Digital Religious Engagement in Relation to Anxiety and Depression in Adults: A Systematic Review

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ABSTRACT

Anxiety and depression are common mental health conditions that substantially affect quality of life. Religious and spiritual engagement has been associated with selected mental health outcomes in conventional offline settings, but the role of digital religious engagement remains unclear. This systematic review aimed to examine digital religious engagement in relation to anxiety and depression in adults. A literature search was performed in Medline, Scopus, PubMed, and the Cochrane Library for studies published from January 2015 to May 2025. Eligible studies examined religious or spiritual engagement delivered, facilitated, or accessed through digital platforms and reported anxiety and/or depression as study outcomes. Risk of bias was evaluated with tools appropriate to each study design, and the findings were synthesized narratively because of substantial heterogeneity. Out of 400 records identified, 6 studies met the inclusion criteria. Several studies reported potentially favorable associations between digital religious engagement and selected mental health outcomes, such as lower odds of anxiety or depression, reduced emotional burden, and decreased depressive symptoms. However, findings were inconsistent across outcomes, populations, and study designs, and some studies reported null or mixed results. Spiritual support appeared relevant to some observed associations, particularly in relation to depression, but the current evidence remains insufficient to support firm mechanistic conclusions. Overall, digital religious engagement may be linked to certain mental health benefits in specific contexts; however, the existing evidence is limited and heterogeneous. Further rigorous longitudinal and controlled studies are necessary.

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1. INTRODUCTION

Anxiety is a mental health condition marked by excessive worry and feelings of discomfort that are not proportional to the actual situation. Anxiety disorders include several forms, such as generalized anxiety disorder, social anxiety disorder, and panic disorder [1]. Anxiety is also linked to physical manifestations, including tachycardia, sleep disturbances, and muscle tension, all of which can negatively affect quality of life and everyday functioning [1]. In many cases, anxiety occurs together with depression and is related to substance use, functional impairment, and other negative health outcomes, making it a significant public mental health issue [1], [2].

Depression is a psychiatric condition characterized by persistent sadness, reduced interest in activities, and a combination of cognitive and physical symptoms that substantially interfere with overall functioning [3], [4]. Typical symptoms include feelings of hopelessness, sleep problems, changes in appetite, and difficulty concentrating, whereas more severe cases may involve self-harm, suicidal behavior, and a significant psychosocial burden [3], [5]. The strong association between anxiety and depression suggests that both disorders need to be assessed together when examining complementary psychosocial and behavioral factors, including those related to religion and spirituality.

Religion and spirituality have increasingly been discussed as complementary resources in relation to anxiety and depression. Evidence from conventional offline settings indicates that religious involvement may be linked to improved mental health outcomes through mechanisms such as hope, meaning-making, social support, and internal coping resources [2], [6]. Practices like prayer, meditation, and participation in religious rituals have been associated with emotional regulation and psychological comfort in certain contexts [7]. However, these findings were largely derived from in-person or traditional settings and therefore cannot be assumed to apply directly to digital religious engagement, which may differ in format, intensity, interactivity, and perceived social presence [8], [9]. Religion and spirituality are also related but conceptually distinct constructs, and this distinction is important when interpreting their relationship with anxiety and depression [10], [11].

The expansion of digital communication, online platforms, and smartphone-based applications has changed the way individuals access religious and spiritual content. This shift became more visible during and after the COVID-19 pandemic, when many religious activities were restricted in physical settings and partially moved into virtual

environments [12], [13]. Individuals increasingly used virtual sermons, online worship services, prayer groups, and faith-based applications to maintain religious or spiritual engagement. Digital religious engagement is not a single uniform construct because it may include passive forms of participation, such as watching sermons, as well as more active or interactive forms, such as joining online prayer groups or app-guided spiritual exercises [13], [14]. These different forms of engagement may not have the same psychological implications, and some may even involve challenges such as reduced interpersonal depth, digital fatigue, or spiritually unsatisfying experiences. Despite this expansion, it remains unclear whether these digital forms of religious engagement are consistently related to anxiety and depression outcomes in adults.

