

# Investigation of the effect of religious doctrines on religious knowledge and attitude and postpartum blues in primiparous women

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## ABSTRACT

**Background:** Postpartum blues is a transient change of moods occurring in the first few days after delivery. The present study aimed to investigate the effect of religious doctrines on postpartum blues in primiparous women.

**Materials and Methods:** In this randomized controlled trial, 84 primiparous women who had average or weak religious attitude were randomly divided into intervention and control groups. In the intervention group, religious doctrines were instructed from 20<sup>th</sup> to 28<sup>th</sup> weeks of gestation through 6 weekly sessions of 60–90 min each. The control group, however, just received the routine care. Spielberger's anxiety scale and the questionnaires assessing religious knowledge and attitude were completed by both groups before, immediately after, and 1–2 months after the intervention. Also, postpartum blues were evaluated by Edinburg Postnatal Depression Scale (EPDS) 10 days after delivery. Then, the data were analyzed using Chi-square, paired *t*-test, independent *t*-test, analysis of variance (ANOVA), and Pearson correlation coefficient.

**Results:** The results showed postpartum blues in 59.5% of the study participants. Besides, the results of independent *t*-test revealed a statistically significant difference between the two groups regarding the mean score of postpartum blues ( $P = 0.036$ ). Although the intervention group's knowledge and attitude scores were higher than those of the control group, no significant difference was found between the two groups regarding the correlation coefficient between postpartum blues and religious knowledge ( $P = 0.088$ ) and religious attitude ( $P = 0.7$ ).

**Conclusions:** The results of the study show that instruction of religious doctrines was effective in increasing the religious knowledge and attitudes and reducing the postpartum blues.

**Key words:** Attitude, blues, Iran, knowledge, postpartum period, primiparous, religious

## INTRODUCTION

Postpartum blues is one of the psychological disorders which occur after delivery. It is, in fact, a transient condition involving an increase in emotional reactions which happen to more than half of the women in the first

week after delivery.<sup>[1]</sup> Postpartum blues include instable moods (both happiness and sadness), excessive sensitivity, unreasonable crying, restlessness, inability to concentrate, anxiety, irritability, and anger.<sup>[2]</sup> In a study, 35% of mothers experienced postpartum blues in the first week after delivery and 20% had postnatal depression in 1 month after delivery.<sup>[3]</sup> In general, pregnancy and puerperium can be highly stressful and stimulate psychological disorders. These disorders might reflect the recurrence or intensification of a previous disorder or indicate the beginning of a new one.<sup>[1]</sup> In any event, anxiety disorders during pregnancy have negative effects on fetal growth and maternal physical and mental health.<sup>[4]</sup>

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The prevalence of postpartum blues has been reported differently in various societies. For instance, it has been reported as 31.3% in Nigeria,<sup>[2]</sup> 50–80% in Iran,<sup>[3]</sup> 58% in India,<sup>[5]</sup> and 70.3% in Korea.<sup>[6]</sup> Moreover, the lowest and highest prevalence rates of postpartum blues have been reported in Japan (15.3%) and the West, respectively. Besides, the lowest and highest prevalence rates of postpartum depression in Asian countries were found in Malaysia (3.5%) and Pakistan (63.3%), respectively.<sup>[7]</sup>

In a meta-analysis of 109 articles, 28 articles were analyzed for major and minor depression. The results revealed that the prevalence of major depression alone during pregnancy and in the first month after delivery ranged from 6.5 to 12.9%.<sup>[8]</sup>

The symptoms of postpartum blues are normally weak and only last for several hours to few days. Thus, they can only be treated by supporting and reassuring the mother. During supportive care, the mother is ascertained that this condition is transient and results from body's biochemical changes.<sup>[1]</sup> Since no pharmacological treatments have been proposed for postpartum blues up to now, utilization of supportive care is quite logical.

