissipate through skillful treatment.

The Stigma of Depression and of Other Psychiatric Disorders

The stigma of psychiatric illness, including depression, is one of the reasons that people avoid seeking help for mental health problems. In view of the fact that depression is a major risk factor for disability and suicide, it is important to eradicate this barrier to treatment. Despite unprecedented progress in science and medicine, there are still many societies in which mental illness and those who suffer from it are discriminated against.

The problem of stigma with respect to depression involves two elements: the patient and society. Depressed patients tend to process information with a negative bias toward themselves and their illness, which stems partly from the nature of their illness. Society also needs to be educated and well informed about depression and other psychiatric disorders, as they are basically a type of medical disorder and deserve the same acceptability. There have been research studies on psychosocial factors that would improve the public's attitude toward this illness as well as the help-seeking challenges that depressed patients face. Ignorance and false traditional notions of mental illness, particularly among uneducated populations, constitute a barrier that reinforces the stigma.

The negative stereotype of mental illness resulting in discrimination against those suffering from it has unfortunately impacted large numbers of patients. Discrimination is unfair treatment that can be overt or covert and that serves as a further impediment for this population to seek help as their right in society.

Social media, the entertainment industry, and public discourse play a crucial role in shaping society's opinions about the nature of and attitude toward mental health and illness. "People with mental health conditions are often depicted as dangerous, violent and unpredictable. News stories that sensationalize violent acts by a person with a mental health condition are typically featured as headline news" (Canadian Mental Health Association 2015). Such reporting, which unfortunately paints a broad picture of those with psychiatric disorders as violent and dangerous, usually fails to discuss the positive side of recovery and effective treatment. As a result, misconceptions and fears about mental illness prevail.

A positive aspect of this phenomenon is that there is an emerging openness to talking about depression on college campuses and in like-minded communities. Likewise, more and more authors, artists, scientists, politicians, and movie stars have come forward to write about their depression and their struggle to heal and overcome the public's attitude and condescending treatment of them (Peck).

Although a large number of overall patients who come to the attention of primary care clinicians are depressed, many of them are not properly diagnosed. They are undertreated because of patients' reluctance to clearly explain the symptoms of their depression to their physician and, when the diagnosis is made, depressed patients may not follow the treatment.

Treatment of Depression

Depression is a treatable illness, and yet, according to the WHO, less than 50% (and in some countries fewer than 10%) of those suffering from this disorder seek help for their depression. There are a number of barriers to getting treatment. Foremost among them is the social stigma attached to mental illness; other barriers are lack of access to treatment resources, insufficient or lack of health care providers, and failure to make proper diagnosis and provide effective treatment to patients ("Depression Fact Sheet").

In addition to stigma and failure of the health delivery system to provide efficient treatment, some patients do not recognize the seriousness of depression as a disabling disease, which, if left unchecked, may lead to other medical disorders. Major depressive disorder (MDD) in particular is associated with a number of chronic physical illnesses, including arthritis, cardiovascular disease, diabetes, chronic respiratory disease, hypertension, cancer, asthma, and various chronic pain conditions. Indeed, based on meta-analyses of longitudinal studies, major depressive disorder was found to be a consistent predictor of the subsequent first onset of heart disease, heart attacks, stroke, diabetes, and cancer. Although the mechanism of the prospective association of MDD with these diseases is not clear, it is linked to poor health behaviors, such as smoking and drinking, obesity, poor compliance to treatment, as well as some biological dysregulations. This association increases the cost of depression and its associated morbidity (Kessler and Bromet).

In light of the above findings, it is important to pay special attention to detect and treat depression among people with the diseases mentioned in order to prolong the lives of patients. Conversely, physical illness may eventually lead to clinical depression (Kessler and Bromet). In addition to the possible relationship of medical illness with depression, another tragic consequence of depression may be suicide.

For the majority of patients with major depression, a combination of pharmacotherapy and psychotherapy is considered an effective approach to treatment (Cuijpers et al.). The choice of antidepressant to be used in medical treatment is based on the concept of neurobiological factors responsible for depression. Thus, different antidepressant medications are designed to have an effect on different neurotransmitter systems of the brain. These biological systems include serotonin, norepinephrine, dopamine, and other neurotransmitters. Depending on the subtype of depression and

related symptoms, an appropriate dosage of antidepressant will be prescribed to regulate a deficiency in the neurotransmitter systems and improve the state of depression.

In the treatment of depression, a number of antidepressants are available. During the past fifty years, significant progress has occurred in the discovery and development of medications to treat depression. Antidepressants have evolved from the tricyclic group to the present group of selective serotonin reuptake inhibitors (SSRIs). Newer antidepressants are currently being developed which are expected to be more efficacious in improving major depression and have fewer side effects.

The choice of antidepressant for treatment depends on the type of depression that a patient suffers from. As there are several types of depression, the choice of which antidepressant to administer will vary. The antidepressant should match not only the type of depression but also take into consideration other factors such as age, gender, safety, and the medical condition of the patient, as well as possible side effects and interaction with other medications. Some patients may require a combination of antidepressants, depending on the severity of the illness and its resistance to treatment. When a patient suffers from depression with psychotic symptoms, an antipsychotic drug may be required as well.

The details of pharmacological properties, groups of antidepressants, and the efficacy and side effects of these medications are beyond the scope of this article. Suffice it to say that they have been evaluated and used worldwide and that patients need to use them under the direction of experienced clinicians. In patients suffering from major depression who have a family history of mood disorders or who admit to having suicidal ideas, intervention with antidepressants or other medical intervention is unavoidable. On the other hand, for a depression precipitated by a family or social crisis, psychotherapy and a problem-solving approach may be adequate unless the intensity of depression or other reasons dictate that different measures be taken.

Of course, it should be understood that not every unhappiness is depression, and not all depression requires treatment with medications. However, when the biological aspects of depression are moderate to severe, treatment with medication becomes necessary. On the other hand, for many years antidepressants have been overprescribed to patients. This is partly because primary care practitioners who are in the forefront of patient care may not be trained in the use of psychotherapy or other psychosocial approaches for the treatment of depressed patients or may not have the time needed to make use of other treatment modalities. Therefore they may be more inclined to prescribe antidepressants for a quicker treatment outcome, without addressing underlying issues. Many psychiatrists, too, are more inclined to resort to pharmacotherapy due to time limitations or other reasons. As a result, there has been an overuse of psychiatric medications in North America, which has led to a backlash against the use of antidepressants. There is a need to re-evaluate the entire system of mental health treatment, with more attention to finding a balance in therapeutic approaches to the care of the patient as a whole.