Despite growing interest in online religious and spiritual practices, there remains a limited number of studies specifically examining digital religious engagement in relation to anxiety and depression in adults. Existing evidence is heterogeneous, with variation in population characteristics, platform types, levels of interactivity, and outcome measurements. Baseline religiosity, social support, loneliness, age, prior mental health status, and unequal access to digital technology may act as important confounding or moderating factors [8], [9]. These factors make it difficult to determine whether observed associations reflect spiritual processes, general social connectedness, or contextual influences. As a result, the current literature remains fragmented and does not yet provide a clear synthesis of whether digital religious engagement is consistently associated with anxiety and depression outcomes in adults. This unresolved gap limits both conceptual clarity and practical interpretation of the mental health relevance of digital religious engagement across settings. Accordingly, this systematic review was conducted to assess the existing evidence on the association between digital religious engagement and anxiety and depression in adults living in contemporary digital contexts. Studies published from 2015 onward were prioritized to better reflect contemporary digital religious practices.

This review is informed by Religious Coping Theory as an interpretive perspective for understanding how digital religious engagement may relate to anxiety and depression. The framework is not applied as a causal model but as a conceptual lens to interpret how faith-related practices may support coping processes in digital environments [2], [15]. Within this perspective, activities such as virtual prayer, online worship, and spirituality-based applications may function as coping

resources that promote meaning, emotional regulation, and perceived connection. Spiritual support may also play a role, particularly when digital participation fosters a sense of belonging and shared experience, although current evidence remains insufficient to establish consistent causal pathways. Therefore, this framework is used to guide interpretation rather than to imply mechanistic conclusions. This review contributes by specifically synthesizing evidence on digital forms of religious or spiritual engagement in adults, while highlighting conceptual heterogeneity and methodological limitations that may explain inconsistent findings across studies.

2. METHOD

A structured and transparent method was used in this systematic review to locate and synthesize evidence concerning digital religious engagement and its relationship with anxiety and depression in adults. The protocol for this review had been prospectively registered in the International Prospective Register of Systematic Reviews (PROSPERO) with registration number CRD420261340402. Reporting of the review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance.

The literature search covered four electronic databases: Medline, Scopus, PubMed, and the Cochrane Library. Studies published between January 2015 and May 2025 were included to capture contemporary forms of digital religious engagement, such as smartphone-based applications, online worship, livestream religious participation, and other internet-mediated spiritual practices. The 2015 cutoff was chosen to better reflect the expansion of smartphone-based communication and contemporary digital platforms relevant to religious and spiritual engagement.

A predefined search strategy was used by combining terms related to digital modality, religion or spirituality, and mental health outcomes. The main search syntax was as follows: ((online) OR (virtual) OR (digital) OR (internet-based) OR (app-based)) AND ((religious) OR (religion) OR (spiritual) OR (faith-based) OR (prayer) OR (worship)) AND ((engagement) OR (involvement) OR (participation) OR (coping) OR (intervention)) AND ((anxiety) OR (depression)). The search syntax was tailored to match the indexing system and search options available in each database. Furthermore, the reference lists of eligible studies were hand-searched to locate potentially relevant articles.

The eligibility criteria were as follows: (1) original studies involving adults or young adults; (2) studies investigating religious or spiritual engagement delivered, facilitated, or accessed through digital platforms, including mobile applications, websites, social media, livestream worship, or other online environments; (3) studies reporting anxiety and/or depression as outcomes; and (4) observational, interventional, or mixed-method quantitative studies published in peer-reviewed journals. For the purpose of this review, digital religious engagement was defined as any religion- or spirituality-related activity accessed, practiced, or facilitated through internet-based or digital media. The exclusion criteria were: (1) non-English publications; (2) studies with inaccessible full texts; (3) articles published before 2015; and (4) studies that did not specifically address digital religious engagement in relation to anxiety or depression. Non-English studies were excluded because of feasibility constraints in full-text screening and data extraction, although this may have introduced language bias.