Basically, religion is defined as commitment to beliefs and action in accordance with an organized church or religious institution. Any research on religious behavior and experience requires a definition of religion and frequency of religious observance. Therefore, religion can be viewed through a one- or multi-dimensional perspective. Lock and Stark suggested that religion has five dimensions.<sup>[9]</sup> Also, Koeing in his book entitled "Religion and Mental Health" introduced a list of 12 religious dimensions.<sup>[10]</sup>

In general, religion is a source of support for dealing with problems and religious resources, such as praying, are used to solve problems. Moreover, religious behaviors, such as prayer, honesty, belief in God, and reading religious books, create a feeling of internal tranquility by creation of hope, encouragement to develop a positive attitude toward the present conditions, and taking the individuals out of the disappointing crisis which cannot be controlled.<sup>[11]</sup> Furthermore, religious beliefs may have a positive impact on individuals' physical health, and may help to overcome psychological problems and has a protective effect on mental health, which leads to improved mental health status.<sup>[12-14]</sup>

In a 10-year longitudinal study which aimed to assess social adaptability, religious presence, and depression episodes in 173 individuals with depressed (high-risk) and non-depressed (low-risk) parents, the rate of major depression in the high-risk group was fourfold higher than that in the low-risk group ( $P < 0.01$ ). Besides, the low-risk group showed more frequent presence in religious ceremonies compared to

the high-risk one ( $P < 0.01$ ). The rate of social adaptability was also higher in the low-risk group in comparison to the high-risk one ( $P < 0.05$ ). Thus, frequent presence in religious ceremonies and high social adaptability were indicated as protective factors against depression.<sup>[15]</sup>

One of the main goals of religion is improvement of the society's mental health level and modification of inter-personal relationships. Psychological researches have also shown success rates of various religions in this regard. Nowadays, following a religious lifestyle has been shown to be accompanied by personal, familial, and social tranquility. Furthermore, praying, religious ceremonies, mosques, churches, and religious shrines have been shown to improve mental health in religious societies. The findings of a study showed that the individuals who continuously took part in religious ceremonies felt more trust and support and their lifestyle was affected by their religious beliefs and actions.<sup>[16]</sup> Moreover, a cross-sectional study was performed on the relationship between piety as well as spirituality and antenatal anxiety in 344 women in the south of US. The results of that study demonstrated that piety and spirituality ( $P = 0.006$ ) and social support ( $P = 0.0001$ ) resulted in lower anxiety level. Also, piety and spirituality reduced the pregnant women's anxiety level.<sup>[17]</sup> Another cross-sectional study also evaluated the relationship between piety and depression in pregnant women and indicated that religion and spirituality prevented the symptoms of depression.<sup>[18]</sup> Nevertheless, some researchers, such as Kroll and Sheehan, have stated that religious and spiritual variables have been neglected in investigation of mental health.<sup>[19]</sup> It is believed that mental health professionals need to understand the spiritual values and combine them in the evaluation and treatment of patients.<sup>[20]</sup> Yet, recently some researchers have emphasized the importance of religion and spirituality in mental health,<sup>[21,22]</sup> and have discussed the positive effects of spirituality and religious behaviors on the psychopathology of drug abuse, insanity, obsessive-compulsive disorder, and anxiety disorder.<sup>[23,24]</sup>

Research has shown that spirituality and spiritual culture could improve physical, mental, and emotional health.<sup>[25]</sup> Furthermore, spiritual care could often make a significant difference in the duration of treatment and patient satisfaction.<sup>[26]</sup> Also, it leads to an increase in the coping mechanism of the illness<sup>[27]</sup> and is effective in reducing the anxiety level.<sup>[28]</sup>

The study by Mok and colleagues (2010) showed that if healthcare professionals applied spirituality to their clinical performance, they could facilitate patient compliance and increase patients' hope. Overall, investigation of spirituality in clinical practice is one of the important and newly introduced areas of research.<sup>[29,30]</sup>

Therefore, the present study aims to investigate the effect of religious doctrines on religious knowledge and attitude and postpartum blues of the primiparous women referring to the selected prenatal clinics affiliated to Tehran University of Medical Sciences in 2013. Using the findings of this study, postpartum blues may be reduced and mothers' mental health may be improved by working on religious beliefs.