This necessity, however, should not undermine the significant progress that has been made in the treatment of depression and its subtypes during recent decades. For example, there is now a greater emphasis on the use of psychosocial approaches, especially for mild to moderate forms of depression, many of which may not require antidepressant treatment unless the intensity of the depression and its resistance to current treatment call for such an intervention. Although in cases of mild and severe depression it is not difficult to decide which treatment modality should be chosen, moderate depression is a gray area in which treatment choices— medication, psychotherapy, or a combination of both—can be more challenging to make. The task is further complicated by the presence of comorbidity, such as the coexistence of depression and psychosis, personality disorder, or consumption of substance abuse, all of which can affect the clinical picture. A large number of outpatients suffering from depression, and especially those with bipolar disorder, are affected by substance abuse, which may alter their mood and at times make their behavior very unpredictable.

When a major depressive episode occurs as part of bipolar disorder or is associated with suicidality, which is resistant to pharmacotherapy, other modalities may need to be considered. Electroconvulsive treatment (transcranial magnetic stimulation) has undergone significant change and scientific improvement in recent years and has proven to be effective when a patient does not respond to antidepressants and other treatments or is a high suicidal risk and cannot wait for other therapeutic interventions. However, this procedure is a work in progress, and while the clinical use of the new and less invasive form of this treatment is increasing, it is used as a last resort.

In the case of seasonal affective disorder (SAD), light therapy is effective in 60 to 70% of patients, as it improves serotonin dysregulation in the brain. A medically prepared intensity lamp improves mood in such patients. To those for whom this therapy is ineffective, it may be necessary to administer antidepressants or take other therapeutic measures. Some people with this disorder choose to winter in tropical regions of the world (Rosenthal).

Psychosocial Approach to Treatment of Depression

There are a number of psychotherapeutic approaches in the treatment of depression and other psychiatric disorders. One of them is interpersonal psychotherapy. This approach follows a medical model and its emphasis is on improving problematic interpersonal relationships, which can predispose one to depression.

Cognitive behavior therapy is another approach to treating depression. It was developed by Aaron Beck, a pioneer in the field, and is based on the theory that depression is associated with negative thoughts, distorted schemes, and faulty information processing. The aim of cognitive behavior therapy is to correct cognitive dysfunction that results in depression and its various symptoms, and the approach has demonstrated significant success in the treatment of outpatients with mild to moderate depressive disorder (Burns). For more severe depression it is less effective than medication; however, the combination of medical and psychosocial treatment is more likely to have a beneficial effect. The hallmark of this therapy is to distinguish between the individual's perceptual experience of reality and objective reality. Moreover, it helps the individual to recognize the emotional consequences of irrational thoughts, beliefs, and behavior (Hirschfeld and Shea).

Psychodynamic therapies have also been used in the treatment of depression. Psychoanalysis, although popular during most of the twentieth century, is now viewed as being less effective than new and more specific psychotherapy approaches, and it is now used more in the form of short-term dynamic psychotherapy. There are also other approaches to psychosocial therapy, including supportive therapy and counseling; however, cognitive behavior therapy is still the most prevalent type of psychotherapy.

Risk and Protective Factors for Depression

The following two sections discuss risk and protective factors with respect to depression. A risk factor refers to a greater likelihood of occurrence of an illness, while a protective factor refers to circumstances that would decrease the likelihood of its development. Epidemiological studies of depression show that three factors—gender, age, and marital status—are important elements associated with depression. Women have a twofold increased risk of depression as compared to men. In general, a stable marriage has a protective effect, while separation and divorce significantly increases the risk of major depression (van de Velde). However, if there is a genetic predisposition with a family history of depression, the illness may develop, whether the subject is married or not. Likewise, because of genetic vulnerability, the distress of separation or divorce will increase the likelihood of developing major depression. Besides the role of genetic vulnerability, a history of traumatic experiences can contribute to the development of depression, unless the issue has been successfully dealt with through therapy.

In recent years there have been reports of depression and suicide among celebrities in the field of entertainment. While various professions may demonstrate a higher rate of suicide or depressive

disorders, individuals in the entertainment industry are perhaps more inclined to consume mood-stimulating drugs to mask their inner struggle with depression. Moreover, the public image of celebrities in this domain may impede their seeking treatment, a response that results in the worsening of depression with serious consequences, including eventual suicide. Furthermore, the coexistence of depression with other mental disorders, such as substance abuse, eating disorders, alcoholism, psychosis, and other diseases mentioned previously, may complicate if not worsen the depression.

As the use of social media as a means of interpersonal communication has become popular, the issue of bullying through this medium has had tragic consequences in North America in recent years, particularly among teenagers and young adults. Bullying among students, whether in real life or online, like any other traumatic experiences, may result in depression.

It has been estimated that almost 20% of adolescents experience a depressive episode by the age of eighteen. In view of the biopsychosocial changes during the period of adolescence, the onset of depression during this important period of life can have a disruptive effect on one's life. It can also have adverse consequences on one's future and thus requires early intervention (Cairns et al.).

Paul T. P. Wong, in his article, "Suicide Risks among College Students from Diverse Cultural Backgrounds," indicates that suicide is more than a medical issue; it is also a cultural and existential one. Impulsivity, mood swings, and involvement in substance abuse can contribute to suicidal behavior. Where there is a history of depression and suicide in a family, it is important that family members who show symptoms of depression be encouraged to seek treatment before the condition worsens. When suicide occurs among peers in high school or university, especially if the deceased person was a close friend, friendly counseling, emotional support, and, if needed, therapy for the youth who is affected is advisable. This is even more important if the youth is depressed.

Alcohol consumption, both in terms of frequency and quantity, plays an important role as a predictor of higher levels of depression. Because adolescents are in a developmental period of their lives, alcohol has neurotoxic effects as well as social consequences. It is also possible that, in order to deal with a depressive mood, some individuals resort to increased consumption of alcohol or stimulant drugs. Likewise, the use of cannabis is also associated with the development of depression and cognitive impairment. Cannabis interferes with serotonin and other neurotransmitters of the brain and increases the likelihood of depression (DuPont 155).

Life crises, stress, and suffering due to failure to achieve cherished life goals may also lead to depression and despair. However, the silver lining to these experiences may be that the individuals enduring these experiences develop resilience that will stand them in good stead in their future experiences (Ghadirian 23).