After removing duplicates, titles and abstracts were screened by three independent reviewers using the predetermined eligibility criteria. Records that at least one reviewer deemed potentially relevant were moved on to full-text evaluation. The full-text articles were then independently evaluated for eligibility by the same reviewers, and any disagreements were settled by discussion and team consensus. The review process was limited by the lack of formal inter-rater reliability statistics.

Data extraction was carried out using a structured extraction form. The collected data included the author names and publication year, country, characteristics of the study population, number of participants, form of digital religious engagement, study design, outcome measures, and the main findings related to anxiety and depression. This information was subsequently used to facilitate both descriptive comparisons and narrative synthesis across all included studies.

Methodological quality and potential sources of bias were assessed with appraisal instruments suited for each type of study design. Randomized controlled trials were evaluated with the Cochrane Risk of Bias 2 (RoB 2) tool. Cohort studies were assessed with the Newcastle–Ottawa Scale (NOS), while cross-sectional studies were evaluated with the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Analytical Cross-Sectional Studies. These tools were selected because the included evidence consisted of mixed study designs, and each tool was applied

according to the specific methodological characteristics of the individual studies. Appraisal findings were summarized narratively and presented in tabular form.

Because the included studies showed variation in their study design, participant characteristics, forms of digital religious engagement, and outcome measurement, quantitative pooling was not considered appropriate. Therefore, findings were synthesized narratively. This review was carried out as a systematic review without conducting a meta-analysis, with emphasis on describing study characteristics, methodological quality, and the consistency or inconsistency of findings across studies.

The overall research process is illustrated in Figure 1 to provide a clear overview of each stage of this systematic review, from initial problem identification through study selection, quality appraisal, narrative synthesis, and final interpretation of findings.

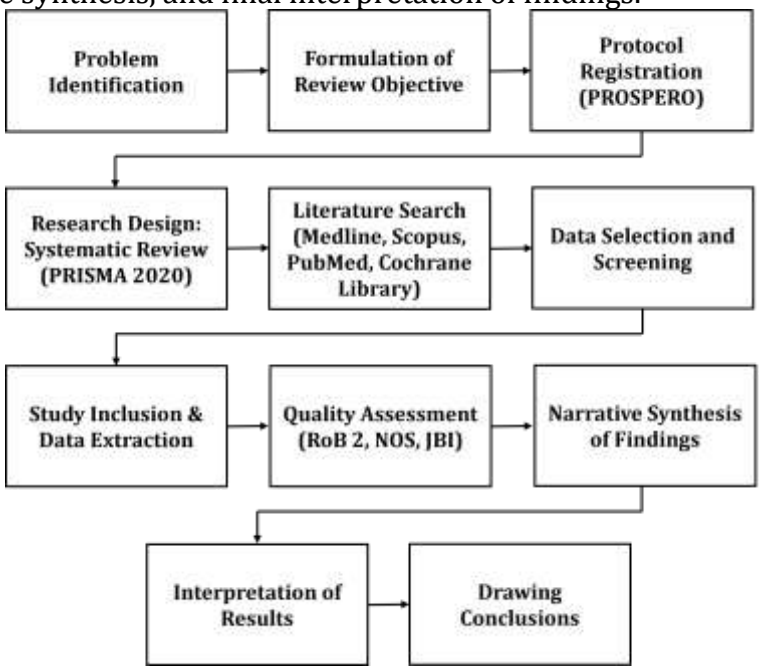

Figure 1. Research Flow Diagram of the Systematic Review

3. RESULTS

3.1 Study Screening and Selection

The process of study selection adhered to the PRISMA flowchart, as shown in Figure 2. Database searches in Medline, Scopus, PubMed, and the Cochrane Library initially identified 400 records. Following the removal of duplicates, 234 unique records remained for title and abstract

screening. Among these, 203 were excluded because they did not address online religious or spiritual engagement in relation to anxiety or depression outcomes. Thirty-one full-text articles were reviewed for eligibility, of which 25 were later excluded for the following reasons: publication date prior to 2015 (n = 4), absence of a specific focus on digital religious engagement or spirituality-based interventions (n = 20), and being published in a non-English language (n = 1). Ultimately, six studies met the inclusion criteria and were incorporated into this systematic review. The main characteristics of these studies—including country, population, study design, type of digital religious engagement, outcome variables, and principal findings—are summarized in Table 1.