## MATERIALS AND METHODS

The present randomized clinical trial was conducted in the selected prenatal clinics of Tehran University of Medical Sciences in 2012–2013. According to the statistical consultation and considering  $\alpha = 0.05$ ,  $\beta = 0.2$ , and power = 95%, a sample size of 84 subjects (42 in each group) was determined for the study.

After obtaining signed written informed consents, the eligible individuals were enrolled into the study. At first, 220 individuals were selected among those referring to the clinics affiliated to Tehran University of Medical Sciences using purposive sampling. Then, they were randomly divided into a control and an intervention group using the table of random numbers. In doing so, the first qualified individual was allocated to the intervention group, the second one to the control group, and the process was continued until 110 pregnant women were entered into each study group. Afterward, the women in both study groups were required to fill out knowledge assessment questionnaire and Revised Attitude Scale-Religious (RAS-R) questionnaire. Accordingly, 42 participants in each group with average or weak religious knowledge and attitude were enrolled into the study, while those with high religious knowledge and attitude were excluded. The educational classes were held for three groups of 14 participants. Groups of 14 were selected in this study to increase the possibility of group discussion and information exchange and promote the quality of the training.

The inclusion criteria of the study were: being pregnant, age range of 18–45 years, not suffering from chronic diseases (heart problems, lung disease, hypertension, and diabetes), having low or moderate anxiety level, being able to participate in educational classes, and signing the consent forms.

Both groups completed demographic questionnaire, Spielberger's anxiety scale, knowledge questionnaire, and RAS-R before and immediately and 2 months after the intervention. Besides, the participants' postpartum blues was evaluated using Edinburg Postnatal Depression Scale (EPDS) after delivery.

Spielberger's scale, which is used for assessment of state and trait anxiety (20 items for each), includes 40 items

giving a score of 80. It is scored using a Likert scale, and scores of 0–19, 20–40, 41–60, and 61–80 are assigned to normal, mild, average, and severe anxiety, respectively. The reliability of this scale was obtained as 0.97. The reliability and validity indexes reported by Aghamohammadi were the basis of the present study.<sup>[31]</sup>

RAS-R includes 25 items in six dimensions of pray, ethics and values, effect of religion on life and behavior (praying and fasting), social issues, world view and beliefs, and science and religion. This questionnaire is scored through a Likert scale. The correlation coefficient of the score of each item and the total score was reliable at 0.0001 level. The reliability of the questionnaire was obtained as 0.948 and 0.933 using Spearman-Brown and Guttman methods, respectively. Besides, its Cronbach's alpha coefficient was computed as 0.954. The reliability and validity indexes reported in Ebrahimi's study were the basis of the current study.<sup>[32]</sup>

Knowledge assessment questionnaire was a researcher-made instrument including 41 items in six dimensions of pray, ethics and values, effect of religion on life and behavior (praying and fasting), social issues, world view and beliefs, and science and religion. This questionnaire was scored through a Likert scale. In order to determine the validity of the questionnaire, it was given to 10 expert professors of schools of nursing and midwifery of Shiraz and Tehran universities of medical sciences. After application of the professors' recommendations, the questionnaire's validity was confirmed. In order to evaluate the questionnaire's reliability, it was given to 30 pregnant women in a pilot study and its reliability was assessed using the SPSS statistical software. In doing so, Cronbach's alpha coefficient was separately computed for different sections of the questionnaire revealing its internal consistency. In addition, the reliability of the entire questionnaire was confirmed by Cronbach's alpha = 81%.