Depression is a major public concern, especially among the elderly population (age 65 and older) and is deemed the most prevalent psychiatric disorder among elderly people. It was reported that in 2004 about 17% of women and 11% of men aged 65 and older showed clinical symptoms of depression (Conner et al.).

Older African Americans are vulnerable to depression, as they suffer more psychosocial distress than their white counterparts due to exposure to racial prejudice, discrimination, poverty, and violence, while, at the same time, they may have less access to psychiatrists and other health professionals. Despite these risk factors, the prevalence of depression among them is not greater than that experienced by older individuals who are white. This may be partly because older African Americans have a strong sense of faith and belief in God and prayer and are strongly connected to their religious community. This, however, does not mean that white Americans lack religiosity or belief in God. Rather, it underlines the importance of having a mental health program that takes into consideration the support provided by religious communities (Conner et al.).

Protective Factors

One of the most important protective factors in dealing with depression is emotional support from friends and family who keep the patient company and make him or her feel that there is someone they can count on, someone who listens and who wants to help. Likewise, the role of a community that provides loving assistance without being judgmental, that listens and that facilitates patients' contact with mental health professionals, is equally vital for the patient. Another protective factor lies in the resilience afforded by faith, religious belief, and acceptance of depression as a life challenge to be faced with hope and optimism.

Belief in God and having a spiritual understanding of the purpose and meaning of life can be very reassuring, especially if the religion teaches that illness and suffering can be a source of spiritual growth for those who appreciate that it is only through testing and stress that we are compelled to examine our beliefs and strengthen our faith. As mentioned at the outset, this attitude is particularly true with the Bahá'í Faith, which teaches that our spiritual development is contingent on our coming to understand that the tests and difficulties of life—such as emotional or physical illness—urge us to rely on our beliefs. Even more to the point, the Bahá'í Writings—the revealed prayers in particular—offer a wealth of reassuring words of wisdom regarding how to approach life's crises and individual suffering.

But as mentioned earlier, the Bahá'í Faith also teaches that the spiritual and physical expressions of reality have a counterpart relationship. Consequently, while prayer and other spiritual practices can assist in our physical or mental health, we should seek the care of a competent physician: “Resort ye, in times of sickness, to competent physicians; We have not set aside the use of material means, rather have We confirmed it through this Pen, which God hath made to be the Dawning-place of His shining and glorious Cause” (Bahá'u'lláh, *Kitáb-i-Aqdas* ¶113).

Ideally, in a community where there are close and caring relationships, assistance and a supportive attitude can be therapeutic, mitigating distress and helping patients to seek treatment. In individualistic cultures where extended family life and human contact are reduced, people are more likely to feel isolated and vulnerable at the time of emotional crisis. Here again, the emphasis in the Bahá'í teachings on the intimate relationships established in the local Bahá'í community can play a critical role in coming to the aid of one suffering from depression and other mental and physical illness.

Depression and Suicide

The greatest risk in terms of the tragic consequences of untreated depression is suicidality. The risk of suicide may vary from one culture to another and even within a cultural population. Suicidality may be expressed differently from one age group to another. Suicidal attempts are more frequent in women than in men, but mortality as a result of a suicidal attempt is far greater among men.

Approximately 1 million lives of all ages are lost every year worldwide due to suicide—that is 3,000 suicide deaths every day. Sadly, for every completed suicide, there are twenty or more individuals who attempt suicide (WHO, World Suicide Prevention Day 2012 brochure).

According to the National Institute of Mental Health (NIMH) in the United States (“Suicide in America: Frequently Asked Questions”), about 38,000 people die by suicide each year. The NIMH indicates that the risk factors for suicide in people of all ages, ethnicities, and genders are as follows:

- Depression, other mental disorders or substance abuse disorder
- A prior suicide attempt
- Family history of a mental disorder or substance abuse
- Family history of suicide
- Family violence, including physical and sexual abuse

- Having guns or other firearms in the home
- Incarceration, being in prison or jail
- Being exposed to others' suicidal behavior, such as that of family members, peers, or media figures

The gravity of suicidality among patients is divided into three risk levels: low, medium, and high. Low-risk patients have no previous suicidal attempts or suicidal ideation, or if they had suicidal thoughts, they had no plan or intention to carry them out. Medium-risk patients have suicidal ideas and plans but have made no attempt to end their lives. High-risk patients are those who have a suicide plan with the intent to carry it out and may have made a recent attempt. The first group requires out-patient follow-up, but the second or medium-risk group should be referred to a psychiatrist for treatment without delay. High-risk patients require constant observation for treatment (Bentley et al.). It should be noted that the situation of a patient with major depression and suicidality may change, depending on the circumstances.

Elderly people, especially those with major depression, are at higher risk for suicide than other age groups (Rushing et al.). Other risk factors include loneliness, lack of social or family support, separation, divorce, non-compliance with treatment, use of alcohol or other substances of abuse to control depression, refusal of medicinal treatment, failure to reach cherished goals, and the loss of close friends or loved ones and the anniversary of their death. Those depressed individuals who are by nature reclusive, lonely, and introverted may be more at risk, as they usually avoid social contact, reject support, and isolate themselves. With a feeling of being depressed comes a sense of hopelessness, helplessness, worthlessness, and guilt, which can further fuel death wishes and suicidal behavior.

Having a history of suicidal attempts increases the risk of suicide. Sometimes a failed love relationship and a strong sense of rejection can trigger suicidal behavior. An unexpected and unexplained mood change in depressed patients who suddenly appear happy and unusually cheerful may suggest that a decision has been made to commit suicide. But there could also be exceptions, such as a dramatic change in one's gloomy situation, consumption of illicit and mind-altering drugs, or any other development that would alleviate the pain of an internal struggle. Expert clinicians may be able to recognize the meaning and significance of such a rapid change of mood and consider necessary intervention.

Seeking out a therapist or physician at the time of crisis is a necessity. As primary care providers are at the front line of health professionals who interact frequently with depressed and suicidal patients, their knowledge and skills are invaluable in therapeutic intervention and counseling. In a review of forty research studies on suicidality, it is reported that 75% of patients who committed suicide had contact with primary care clinicians during the year of their death, as compared to one-third who had contact with mental health services. Although it is difficult to predict which patients with suicidal thoughts will attempt suicide and thus seriously endanger their lives, assessment of suicidality should be vigorously pursued. And in light of the fact that primary care clinicians see a large number of depressed patients, many of whom may subsequently be at high risk for suicide, it is important that screening for high-risk depressed patients be undertaken with great care (Schreiber and Culpepper 2015). To what extent screening patients for potential suicidality in primary care can reduce mortality rates needs to be further explored.