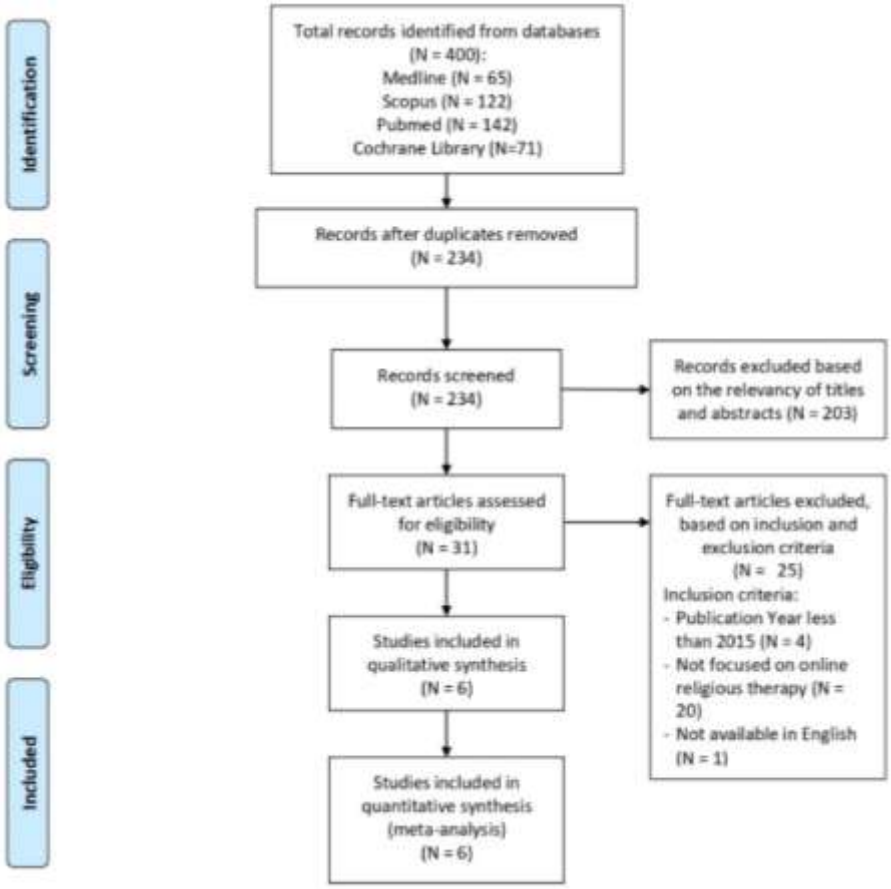

Figure 2. PRISMA flow diagram illustrating the identification, screening, and inclusion of studies.

3.2 Characteristics and Summary of Included Studies

The included studies showed considerable variation in population, intervention format, study design, and outcome assessment. Study populations ranged from adolescents and young adults to broader adult community samples, and also included a specific caregiving population, namely families of children with cancer. The forms of digital religious engagement were heterogeneous and included online worship during lockdown, online prayer and worship, virtual spiritual education, spirituality-informed e-mental health programs, online religious involvement with spiritual support, and spiritual self-care mobile applications. Methodological approaches included longitudinal observational research, randomized controlled trials, cross-sectional surveys, and structural equation modeling. Outcome assessment likewise varied, with some studies examining anxiety and depression directly, whereas others included related outcomes such as emotional burden, self-harm thoughts, life satisfaction, or well-being. This heterogeneity restricted the ability to make direct comparisons between studies.