EPDS was used to measure postpartum blues 10 days after delivery. This scale is used to identify women with postpartum depression. Kyung Chu *et al.* conducted a study in Korea in 2009–2010 and showed the sensitivity and reliability of this scale to be 92.4% and 86%, respectively, which is the basis of the present study.<sup>[33]</sup>

In the intervention group, instruction of religious doctrines was given from the 20<sup>th</sup> to 28<sup>th</sup> week of gestation. The educational classes were held through 6 weekly sessions of 60–90 min each. The first three sessions were conducted by the researcher, while the last three sessions were managed by a religious specialist. After the end of the classes, the educational content was practiced through role play and group discussion. Finally, postpartum depression was evaluated in the two groups 7–10 days after delivery.

### Ethical considerations

This research project was approved by the local ethics committee of Shiraz University of Medical Sciences and written informed consents were obtained from all the participants. After the intervention, if the control group participants were willing to learn the educational content, they were provided with the related pamphlet.

### Statistical analysis

The data obtained were entered into the SPSS statistical software (v. 16) and were analyzed using Chi-square, paired *t*-test, independent *t*-test, and analysis of variance (ANOVA).

### RESULTS

In the present study, the mean age of the participants was  $25.51 \pm 4.08$  and  $23.45 \pm 3.30$  years in the intervention and control groups, respectively. In addition, most of the participants in both intervention and control groups were diploma holders (52.4% and 60%, respectively).

The study results revealed no significant difference between the two groups regarding demographic variables. Also, no significant difference was found between the two groups concerning state and trait anxiety before the intervention ( $P = 0.9$  and  $P = 0.2$ , respectively). According to the results, the rate of postpartum blues was 41.9% in the intervention group, 76.2% in the control group, and 59.5% in the entire study population [Table 1]. The results of independent *t*-test indicated a significant difference between the two groups regarding the mean score of postpartum blues ( $P = 0.036$ ). The mean score of postpartum blues was  $13.04 \pm 6.22$  in the intervention group and  $15.73 \pm 5.26$  in the control group [Table 2].

Before the intervention, both intervention and control groups had average and low levels of religious knowledge and attitude. As Table 3 depicts, the intervention group participants' level of religious knowledge and attitude increased and 42.9% of them obtained  $>12$  EPDS scores 2 months after the intervention. In the control group, on the other hand, 76.2% of the participants obtained  $>12$  EPDS scores, but their knowledge and attitude did not improve. Moreover, 18 participants in the intervention group and 32 in the control group experienced postpartum blues. In spite of higher knowledge scores in the intervention group, Pearson correlation coefficient revealed no significant relationship between the religious knowledge before delivery and the postpartum blues in the intervention ( $P = 0.088$ ) and the control ( $P = 0.745$ ) groups. Also, in spite of the increase in the intervention group's attitude scores, Pearson correlation coefficient demonstrated no significant association between the religious attitude before delivery and the postpartum blues in the intervention ( $P = 0.7$ ) and the control groups (SPSS did

**Table 1: Frequencies of postpartum blues (EPDS) in primiparous women in the control and intervention groups**

Groups	EPDS $\geq 12$		EPDS $< 12$	
	Number	Percent	Number	Percent
Control	32	76.2	10	23.8
Intervention	18	42.9	24	57.1

EPDS: Edinburg postnatal depression scale

**Table 2: Comparison of mean and standard deviation of scores of postpartum blues (EPDS) in the primiparous women in the control and intervention groups**

Groups	Intervention group	Control group	P value
Number	42	42	0.036
Mean $\pm$ standard deviation	13.04 $\pm$ 5.26	15.73 $\pm$ 5.26	
Lowest score	2	3	
Highest score	34	25	
Median	12	16	

Independent sample *t*-test,  $df=82$ ,  $t=-2.138$ . EPDS: Edinburg postnatal depression scale

**Table 3: Comparison of the relationship between EPDS score and religious knowledge and attitude in the primiparous women in the control and intervention groups 2 months after the intervention**