There are also varying degrees of guilt experienced by loved ones, especially family members, of those who commit suicide. Psychological and emotional reaction to such a traumatic tragedy can be overwhelming and requires special attention to the wellbeing of family members, particularly the younger ones who may also suffer from depression.

Here again, religion and culture also play a role in the prevention of suicide. In a study of the influence of religiosity on suicidal behavior in Brazil, 110 individuals who had attempted suicide were compared with 114 control individuals with no history of suicidal attempts. In this study, religiosity was assessed

according to three aspects as follows: (1) organized religious activities, (2) non-organized religious activities, and (3) intrinsic religiosity. Results showed that religiosity in its three dimensions was an important protective factor against suicidal attempts (Carib et al.). Another study of 454 students revealed that it was more the social support provided by religious communities that mediated reduced suicidal behaviour, and not religiosity as such (Robins and Fiske).

Religious education provides a framework of attitudes and intrinsic values that can have a positive effect on mood and mental health. But in most psychiatric literature, religion has also been held responsible for negative effects. For example, it has been shown that in some religious individuals, a strong sense of guilt can further deepen their depression and despair. However, the adverse influence of religion is often due to misinterpretation of the original teachings. In most religions, human life is considered sacred and human beings are considered to have been created in the image of God. This notion can have a profound effect on safeguarding the body as the temple of the soul.

In the Christian Bible and the Jewish Talmud, suicide is mentioned without elaboration as to the ethical aspect of it. But from the time of Saint Augustine, the Christian Church has developed a theological stance against suicide. In the Holy Qur'án, suicide is expressly condemned in an explicit statement, "do not kill or destroy yourself" (4:29). Potential offenders are warned that they will be punished by being cast into the fire in the next world (Pritchard & Amanullah). As a result, suicide rates historically have been much lower in countries with strict Islamic rules.

With regard to the Bahá'í view of suicide, in a letter written on behalf of the Universal House of Justice, we find the following excerpt from a letter written on behalf of Shoghi Effendi² to a believer: "Suicide is forbidden in the Cause. God Who is the Author of all life can alone take it away, and dispose of it the way He deems best. Whoever commits suicide endangers his soul, and will suffer spiritually as a result in the other worlds beyond.' The House of Justice admonishes you to put all thought of suicide and death out of your mind and concentrate on prayer and effort to serve the Cause of Bahá'u'lláh" (*Lights of Guidance* no. 677).

In reflecting on this ostensibly harsh statement regarding the consequences of suicide, one would do well to consider the following analogy, especially in counseling those suffering from depression or other affective disorders. Let us compare this life to the life of the fetus in the mother's womb as it grows and evolves during its nine-month term. Should this process be suddenly cut short, the result would be catastrophic: the baby might die instantly or be born defective and unable to lead a full life in this world. Similarly, the failure to develop our spiritual capacities in this life may well result in limiting our initial success in the life hereafter. Furthermore, consistent with the logic of an ever-forgiving and merciful God, a letter written on behalf of Shoghi Effendi to an individual believer states, "The manner in which the Supreme Being, in His justice as well as in His mercy, will deal with every individual soul is a mystery unknown to us on this earthly plane" (*Lights of Guidance* no. 676).

Holistic Approach and Healing

The concept of holism and a holistic approach to health views human functioning as a whole with components that are closely interrelated. According to a holistic philosophy, spiritual, physical, mental, and emotional functionality are all equally relevant to human health. Using a holistic model, one cannot treat one component of an illness without understanding the interaction between all components and maintaining a balance in the process (Westgate 27). Therefore, in treating depression, a holistic clinician would address the physical, emotional, cognitive, social, and spiritual aspects of the patient's wellbeing.

Hippocrates stated, "It is more important to know what sort of person has a disease than to know what sort of disease a person has" (cited in Gabbard 1). With the rapid progress of medical technology,

² Appointed successor of 'Abdu'l-Bahá as head of the Bahá'í Faith.

physicians are tending to become more disease-oriented and less person-oriented. But is treating the illness the same as healing the person?

Physician and end-of-life care specialist Michael Kearney believes that treatment and healing are two distinct processes. Treatment implies the physician's relationship with the disease and its eradication. But healing is a process through which the physician relates to the patient as a person. In this relationship, the physician aims to restore hope and wholeness in the patient, and through this process the patient is able to draw a meaning from the illness and develop a capacity to grow. In light of this distinction, a patient may be successfully treated but not healed; that is, the patient's hope and wholeness may not be restored (40).

Along with the conventional treatment modalities for depression, it is necessary to reflect on a healing process that is not a substitute for treatment but is complementary to it. This complementarity is especially relevant in the treatment of depression or other psychiatric disorders. A patient needs not only to feel the presence of the physician as a healer, but also to experience a sense of empathy, respect, and understanding from the healer.

This holistic approach thus requires that physicians and other health professionals refine their attitude and vocabulary, refraining from referring to a patient as an entity with a disease, such as "a bipolar," "a schizophrenic," "an obsessive-compulsive," or "an epileptic." The person must come first as someone who suffers from an illness. A spiritual perspective on the nature of human beings facilitates this process of refinement of attitude.

There are a few factors in the psychology of wellbeing included within the current largely materialistic definition and classification of depression and other psychiatric disorders in *DSM-5*, that is, losses more related to the biological side of depression such as loss of appetite, sleep, sexual desire, and energy. However, there are others that the publication does not take into account, such as loss of our feeling toward some deeper aspects of our being, especially including the meaning and purpose of life. These central spiritual and philosophical concerns are closely related to loss of hope, for when life seems to have no meaning, one may well succumb to a sense of emptiness and lassitude. One may feel that there is nothing to look forward to. In our present predominant culture of consumerism, this feeling of emptiness is common, and to compensate for this prevalent attitude, one may develop an almost pathological overdependence on material things to achieve some degree of satisfaction. Material satisfaction of extrinsic desires thus becomes a substitute for deeper intrinsic needs and spiritual values. Indeed, it is not surprising that many drug addicts are searching for something beyond pleasure, and it is precisely in such a context that Bahá'u'lláh reminds us, "Noble have I created thee, yet thou hast abased thyself. Rise then unto that for which thou wast created" (Hidden Words, Arabic no. 22). Yet another factor is the loss of love and connectedness. By connectedness here is meant a sense of interpersonal relationship with others as members of one human family. This is the most cherished part of humanness—to build a community in love and unity, to feel each others' joy and sorrow, and to be united. More importantly, because human nature is essentially metaphysical (it emanates from the soul), one who avoids or disavows developing spiritual values will necessarily become unfulfilled and, subsequently, experience the affective results of that deficiency.