Table 1. Summary of Included Studies on Digital Religious Engagement in Relation to Anxiety and Depression

No	Author, Year	Country / Population	Digital Religious Engagement	Design / Outcome Measures	Main Findings
1	Shiba et al., 2022	United Kingdom; adults (n = 8,951)	Online worship during lockdown	Longitudinal study: mental health and well-being indicators during the COVID-19 period	No significant association was observed with depression or anxiety; more frequent participation was linked to reduced odds of self-harm thoughts (OR = 0.24, $p < 0.01$)
2	Asadzandi	Iran; families of children	Virtual spiritual education	Randomized controlled	Emotional burden affecting anxiety and depression

No	Author, Year	Country / Population	Digital Religious Engagement	Design / Outcome Measures	Main Findings
	et al., 2021	with cancer (n = 72)	was developed using the Sound Heart model	trial; emotional burden related to anxiety and depression, pre- and post–assessment	decreased significantly in the intervention group (11.6 ± 4.9 pre; 9.4 ± 3.4 post; $p < 0.001$); not significant in controls ($p = 0.19$)
3	Rickhi et al., 2015	Canada; teenage and young adult participants (n = 62)	Online LEAP program (8 weeks)	Pilot randomized controlled trial; anxiety and depression over 8 weeks	Depression decreased significantly ($p < 0.05$), whereas no significant effect was found for anxiety
4	Baggaley et al., 2024	939 UK religious congregants	Online prayer and worship	Cross-sectional survey: depression and anxiety	Online prayer/worship was associated with lower odds of depression (OR = 0.37) and anxiety (OR = 0.52)
5	Yoo, 2022	South Korea; adults (n = 210)	Online religious involvement and spiritual support	Structural equation modeling: depression and anxiety	Among men, online religious involvement was associated with depression in the pathway involving

No	Author, Year	Country / Population	Digital Religious Engagement	Design / Outcome Measures	Main Findings
					spiritual support; no significant association was found for anxiety
6	Park et al., 2023	United States; Gen Z and young millennials (n = 475)	Skylight spiritual self-care app	Cross-sectional survey: anxiety and depression	Lower anxiety scores were reported (β = −2.01 and β = −2.58; $p < 0.05$); whereas no significant effect was found for depression

3.3 Quality Appraisal of Included Studies

The methodological quality of the included studies was overall rated as low to moderate. The randomized controlled trials evaluated with the RoB 2 tool raised some concerns regarding bias, primarily due to small sample sizes and incomplete clarity in reporting. The cohort study, assessed with the Newcastle–Ottawa Scale, exhibited relatively stronger methodological quality and was considered to have a low risk of bias. The cross-sectional studies, evaluated using the JBI checklist, were considered to have a moderate risk of bias, mainly because they relied on self-reported measures, convenience sampling, and limited control for confounding variables. A summary of these appraisal findings is presented in Table 2.

Table 2. Risk of Bias and Quality Assessment of Included Studies

Study	Design	Quality Assessment Tool	Quality Assessment Results	Inclusion Decision
Rickhi et al. (2015)	RCT	RoB 2	Some concerns of bias	Included

Study	Design	Quality Assessment Tool	Quality Assessment Results	Inclusion Decision
Asadzandi et al. (2021)	RCT	RoB 2	Some concerns of bias	Included
Shiba et al. (2022)	Cohort	NOS	Low risk of bias	Included
Park et al. (2023)	Cross-sectional	JBI checklist	Moderate overall risk of bias	Included
Yoo (2022)	Cross-sectional	JBI checklist	Moderate overall risk of bias	Included
Baggaley et al. (2024)	Cross-sectional	JBI checklist	Moderate overall risk of bias	Included

3.4 Main Findings on Anxiety and Depression

In a cross-sectional study involving 939 religious congregants in the United Kingdom, Baggaley et al. (2024) reported that online prayer and worship were linked to reduced odds of depression (OR = 0.37) and anxiety (OR = 0.52) [16]. In contrast, Shiba et al. (2022), using longitudinal data from 8,951 adults in the United Kingdom during the COVID-19 lockdown, found limited evidence for an association between online religious participation and subsequent depression or anxiety [12]. However, their findings indicated that engaging in online religious activities more than once per week was associated with reduced odds of self-harm thoughts, while less frequent participation correlated with higher life satisfaction and happiness [12].