EPDS Groups	Intervention groups		Control groups	
	Average level	High level	Average level	High level
Knowledge				
EPDS $< 12$				
Frequency	4	20	9	1
Percent	9.5	47.6	21.4	2.4
EPDS $\geq 12$				
Frequency	1	17	30	2
Percent	2.4	40.5	71.4	4.7
Attitude				
EPDS $< 12$				
Frequency	5	19	10	0
Percent	11.9	45.2	23.8	0
EPDS $\geq 12$				
Frequency	4	14	32	0
Percent	9.5	33.3	76.1	0

Analysed ( $n=42$ ). \*Excluded from analysis (give reasons) ( $n=0$ ). EPDS: Edinburg postnatal depression scale

not respond for the control group because all the participants showed an average level of religious attitude) [Table 3].

### DISCUSSION

The results of the present study indicate that instruction of religious doctrines improved the intervention group



participants' religious knowledge and attitude and reduced their postpartum blues. In fact, the prevalence of postpartum blues in the intervention group was 33.3% lower compared to the control group. These results were comparable to those of a cross-sectional study conducted on 130 women in a hospital in Bangalore, India. The results showed the prevalence rate of postpartum blues to be 58.5% at 2 weeks after delivery. Overall, the rate of postpartum blues is closely related to the screening technique and the population under study. The findings of the aforementioned study revealed a significant relationship between postpartum blues and demographic, cultural, and social variables. Gender bias has a deep route in Indian culture, particularly in the economically lagging societies. Thus, 69% of the cases experiencing postpartum blues were those giving birth to girl infants. In the present study, the prevalence of postpartum blues was 59.5%, which is quite close to the value reported in the previous study. This rate was lower in the intervention group compared to the control group, and 53.7% of the participants with postpartum blues had given birth to girl infants.<sup>[5]</sup> In another study performed in Sweden, the women who had given birth to boy infants reported considerable postpartum blues in the first 5 days after delivery.<sup>[34]</sup> In the current study, 46.3% of the women who experienced postpartum blues had given birth to boy infants, and this indicates that severe gender bias does not exist among Iranian women.

The findings of the study by Yohannes *et al.* showed that the individuals who took part in religious activities were less depressed.<sup>[35]</sup> Similarly, the results of the study by Peselow *et al.* demonstrated that in comparison to the control group, patients with stronger religious beliefs were less severely depressed. In addition, the degree of symptoms of depression, hopelessness, and cognitive distortions during 8 weeks improved for those patients who were more spiritually inclined.<sup>[36]</sup> Also, a large number of studies in other countries have shown that the individuals who had religious beliefs or did religious activities had better mental health and adaptability.<sup>[37,38]</sup>

In the present study, instruction of religious doctrines reduced the EPDS scores in such a way that the prevalence of postpartum blues in the intervention group was 33.3% lower compared to the control group. The findings in the studies of Forman,<sup>[39]</sup> Boyd and Blehar,<sup>[40]</sup> and Lumley and Austin<sup>[41]</sup> have shown that social support is of great importance for women both during pregnancy and after delivery. In fact, valuing the women provides them with more hope and tranquility to enjoy their experience of pregnancy. These supports attract mother's attention to the positive aspects of her infant's birth and reduce the effect of hormonal and biological changes on her mental health.

In addition, mothers who receive emotional and social support after delivery perform their maternal role more efficiently and are more satisfied with being a mother.<sup>[42]</sup> In this study, out of the 61.9% pregnant women who claimed to be emotionally supported by their husbands, 59.5% experienced postpartum blues.