Prevention

In view of the seriousness of depression, it is important to consider how protective intervention may serve as a possible preventive strategy to delay or reduce the likelihood of the onset of this illness and its consequences. Many people are unaware of the symptoms of depression and the fact that inability to cope with emotional crisis may lead to depression. Preventive education and public awareness can especially enable those with a family history of depression to recognize the initial symptoms and seek out counseling and treatment, as early diagnosis and intervention are vital in preventing an acute or chronic state of major depression.

As already discussed in this article, the problem of stigma delays treatment, as does the lack of professional resources and facilities in different parts of the world. In their paper “Preventing the Onset of Major Depressive Disorder,” Van Zoonen and colleagues point out that there should be universal prevention for the general public, regardless of risk factors. But there should also be selective prevention targeted toward individuals who are at higher risk for developing psychiatric disorders such as those who have been identified as having early symptoms and those with a genetic predisposition to depressive disorders. These authors report that prevention of depression seems feasible and may, in addition to treatment, contribute to delaying or preventing the onset of depressive disorders (319).

Depression: A Disease of Modernity?

The notion of depression as a “disease of modernity” has attracted considerable attention in recent years. From the beginning of the twentieth century to the present, people’s health and daily life have gone through significant changes. Most infectious diseases of the past have been eradicated, while new types of illness hardly known before have emerged—osteoporosis, different types of eating disorders (such as anorexia nervosa), Alzheimer’s disease, post-traumatic stress disorder, and more chronic diseases as an aging population increases in numbers. Likewise, different types of mood disorders have been recognized and their prevalence explored.

Most community-based cross-sectional research on mental illness shows a greater lifetime risk for depression since the beginning of last century. Although the retrospective methodology that was used for these studies is not sound, there are indications that lifestyle and psychosocial factors may have a role in the occurrence of some types of depression (Hidaka 206). In Hidaka’s view, a key component of the modern and Western culture that has contributed to the rise of depression is reduced physical activity, a tendency that results in weight gain and obesity and their adverse health consequences. In addition, he writes, “A toxic social environment characterized by increasing competition, inequality and social isolation may also contribute to a depressionogenic milieu” (208).

Questions have also been raised about the reasons for the rise of higher risk for depression among young people despite the fact that they live with more wealth, greater prosperity, and a higher standard of living. According to David Myers, a professor of psychology, during the past forty years people have become twice as rich but are not happier than they were forty years ago. In fact, the divorce rate has doubled, teen suicide has tripled, and reported violence has almost quadrupled. The prevalence of depression has soared, particularly among adolescents and young adults (Myers 61).

It might seem counter-intuitive that most modernized countries with a high GDP (gross domestic product) per capita also tend to have higher rates of depression, though this finding may be debateable because it is not only GDP that may impact the prevalence of depression (Hidaka 207). Nevertheless, a gradual erosion of values caused by attachment to materiality and the unrealistic expectation that wealth and affluence bring happiness and contentment may be psychosocial factors responsible for many cases of mild to moderate depression.

There are other studies that also suggest a relationship between depression and modernization. For example, there is a higher prevalence of depression among Mexican Americans born in the United States who have adopted the American lifestyle, as compared to new immigrants from Mexico. On the other hand, minorities, especially migrants and refugees, after arriving in a new country, may find the challenge of adapting to a new environment and culture very stressful (Vega et al. 532).

Another example of this relationship between depression and modernization has been observed in metropolitan China, which, during recent decades, has experienced significant cultural transformation and, at the same time, has seen the prevalence of depression rise significantly. It is reported that Chinese people born in 1966 were 22.4 times more likely to suffer a lifetime depression episode as compared to those born in 1937 (Hidaka 208; Lee et al.). It is also noted that, in developed countries, urban dwellers

have a higher prevalence of psychiatric disorders, particularly mood and anxiety disorders, as compared to their rural counterparts (Peen et al.).

Related to these findings about modernization and depression is the finding that in the Amish culture, where there is a strong sense of community combined with a coherent religious perspective and shared values, the rates of major depression and bipolar disorder are very low—approximately 1% for each of these disorders (Egeland and Hostetter). In short, there remains little doubt that assuming a predominately materialistic perspective and way of life, characterized by an overdependence on material means to satisfy intrinsic needs, produces a climate in which depression is much more likely to develop, whereas a society or community life characterized by an emphasis on the development of spiritual values and collaboration among its members creates an atmosphere where depression and other related disorders are much less likely to occur.

As a result of these findings, some theories have been postulated that the decline of a spiritual perspective on life has produced a significantly more negative impact on depression and mental health in general. For example Viktor Frankl³ concluded that the existential neurosis of modern society is meaninglessness, which creates what he called an “existential vacuum.” Psychology professor Brink similarly hypothesized that people become more vulnerable to depression as a result of losing touch with the spiritual aspect of human nature and of reality as a whole.

In conclusion, some have argued that not only does spirituality play a vital role in human growth and fulfilment but also that there is a link between a lack of spirituality and increased feelings of hopelessness, meaninglessness, and depression (Westgate 27). The result of this decline in spiritual values and beliefs is a demonstrably negative impact on mental health in society, a decline that psychologist and author Rollo May notes in his 1975 article, suggesting that one major reason for the growing need for psychotherapy is the loss in our society of a connection with a sense of a shared identity as expressed through common “myths, values and symbols.”

Religion, Spirituality, and Depression

As has become apparent in our analysis of depression—its causes and treatment—the role of religion and spirituality has been seen to have a significant impact on the occurrence of this disorder and its treatment. It has also been noted that the Bahá’í Faith, because it upholds the harmony of science and religion, has a particularly valuable perspective about the relationship between spirituality and health—both mental and physical. In the following pages we will examine some of the Bahá’í views about how religion can assist us in preventing and treating this prevalent affective disorder.