Asadzandi et al. (2021) found that virtual spiritual education based on the Sound Heart model significantly reduced the emotional burden among families of children with cancer in the intervention group, with mean scores decreasing from 11.6 ± 4.9 to 9.4 ± 3.4 ($p < 0.001$); no statistically significant change was identified in the control group ($p = 0.19$) [17]. Rickhi et al. (2015) reported that an eight-week spirituality-informed e-mental health intervention significantly decreased depressive symptoms in adolescents and young adults, though it did not have a significant effect on anxiety [18]. Park et al. (2023) found that use of the Skylight spiritual self-care application was associated with lower anxiety levels, while its association with depression was not statistically significant [19].

3.5 Findings Related to Spiritual Support

Yoo (2022) investigated the connections between online religious participation, spiritual support, depression, and anxiety during the COVID-19 pandemic using structural equation modeling and multi-group analysis. The results showed that spiritual support mediated the association between online religious involvement and depression among men, while no significant association was found for anxiety [8].

4. DISCUSSION

4.1 Overall Findings

This review indicates that certain forms of digital religious engagement may be linked to specific improvements in mental health outcomes within particular contexts. Overall, the included studies suggested that digital religious or spiritual engagement may be associated with better mental health outcomes in some contexts, although the findings were not consistent across populations, study designs, and outcome domains. However, the evidence base remains limited and heterogeneous, and the findings do not justify a broad conclusion that digital religious engagement consistently reduces anxiety and depression in adults. Therefore, the overall evidence does not support a uniform conclusion that digital religious engagement consistently reduces both anxiety and depression across all populations. A more appropriate interpretation is that some studies reported potentially beneficial associations for particular outcomes, whereas others showed null, mixed, or outcome-specific findings [9], [13].

These findings suggest that the association between online religious engagement and mental health may vary depending on the particular psychological outcome assessed. Taken together, potentially beneficial associations were observed for selected outcomes, but these were not consistent across all studies or across both anxiety and depression. From an interpretive perspective, digital religious engagement may provide some individuals with perceived connection, meaning, encouragement, or emotionally supportive routines. Activities such as online worship, prayer groups, spiritual education, or app-based self-reflection may offer users a structured way to cope with stress, uncertainty, or isolation. Nevertheless, these possible pathways should be interpreted cautiously because they may overlap with broader forms of social support, community belonging, self-care behavior, or pre-existing religiosity rather than reflecting a distinct spiritual mechanism [2], [13], [14].

4.2 Heterogeneity and Methodological Considerations

Marked heterogeneity across the included studies considerably reduced their comparability. The reviewed studies differed in age group, religious context, digital platform, study design, and measured outcomes. Some studies focused on adolescents and young adults, whereas others involved general adult populations or families of children with cancer. The interventions also ranged from passive participation in online worship to structured spiritual education and app-based spiritual self-care. Because these forms of engagement are not equivalent in intensity, interactivity, or content, their psychological implications are unlikely to be uniform [9], [14].

Important methodological limitations need to be considered when interpreting several of these findings. The currently available evidence remains too limited and heterogeneous to support a firm conclusion regarding mediation across populations or settings, particularly because temporal precedence and consistency across studies have not been established. Cross-sectional studies can only demonstrate association and do not establish causality. Small trials may provide useful preliminary evidence but remain vulnerable to limited statistical power and residual confounding. Even in longitudinal or structural models, the available evidence does not yet establish stable temporal or mechanistic pathways linking digital religious engagement to improved mental health outcomes [8], [9], [15].

The finding that spiritual support was associated with the relationship between online religious involvement and depression should be interpreted cautiously. The current evidence does not demonstrate a confirmed mediating pathway because temporal precedence, baseline support, and differentiation from general social support were not consistently established. A more defensible interpretation is that spiritual support may be relevant in some settings, but its role remains preliminary and context dependent [2], [8].