Previously, a cross-sectional study was conducted on 30 subjects with high and 30 subjects with low religious beliefs in Punjab and Haryana. In that study, 20–45-year-old patients with an episode of depression (mild, average, severe) without psychosis symptoms were selected using International Statistical Classification of Diseases and Related Health Problems (ICD-10). According to the results, depression presented in a shorter period of time in the subjects with low religious beliefs but after a longer period of time in those with high religiosity. This was due to the fact that the intensity of depression recurrence was lower in the participants with high religious beliefs and that these participants used religion as a defense mechanism against the depression symptoms, leading to their late referral to psychological clinics. In that study, the mean scores of Beck Depression Inventory (BDI), Beck Hopelessness Scale (BHS), and Suicide Intent Questionnaire (SIQ) were lower in the group with high religious beliefs compared to the one with low religious beliefs. The results of that study showed a negative relationship between the level of religiosity and BHS total score ( $r = 0.305$ ,  $P < 0.05$ ). Also, a significant relationship was observed between the level of religiosity and SIQ score ( $r = 0.345$ ,  $P = 0.007$ ). Overall, as the level of religiosity increased, the rate of depression, hopelessness, and intention to suicide decreased. Some researchers believe that religiosity reflects psychological disorder,<sup>[43]</sup> while some others are opposed to this belief.<sup>[43]</sup> The findings of the present study demonstrated that instruction of religious doctrines reduced the rate of postpartum blues. The effects of the instructions remained even after 2 months and reduced the EPDS scores in the intervention group.

In an epidemiologic study which was conducted on 6275 participants in Korea in 2001, information about the mental health of 18–64-year-old individuals who lived in their own houses was collected. In that study, any psychological disorder which had occurred during the past 12 months was assessed through diagnostic interviews. The study results, in contrast to those of the present study, indicated no significant relationship between high prevalence of depression and spiritual values.<sup>[30]</sup> This difference might be due to the difference in the type of religion and religious values in Korean (Buddhism, Protestant, Catholic, and Atheism) and Iranian societies (Islam). Besides, this study was conducted

on pregnant women, while the aforementioned study included both male and female subjects.

Religious doctrines and praying, which are a kind of self-relaxation, create “a feeling of being good” in individuals. There is an extraordinary power in belief in God, which gives a spiritual power to people, helps them cope with difficulties in life, and eliminates their worries and anxiety. Nowadays, material life has attracted most people’s attention and there is a great competition among people to achieve materials.<sup>[44]</sup> Thus, people require more spirituality today. This tendency toward materials and competition for possessing them cause great mental pressure for individuals and expose them to various anxieties and psychological disorders. Yet, holy religions respond to all individuals’ materialistic, spiritual, physical, and mental needs and provide them with tranquility, hope, exhilaration, and strength all through the life. Moreover, they prevent humans from inactivity, insanity, and intellectual decline and help them improve. Religions also provide individuals with stability of personality, perseverance, balance in thought, emotion, and behavior, and mental health. As Kendler *et al.* mentioned, a religious person considers God as the judge, which results in reduction of disorders and anti-social behaviors.<sup>[45]</sup>

To sum up, pregnant women are recommended to improve their religiosity to develop a strong spirit for coping with psychological problems and calmly passing through the pregnancy and postpartum periods.

## CONCLUSION

The findings of the present study show that religious education increased women’s knowledge, improved their attitudes, and eventually empowered them against postpartum blues. Maternal depression may affect infant’s life and impact its psychological development. Therefore, health caregivers are required to expand their preventive measures to non-pharmacological methods and help pregnant women by reducing the tension they experience during the pregnancy period.