To begin with, the Bahá’í Writings state that religion is a system of knowledge, divine in origin, whose purpose is to guide humanity: “. . . the religions of God are the true source of the spiritual and material perfections of man, and the fountainhead for all mankind of enlightenment and beneficial knowledge” (‘Abdu’l-Bahá, *Secret of Divine Civilization* 94). Of course, as an ineffable condition or reality, spirituality is a phenomenon beyond our exact understanding, though according to the Bahá’í teachings, spirituality is a power capable of connecting us with the Creator: “The process of developing one’s spiritual capacities is called . . . *spirituality*. . . Spirituality is the process of the full, adequate, proper, and harmonious development of one’s spiritual capacities” (Hatcher 935).

The Bahá’í Writings further teach that it is the human spirit or soul that is the essential reality of the human being and it is that capacity that, according to ‘Abdu’l-Bahá, “distinguishes man from the animal” (*Some Answered Questions* 208). Shoghi Effendi further explains that “. . . we have three aspects of our humanness, so to speak, a body, a mind and an immortal identity—soul or spirit. We believe the mind forms a link between the soul and the body, and the two interact on each other” (*Arohanui—Letters to New Zealand* 89).

³ Viennese neurologist and psychotherapist, Holocaust survivor, and founder of logotherapy.

At its best, then, religion is capable of providing these sorts of spiritual insights into the nature of human beings. But it is also capable of inspiring strength, faith, and the means wherewith we can cope with adversity. For example, in a research article published in the *New England Journal of Medicine*, it was reported that 90% of Americans coped with the stress of the tragedy of September 11, 2001, by “turning to religion” (Schuster et al.). Gallup polls in the United States, a few years later, reported that over 75% of Americans consider religion to be an important part of their daily life (Koenig “Depression in Chronic Illness: Does Religion Help?”). Summing up the reasons for this phenomenon, Koenig states,

Religious beliefs provide a sense of meaning and purpose during difficult life circumstances that assist with psychological integration; they usually promote a positive world view that is optimistic and hopeful; they provide role models in sacred writings that facilitate acceptance of suffering . . . and they offer a community of support, both human and divine, to help reduce isolation and loneliness. Unlike many other coping resources, religion is available to anyone at any time, regardless of financial, social, physical, or mental circumstances.” (“Research on Religion, Spirituality, and Mental Health” 285)

The World Health Organization (WHO) has declared that spirituality constitutes an important dimension of the quality of life and should be given special attention (WHO Quality of Life Position Paper). During the past forty years there has been a flurry of interest, research, and publications on the interrelationship between spirituality, religion, and medicine. There have likewise been numerous studies on the relationship between religious beliefs, spirituality, and depression. Most of these studies agree that affiliation with religion and actively attending worship services are likely to produce protective effects to guard against developing depression (Koenig et al. “Religiosity and Remission of Depression in Medically Ill Older Patients”; Miller; Durkheim; Braam) Of course, not all researchers agree as to whether it is religious affiliation or spirituality that has the greater effect in this regard—these concepts are somewhat distinct but they overlap. Spirituality is a broader concept that includes values and beliefs, while religiosity reflects institutional aspects of religious beliefs and devotion to it (Westgate 27).

McCullough and Larson in their review of the literature found that

some measures of religious involvement are indeed associated with depression. People who are involved frequently in organized religion and who highly value their religious faith for intrinsic reasons are at substantially reduced risk of depressive disorder and depressive symptoms. They appear to recover more quickly from depressive episodes and are less likely to become depressed over time. Conversely, people who are involved in religion for reasons of self-interest are at a decidedly higher risk for depressive symptoms. Whilst the longitudinal data at present is limited, it does give tremendous incentive for further inquiry into the possibly causal nature of the religious involvement-depression relationship. (126)

Baetz et al. conducted an epidemiological study on spirituality and mental health with research data drawn from 70,884 individuals aged fifteen years and older. This study was part of the Canadian National Health Survey, and the results showed that those who regularly attended worship services had significantly fewer depressive symptoms. However, individuals who believed that they were spiritual and religious but did not regularly attend worship services had a higher level of depressive symptoms.

A similar result was reported by Koenig in North Carolina (USA) in a survey of older medical inpatients with major or minor depression. Results showed that individuals who identified themselves as being spiritual but not religious were significantly more likely to suffer major or minor depression. In contrast, patients who considered themselves both religious and spiritual were almost 80% less likely to

have depression. The results showed that religious involvement has a positive effect and may protect older patients from depression (“Religion and Depression in Older Medical Inpatients”).

A research conducted by Dervic et al. studied the role of religion and spirituality in suicidal behavior by examining risk and protective factors with respect to such behavior in a group of depressed adults with a childhood history of abuse. Their finding was consistent with previous research results that have suggested that religiosity protects against suicidal behavior.

In Miller’s 1999 study researchers found that religiosity protected against recurrence of depression, while in Koenig’s 1998 study it was noted that religiosity hastened remission among moderately depressed patients. The findings of both studies, however, support the strength of intrinsic religiosity as a protective factor in the course of depression. A research study by Walsh and colleagues revealed that “[p]eople who profess stronger spiritual beliefs seem to resolve their grief more rapidly and completely after the death of a close person than do people with no spiritual beliefs” (1).

Koenig et al. in their systematic review of research findings from 1872 to 2012 reported that 61% of 414 observational studies found a significant inverse relationship between religious or spiritual (R/S) involvement and depression (as R/S increased, depression decreased). They also reported that of 70 prospective studies, 58% found that individuals with more active R/S involvement were less likely to suffer from depression or more likely to recover from it (“Depression”).

Research also indicated that maternal religiosity had a protective effect against maternal depression. In addition, maternal religiosity and mother-offspring concordance of denomination (both Protestant or both Catholic) were protective against offspring depression (Miller).

There has been speculation on the dynamic of the effects of religion on depression, and two theories emerge in this respect (Braam et al.). One emphasizes cognitive psychological mechanisms such as religion as an aid in structuring personal life and coping strategies. The second is a sociological theory suggesting that religion protects older adults from depression because it enhances social support. However, beyond these psychosocial theories, religion has a deeper influence as an agent for spiritual empowerment and transformation.

As religion and spiritual beliefs positively influence people’s attitudes toward themselves and their wellbeing and help them develop better insights for coping in the face of physical and emotional disorders, those holding such beliefs seem to be less vulnerable to depression. But again, it is hard to make generalizations because biological and genetic predisposition increases vulnerability to depression, regardless of one’s religious beliefs.