4.3 Contextual Challenges and Generalizability

Digital religious engagement may also be shaped by practical and contextual barriers. Limited device availability, unstable internet access, and unequal digital literacy may reduce participation in online religious activities. In addition, digital worship may not fully reproduce the communal and interpersonal dimensions of face-to-face religious practice. These constraints suggest that digital formats may not function

as equivalent substitutes for in-person religious participation across all groups [13], [14].

These barriers may also introduce systematic bias into the evidence base. Individuals with lower digital literacy, less stable internet access, weaker institutional religious affiliation, or greater psychosocial vulnerability may be less likely to engage in digital religious activities while also being more vulnerable to anxiety or depression. As a result, the included evidence may disproportionately reflect participants who were already better positioned to access and benefit from online engagement. Generalizability is further limited by variation across countries, religious traditions, and broader sociocultural settings, as the meaning of online worship, spiritual support, and religious coping may differ according to doctrine, community practice, technological infrastructure, and the social acceptability of digital spirituality [9], [13], [14].

4.4 Limitations

Several limitations of this review need to be acknowledged. The total number of included studies was small, and the available evidence showed heterogeneity in study design, intervention format, population, and outcome assessment. Many studies relied on self-reported symptom measures rather than structured clinical interviews, which may capture subjective distress differently and contribute to inconsistency across findings. Publication bias, sensitivity analysis, and formal statistical heterogeneity could not be meaningfully assessed because no meta-analysis was conducted. Additionally, the exclusion of non-English studies may have introduced language bias, and the fact that most included studies were conducted in specific cultural and geographical contexts further limits the broader applicability of the findings.

Future studies should prioritize larger and more methodologically rigorous longitudinal or controlled studies, clearer reporting of effect sizes and confidence intervals, more standardized outcome measurement, and more explicit examination of how spiritual support, social support, culture, and digital access shape the association between digital religious engagement and mental health outcomes. These improvements are necessary before stronger conclusions can be drawn regarding the mental health relevance of digital religious engagement across populations and settings.

5. CONCLUSION

This systematic review suggests that digital religious engagement may be linked to specific improvements in anxiety- and depression-

related outcomes in certain contexts. However, the available evidence remains limited and heterogeneous in terms of population, study design, intervention format, and outcome measurement. The findings, therefore, require cautious interpretation and should not be taken as definitive evidence of effectiveness, mechanism, or general applicability. Some included studies reported potentially beneficial associations, whereas others showed null, mixed, or outcome-specific findings. Future research should use more rigorous longitudinal or controlled designs, standardized outcome measures, and clearer examination of spiritual support, social support, digital access, and cultural context to determine the mental health relevance of digital religious engagement more reliably.

REFERENCES

[1] B. W. Penninx, D. S. Pine, E. A. Holmes, and A. Reif, "Anxiety disorders," Mar. 06, 2021, *Elsevier B.V.* doi: 10.1016/S0140-6736(21)00359-7.

[2] A. Agorastos, C. G. Huber, and C. Demiralay, "Influence of religious aspects and personal beliefs on psychological behavior: focus on anxiety disorders," *Psychol. Res. Behav. Manag.*, p. 93, Mar. 2014, doi: 10.2147/PRBM.S43666.

[3] O. Remes, J. Francisco, and P. Templeton, "Biological, Psychological, and Social Determinants of Depression: A Review of Recent Literature," *Brain Sci.*, vol. 11, no. 12, Dec. 2021, doi: 10.3390/brainsci11121633.

[4] A. Kaltenboeck and C. Harmer, "The neuroscience of depressive disorders: A brief review of the past and some considerations about the future," *Brain Neurosci. Adv.*, vol. 2, p. 239821281879926, Jan. 2018, doi: 10.1177/2398212818799269.

[5] J. C. Fruehwirth, S. Iyer, and A. Zhang, "Religion and depression in adolescence," *Journal of Political Economy*, vol. 127, no. 3, pp. 1178–1209, Jun. 2019, doi: 10.1086/701425.