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## REFERENCES

1. Cunningham FG, Kenneth JL, Steven LB, John CH, Dwight JR, Catherine YS. Williams obstetrics, Parkland Hospital. 23<sup>rd</sup> edition. New York: McGraw-Hill; 2010. p. 1175.
2. Adewuya AO. The maternity blues in Western Nigerian woman: Prevalence and risk factors. *Am J Obstet Gynecol* 2005;193:1522-5.
3. Yamashita H, Yoshida K. Screening and intervention for depressive mothers of new-born infants. *Seishin Shinkeigaku Zasshi* 2003;105:1129-35.
4. Woods SM, Melville JL, Guo Y, Fan MY, Gavin A. Psychosocial stress during pregnancy. *Am J Obstet Gynecol* 2010;202:61.
5. Manjunath NG, Venkatesh G, Rajanna. Postpartum Blue is Common in Socially and Economically Insecure Mothers. *Indian J Community Med* 2011;36:231-3.
6. Edhborg M. Postpartum depressive symptoms in family perspective: Some indicators experiences and consequences. Stockholm: Karolinska University Press; 2004. p. 4-8.
7. Klainin P, Arthur DG. Postpartum depression in Asian cultures: A literature review. *Int J Nurs Stud* 2009;46:1355-73.
8. Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: A systematic review of prevalence and incidence. *Obstet Gynecol* 2005;106:1071-83.
9. Glock CY. On the study of religious commitment. *Relig Educ Res Suppl* 1962;57:98-110.
10. Koenig HG. Handbook of religion and mental health. San Diego: Academic press; 1988.
11. Koenig HG1, Hays JC, George LK, Blazer DG, Larson DB, Landerman LR. Modeling the cross-sectional relationships between religion, physical health, social support, and depressive symptoms. *Am J Geriatr Psychiatry* 1997;5:131-44.
12. Hasanović M, Pajević I. Religious Moral Beliefs Inversely Related to Trauma Experiences Severity and Presented Posttraumatic Stress Disorder Among Bosnia and Herzegovina War Veterans. *J Relig Health* 2015;54:1403-15.
13. Aukst-Margetić B, Margetić B. Religiosity and health outcomes: Review of literature. *Coll Antropol* 2005;29:365-71.
14. Hasanović M, Pajević I. Religious moral beliefs as mental health protective factor of war veterans suffering from PTSD, depressiveness, anxiety, tobacco and alcohol abuse in comorbidity. *Psychiatr Danub* 2010;22:203-10.
15. Barton YA, Miller L, Wickramaratne P, Gameroff MJ, Weissman MM. Religious attendance and social adjustment as protective against depression: A 10-year prospective study. *J Affect Disord* 2013;146:53-7.
16. Ellison CG. Religious involvement, social ties and social support in a Southeastern community. *J Sci Study Relig* 1994;33:46-61.
17. Mann JR, McKeown RE, Bacon J, Vesselinov R, Bush F. Religiosity, spirituality and antenatal anxiety in Southern U.S. women. *Arch Womens Ment Health* 2008;11:19-26.
18. Mann JR, McKeown RE, Bacon J, Vesselinov R, Bush F. Religiosity, spirituality, and depressive symptoms in pregnant women. *Int J Psychiatry Med* 2007;37:301-13.
19. Kroll J, Sheehan W. Religious beliefs and practices among 52 psychiatric inpatients in Minnesota. *Am J Psychiatry* 1989;146:67-72.
20. Chaudhry HR. Psychiatric care in Asia: Spirituality and religious connotations. *Int Rev Psychiatry* 2008;20:477-83.
21. King MB, Dein S. The spiritual variable in Psychiatric research. *Psychol Med* 1998;28:1259-62.