There has been recent interest in exploring the relationship between optimism, depression, and spirituality. Mofidi et al. in their survey of racially diverse adults in rural North Carolina reported that an indirect link exists between spirituality and depression symptoms. This relationship is mediated by optimism, social support, and volunteering. In the survey it was noted that a spiritual worldview of life events and reliance on a higher power through faith may generate a sense of optimism and confidence that can act as a deterrent to depression.

Methodological Issues

It is difficult to determine the effect of religious beliefs, spirituality, and prayer on the healing process because methods used to research material phenomena are ill-suited to the exploration of intangible and non-material processes. Although prayer can actually have some physiological effects—for example, relaxation and other observable results—it is difficult to unravel the mechanism through which prayer exerts its spiritual effect. Prayer, like love and compassion, is an intangible and subjective phenomenon that cannot be easily measured and precisely quantified.

Consequently, the study of the relationship between spirituality/religiosity and mental health has encountered many methodological challenges. Baetz et al. note the following difficulties in studies of the interrelationship between religion and depression:

- Lack of uniformity of measures of religiousness being used in studies. Such measures include organized religious affiliation, beliefs or other constructs of religiousness (worship service attendance), non-organizational component (frequency of prayer).
- Some individuals may identify themselves as spiritual but not religious or vice versa. The definition of spirituality itself is unclear and so is its relationship with depression.
- Research studies have generally used specific populations such as people of a particular race, age group and geographic region with higher or lower rates of religiousness which make it difficult to generalize.

In reviewing studies on religious affiliation in depression, we encounter several other confounding factors. Some methodological issues may have affected the outcome of studies, such as selection of participants and differential test validity for some religious or ethnic groups. Other important factors that may affect the outcome are genetics, sociological characteristics, lifestyle differences, significant religious/spiritual practice variations, and latent predispositions for psychiatric disorders (McCullough and Larson).

Misconceptions about Psychiatric Disorders

People of different cultures and religious populations have various misconceptions about mental health and disorders. The basis for these kinds of thoughts is ignorance, misinformation, stigmas, and a variety of unfortunate sociocultural views. The following are but a few examples of such attitudes, which underscore the important need for public education about depression and other mental health issues.

Regarding the treatment of psychiatric disorders, there is a misconception that medication prescribed by physicians in the treatment of major depression is a “chemical” that is bad for the mind and body. In fact, every medication prescribed, whether for medical or psychological problems, may have some side effects. Reluctance to accept the medicine may in some cases reflect the individual’s denial of the reality of his or her illness that requires treatment. Although there are many modalities in the treatment of depression—such as various forms of psychotherapy—there are times when the use of antidepressants or other medications is unavoidable to prevent deterioration and worsening of the illness. Unfortunately, in recent years there have been some articles suggesting that antidepressant treatment is ineffective and harmful. Although these articles create sensational publicity, they do not reflect the extensive and significant scientific research findings that prove quite the contrary.

Among Bahá’ís, as well as in many other religious communities, there are a number of misconceptions about mental illness in relation to spirituality and religion, only a few of which are mentioned here. One misconception held by some is that if one is a faithful and devoted person, one should not develop depression or suffer other psychiatric disorders. Akin to this attitude is the equally unfortunate and dangerous assumption that mental illness is a sign of spiritual weakness; that one enduring such a disorder is somehow “less spiritual”; and that if one were sufficiently religious, he or she should be able to overcome these emotional conditions through faith, prayer, and trust in God.

Another common but most deplorable misconception is the notion that a psychiatric disorder is a punishment from God. Such a belief may cause the individual’s depression to worsen and may contribute further to his or her sense of abasement or bring about the conclusion that he or she is unworthy of receiving treatment. Indeed, this misconception has caused some researchers to suggest that strong religious beliefs often bring about guilt and other equally pejorative “side effects.”

In a letter written on behalf of Shoghi Effendi to an individual believer, we find the following most salient and elucidating statement about the relationship between mental illness and spirituality: “[W]e

must always remember these illnesses have nothing to do with our spirit or our inner relation to God” (*Lights of Guidance* 282). He furthermore states, “You must always remember, no matter how much you or others may be afflicted with mental troubles and the crushing environment of these State Institutions, that your spirit is healthy, near to our Beloved, and will in the next world enjoy a happy and normal state of soul. . . . Let us hope in the meantime scientists will find better and permanent cures for the mentally afflicted. But in this world such illness is truly a heavy burden to bear!” (282).

Some individuals have difficulty in making a distinction between a psychiatric illness and a spiritual disorder or feebleness. Unable to distinguish between the two, they may become convinced that the only way to overcome the former is through intense prayer, and they may likewise refrain from seeking proper treatment. Consequently, the illness will continue to progress, eventually resulting in the need for active intervention, such as hospitalization or even in tragic consequences unless effective treatment is implemented.

According to the Universal House of Justice,

[M]ental illness is not spiritual, although its effect may indeed hinder and be a burden in one’s striving toward spiritual progress. In a letter written on behalf of the Guardian to a believer we find: “Such hindrances (i.e. illness and outer difficulties), no matter how severe and insuperable they may at first seem, can and should be effectively overcome through the combined and sustained power of prayer and of determined and continued effort.” That effort can include the counsel of wise and experienced physicians, including psychiatrists. Working for the Faith, serving others who may need you, and giving of yourself can aid you in your struggle to overcome your sufferings. . . . (*Lights of Guidance* 285)

Bahá’u’lláh affirmed: “Know thou that the soul of man is exalted above, and is independent of all infirmities of body or mind. That a sick person showeth signs of weakness is due to the hindrances that interpose themselves between his soul and his body, for the soul itself remaineth unaffected by any bodily ailments” (*Gleanings* 153–54).

The Bahá’í Writings and Depression

As we have already noted, the Bahá’í Writings offer a particularly interesting perspective from which we can study the relationship between religion or spirituality and depression because of the emphasis in the Bahá’í teachings regarding the harmony between science and religion. For example, ‘Abdu’l-Bahá states, “Religion and science are inter-twined with each other and cannot be separated. These are the two wings with which humanity must fly. . . . Therefore, science, education and civilization are most important necessities for the full religious life” (*‘Abdu’l-Bahá in London* 28). Indeed, from the Bahá’í point of view, religion and science are two major systems of knowledge that precisely complement one another.