[6] J. H. Bos, C. Vrijhoef, J. H. M. Hovenkamp-Hermelink, and H. Schaap – Jonker, "Effect of religion on the course of anxiety disorders and symptoms over 9-year follow-up," *J. Affect. Disord. Rep.*, vol. 17, p. 100797, Jul. 2024, doi: 10.1016/j.jadr.2024.100797.

[7] H. F. Rahman, A. Rasid, H. Khotimah, H. Siswanto, and A. H. Wahid, "Ruqyah therapy to reduce COVID-19 patients' anxiety in Indonesia," *Int. J. Health Sci. (Qassim)*, vol. 6, no. 3, pp. 1427–1435, Sep. 2022, doi: 10.53730/ijhs.v6n3.12826.

[8] J. Yoo, "Online Religious Involvement, Spiritual Support, Depression, and Anxiety during the COVID-19 Pandemic," *Religions (Basel)*, vol. 13, no. 11, Nov. 2022, doi: 10.3390/rel13111052.

[9] A. W. Braam and H. G. Koenig, "Religion, spirituality and depression in prospective studies: A systematic review," *J. Affect. Disord.*, vol. 257, pp. 428–438, Oct. 2019, doi: 10.1016/j.jad.2019.06.063.

[10] B. Van Niekerk, "Religion and spirituality: What are the fundamental differences?" *HTS Teologiese Studies / Theological Studies*, vol. 74, no. 3, May 2018, doi: 10.4102/hts.v74i3.4933.

[11] P. J. Casey, "Religion, Definition of," in *The Encyclopedia of Philosophy of Religion*, Wiley, 2021, pp. 1–7. doi: 10.1002/9781119009924.eopr0330.

[12] K. Shiba *et al.*, "Associations of online religious participation during COVID-19 lockdown with subsequent health and well-being among UK adults," *Psychol. Med.*, vol. 53, no. 9, pp. 3887–3896, Jul. 2023, doi: 10.1017/S0033291722000551.

[13] A. Berger and O. Golan, "Online religious learning: digital epistemic authority and self-socialization in religious communities," *Learn. Media Technol.*, vol. 49, no. 2, pp. 274–289, Apr. 2024, doi: 10.1080/17439884.2023.2169833.

[14] G. Evolvi, "Religion and the internet: digital religion, (hyper)mediated spaces, and materiality," *Zeitschrift für Religion, Gesellschaft und Politik*, vol. 6, no. 1, pp. 9–25, May 2022, doi: 10.1007/s41682-021-00087-9.

[15] H. G. Koenig, F. Al-Zaben, and T. J. VanderWeele, "Religion and psychiatry: recent developments in research," *BJPsych Adv.*, vol. 26, no. 5, pp. 262–272, Sep. 2020, doi: 10.1192/bja. 2019.81.

[16] R. F. Baggaley *et al.*, "Impact of the COVID-19 pandemic on communal religious worshippers' mental health and the benefits of positive religious coping," *Heliyon*, vol. 10, no. 21, p. e39093, Nov. 2024, doi: 10.1016/j.heliyon.2024.e39093.

[17] M. Asadzandi, S. Farahany, H. Abolghasemy, M. Saberi, and A. Ebadi, "Effect of spiritual care on the care burden of families of children with cancer: a randomized controlled trial," *Family Medicine & Primary Care Review*, vol. 23, no. 3, pp. 279–283, 2021, doi: 10.5114/fmpcr. 2021.108189.

[18] B. Rickhi *et al.*, "Evaluation of a spirituality-informed e-mental health tool as an intervention for major depressive disorder in adolescents and young adults - a randomized controlled pilot trial," *BMC Complement. Altern. Med.*, vol. 15, no. 1, Dec. 2015, doi: 10.1186/s12906-015-0968-x.

[19] S. Y. Park, J. Huberty, J. Yourell, K. L. McAlister, and C. C. Beatty, "A Spiritual Self-Care Mobile App (Skylight) for Mental Health, Sleep, and Spiritual Well-Being Among Generation Z and Young Millennials: Cross-Sectional Survey," *JMIR Form. Res.*, vol. 7, p. e50239, sept. 2023, doi: 10.2196/50239.