22. Musarezaie A, Moeini M, Taleghani F, Mehrabi T. Does spiritual care program affect levels of depression in patients with Leukemia? A randomized clinical trial. *J Educ Health Promot* 2014;3:96.
23. Piko BF, Fitzpatrick KM. Substance use, religiosity, and other protective factors among Hungarian adolescents. *Addict Behav* 2004;29:1095-107.
24. Lucchetti G, Koenig HG, Pinsky I, Laranjeira R, Vallada H. Religious beliefs and alcohol control policies: A Brazilian nationwide study. *Rev Bras Psiquiatr* 2014;36:4-10.
25. Dew RE, Daniel SS, Goldston DB, McCall WV, Kuchibhatla M, Schleifer C, et al. A prospective study of religion/spirituality and depressive symptoms among adolescent psychiatric patients. *J Affect Disord* 2010;120:149-57.
26. Helming MA. Integrating spirituality into nurse practitioner practice: the importance of finding the time. *J Nurse Pract* 2009;5:598-605.
27. Narayanasamy A. Spiritual coping mechanisms in chronic illness: A qualitative study. *J Clin Nurs* 2004;13:116-7.
28. Koszycki D, Raab K, Aldosary F, Bradwejn J. A multifaceted spiritually based intervention for generalized anxiety disorder: A pilot randomized trial. *J Clin Psychol* 2010;66:430-41.
29. Mok E, Wong F, Wong D. The meaning of spirituality and spiritual care among the Hong Kong Chinese terminally ill. *J Adv Nurs* 2010;66:360-70.
30. Lundberg PC, Kerdonfag P. Spiritual care provided by Thai nurses in intensive care units. *J Clin Nurs* 2010;19:1121-8.
31. Aghamohammad M. Religious Preoperative anxiety. *Ann Gen Psychiatry* 2008;69:1195-200.
32. Ebrahimi A, Neshat Doost H, Kalantari M, Molavi H, Asadolahi GH. Factor structure, reliability and validity religious attitude scale. Vol. 10. Isfahan, Iran: Isfahan University; 2008. p. 107-16.
33. Choi SK, Kim JJ, Park YG, Ko HS, Park IY, Shin JC. The simplified Edinburgh Postnatal Depression Scale (EPDS) for antenatal depression: Is it a valid measure for pre-screening? *Int J Med Sci* 2012;9:40-6.
34. Sylvén SM, Papadopoulou FC, Mpazakidis V, Ekselius L, Sundström-Poromaa I, Skalkidou A. Newborn gender as a predictor of postpartum mood disturbances in a sample of Swedish women. *Arch Womens Ment Health* 2011;14:195-201.
35. Yohannes AM, Koenig HG, Baldwin RC, Connolly MJ. Health behaviour, depression and religiosity in older patients admitted to intermediate care. *Int J Geriatr Psychiatry* 2008;23:735-40.
36. Peselow E, Pi S, Lopez E, Besada A, Ishak WW. The impact of spirituality before and after treatment of major depressive disorder. *Innov Clin Neurosci* 2014;11:17-23.
37. Koenig HG, McCullough ME, Larson DB. *Handbook of religion and health*. New York: Oxford; 2001. p. 53-60.
38. Vaillant G, Templeton J, Ardel M, Meyer SE. The natural history of male mental health: Health and religious involvement. *Soc Sci Med* 2008;66:221-31.
39. Forman ND. Postpartum depression: Identification of women at risk. Department of obstetrics and Gynecology. Aarhus, University Hospital, Denmark 2002;105:714-5.
40. Boyd RC, Pearson JL, Blehar MC. Prevention and treatment of depression in pregnancy and postpartum period- summary of a maternal depression roundtable: A U.S. perspective. *Arch Womens Ment Health* 2002;4:79-82.
41. Lumley J, Austin MP. What intervention may reduce postpartum depression. *Curr Opin Obstet Gynecol* 2001;13:605-11.
42. McVeigh CA. Investigating the relationship between satisfaction with social support and functional status after childbirth. *MCN Am J Matern Child Nurs* 2000;25:25-30.
43. Gupta S, Avasthi A, Kumar S. Relationship between religiosity and psychopathology in patients with depression. *Indian J Psychiatry* 2011;53:330-5.
44. Azhar MZ, Varma SL. Religious psychotherapy as management of bereavement. *Acta Psychiatr Scand* 1995;91:233-5.
45. Kendler KS, Liu XQ, Gardner CO, McCullough ME, Larson D, Prescott CA. Dimensions of religiosity and their relationship to lifetime psychiatric and substance use disorders. *Am J Psychiatry* 2003;160:496-503.

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