As this axiom relates to the interaction between healing and spirituality, we find the following related passage in the writings of ‘Abdu’l-Bahá:

There are two ways of healing sickness, material means and spiritual means. The first is by the use of remedies, of medicines; the second consists in praying to God and in turning to Him. Both means should be used and practiced. Illness caused by physical accident should be treated with medical remedies; those which are due to spiritual causes disappear through spiritual means. Thus an illness caused by affliction, fear, nervous impressions, will be healed by spiritual rather than by physical treatment. Hence, both kinds of remedies should be considered. (quoted in *Bahá’í World Faith* 375–76)

This dual approach to healing is very important in the field of treating depression and other emotional disorders, and the exploration of the interaction between spiritual activities and healing warrant a great deal of study. For example, prayer is one important expression of faith and perhaps the oldest means for alleviating the anguish of suffering and depression. According to the Bahá'í teachings, the reason for the efficacy of this process is that prayer for healing connects the suppliant's soul with the Creator and thus assists the patient to accept the reality of a sickness. And yet, while prayer is used for this purpose worldwide in virtually every major religion, it should not be considered a substitute for medical treatment. Nevertheless, researchers have shown deep interest in the effect of prayer on emotional and medical disorders, though the current methodology used to measure the effects of prayer, spirituality, compassion, and other non-material practices is not sufficiently refined to be of significant value.

While medical science can explain the nature of depression and its diagnosis and treatment, the Bahá'í Writings provide spiritual insights on depression and suffering. They define an individual's attitude with respect to acknowledging the illness and seeking treatment for it. In the Western world, suffering has been perceived as another form of illness or morbidity, devoid of meaning. The word "suffering" derives from the Latin word *sufferentia*, meaning "endurance." Although some sadness and sorrow may emerge from our attachment to the material world, we should make a distinction between the sadness of clinical depression and the sorrow that is related to spiritual causes.

With regard to the source of human sorrow and sadness that is not the result of clinical depression, 'Abdu'l-Bahá explains, "In this world we are influenced by two sentiments, Joy and Pain. . . . There is no human being untouched by these two influences; but all the sorrow and the grief that exist come from the world of matter—the spiritual world bestows only the joy! If we suffer it is the outcome of material things, and all the trials and troubles come from this world of illusion" (*Paris Talks* 109–10). In addition, 'Abdu'l-Bahá notes that "[t]oday, humanity is bowed down with trouble, sorrow and grief, no one escapes; the world is wet with tears; but, thank God, the remedy is at our doors. Let us turn our hearts away from the world of matter and live in the spiritual world! It alone can give us freedom! If we are hemmed in by difficulties we have only to call upon God, and by His great Mercy we shall be helped" (*Paris Talks* 110).

As noted, these insightful passages refer to the general aspects of human sorrow and sadness. The Bahá'í Writings do not provide specific guidelines for medical or psychological diagnoses and treatment of disorders such as major depression, bipolar disorder, or schizophrenia. The believers are advised, for these and all other medical illnesses, to seek treatment from competent physicians. What is mentioned above describes a spiritual or Bahá'í perspective related to the general suffering and affliction engulfing humanity in order to demonstrate how a spiritual attitude can assist humanity in coming to terms with the challenges and adversities that characterize contemporary society.

Viktor Frankl, the Viennese psychiatrist who survived internment in a concentration camp during World War II, wrote about the meaning of suffering. He believed that whenever someone faces a situation that is unavoidable, such as an incurable disease, he or she is given a last chance "to actualize the highest value, to fulfill the deepest meaning, the meaning of suffering" (*Man's Search for Meaning* 178–79).

In his book *Man's Search for Meaning*, Dr. Frankl recounts his meeting with an elderly general practitioner who came to his office for treatment for severe depression. The patient explained that his depression had begun two years earlier when his wife, whom he loved very much, died. Dr. Frankl wondered how he could help this man and decided to confront him with the question, "What would have happened, Doctor, if you had died first, and your wife would have had to survive you?" His patient said, "Oh, for her this would have been terrible; how she would have suffered!" Then Dr. Frankl replied, "You see, Doctor, such a suffering has been spared her, and it is you who have spared her this suffering; but now, you have to pay for it by surviving and mourning her." This explanation comforted the patient

who left the office with a sense of acceptance regarding his condition. Frankl wrote, “Suffering ceases to be suffering in some way at the moment it finds a meaning, such as the meaning of sacrifice” (178–79). The above account reflects how the interpretation of the meaning of a loss can restore peace of mind.

Traumatic life events and existential crises can lead to a depressive condition that will require treatment. Depression and suffering are intertwined, but not everyone who suffers from a life crisis is clinically depressed. While depressed patients, especially those with protracted and severe depression, may experience suffering and despair, other individuals may experience a range of emotional disturbances that are associated with a depressive mood, such as grief, sorrow, and sadness due to losses, but this does not mean they will become clinically depressed.

The value of a spiritual perspective in dealing with depression, such as that found in the Bahá’í Writings, is that when they accurately portray life, they are capable of raising individual awareness to a greater understanding of the meaning of life and the nature of the human experience as being essentially spiritual. They thereby inspire hope and confidence that life’s challenges can be overcome and are an important means by which personal spiritual growth can take place in our life’s journey. For example, the following statement of ‘Abdu’l-Bahá is very illuminating in this regard: “Do not grieve at the afflictions and calamities that have befallen thee. All calamities and afflictions have been created for man so that he may spurn this mortal world—a world to which he is much attached. When he experienceth severe trials and hardships, then his nature will recoil and he will desire the eternal realm—a realm which is sanctified from all afflictions and calamities” (*Selections* 239). Moreover ‘Abdu’l-Bahá reassures us with these words: “Grieve thou not over the troubles and hardships of this nether world, nor be thou glad in times of ease and comfort, for both shall pass away” (*Selections* 177).

In this same context, the Universal House of Justice, the supreme governing body of the Bahá’í Faith, draws our attention to the plight of humanity, presently engulfed as we are by global tests and tribulations:

Our world is passing through the darkest period in the entire history of civilization, in which unnumbered millions of people suffer grievous wrongs that drive them to the edge of despair. It is one of the mysteries of the spiritual realm that the destinies of those who have great contributions to make should entail suffering of the kind your letter so movingly describes. What we do know, beyond any possibility of doubt, is that these black clouds will lift, that the spiritual potentialities of those who are now undergoing such severe testing will find fulfilment and that the whole world will benefit. (letter to an individual, unpublished)

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