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Studying the Relationship between Religious Orientation and Vitality and Mental Health of Male and Female Prisoners

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Abstract

Aim: The present study investigated the relationship between religiosity (religious orientation) and vitality and mental health in male and female prisoners of North Khorasan Province, Iran.

Methods: 130 of 200 male and female prisoners were selected as sample size, and religiosity questionnaires were distributed among them (Intrinsic-extrinsic religious belief in this study was measured by Religious Orientation Scale, developed by Allport Regression test was used to analyze the data gathered in this study.

Findings: the research finding showed a significant relationship between religious orientation and mental health and vitality of prisoners, which means that the relationship between mental health and being religious is stronger than the relationship between vitality and being religious. In other words, the more is religiosity, the less are symptoms, and as a result, the more are mental health and vitality. The results showed that the proportion of mental health and vitality of males was larger than females. Also the proportion of religiosity among females was larger than males.

Conclusion: The results showed that there is a significant relationship between religious orientation and the mental health of prisoners.

Keywords: Religiosity, Mental health, Vitality, Intrinsic-extrinsic religious orientation, Orientation

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Introduction

Researchers have shown that mental health is effective in social and individual improvement and mobility [1]. That is why mental disorders is one of the big problems in the world today in a way that, according to records, one-fourth of American society have some sort of mental afflictions. In most cases, individuals with mental disorders not only reduce their social and individual adjustments, but cause problems for their families' mental health and psychological security and other social groups' as well. Also in some cases, the severity and sort of problems may cause trouble for or threaten the rights of other society members, and as a result, may lead to conflict the law and judicial authorities. Besides, findings of different researches show that 10 to 15% of prisoners suffer from mental disorders and the rate of its incidence among criminals and prisoners is very higher than among other members of society.

On the other hand, one of the main concerns of the today society is lack of spiritual health in some groups. Spirituality means sense of life or a way of being and experiencing through awareness of a virtual dimension and identifying its tangible values. Spirituality and orientation towards religion is a kind of robust protective shield against psychological distresses, and acts like panacea in today's stressful world [2]. Spirituality, in connection with other personal treats and psychological characteristics, helps to better deal with stresses. Reinforcing religious beliefs in all stages of life is a preventive action in reducing mental disorders [3]. Studies show that spirituality has a direct relation with physical and mental health [4].

There are numerous studies, which support the theory that spiritual well-being might help better mental functioning and psychological adjustment [5].The World Health Organization (WHO) has also viewed spirituality as the fourth dimension of human health. Elements such as promiscuity, irreligion and crime are important factors in the pathology of lack of mental health. In other words, spirituality is one the key issues raised in positive psychology. Religion and spiritual experiences are of important and effective factors in psycho-physiological link states [6]. Weakening the function of religion in a society is counted as a great danger.

Religious beliefs of individuals are of important factors in protecting the society against corruption and deviance. According to Raffie-poor, the most important reason is the internal control system in human and that the internal control system is religion [7] in a way that it affects individual's attitude, insight and acts [8]. Larus considers preoccupation of thought and the supernatural affairs of most global and stable attitudes of human kind.

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From the viewpoint of classic sociologists such as Kenneth, humans need religion constantly because they tend to show affection to something better than themselves [9]. Studies have shown that if beliefs and religious values held by people are intrinsic and really accepted, then religious values can harmonize and unify characters [10]. Islamic scientific sources and Muslim scientists' theories show the necessity of having religious beliefs and the fact that it can prevent lots of diseases and in particular psychological ones [11]. There is a positive correlation between the necessity of having religious belief in practice and mental health. According to Allameh Tabatabaei, human mental capacity will expand more if s/he has faith in monotheism and obey innate religious rules; otherwise, s/he will live a foggy life and will be unsatisfied with his or her attempts [12]. Given the relation between religion and psychology [13], attending in religious ceremonies reduces symptoms of mental illness. Many research works have demonstrated the positive correlation between religion and physical health. Acklin, Brown and Meuger (1983), studying the relationship between religion and the power to fight cancer, found that religious attitude of patients to cancer leads to positive attitude to life in them. Kakazrosky (1989) also, examining different patients, showed that religion relieves anxiety in patients [14]. Listening to Quran relieves anxiety in heart patients too [15]. Remezani (2001) found that providing psychological treatments while using religious methods for HIV patients help decrease their anxiety and set the scene to avoid contagion. Colip [1936], examining children suffer ring from Leukemia, showed that worshipping can promote their longevity. As for elders, a positive correlation exists between their physical and mental health and having religious beliefs [16]. In a study carried out by Lu and Handal [1995] among 500 students aged 16 to 47, they found a significant relationship between religion and becoming accustomed to university life throughout their first year of studies. Research findings about religiosity and other variables show that there exists a positive and significant relationship between the religious attitude rate of the Christians and their belief in external control source or supernatural power [17]. Religion has a key role in protecting individuals against attitudes towards misdeed [18]. Holding religious beliefs is an important element for readjustment and repentance of prisoners [19]. This study attempted to prove the following four hypotheses:

1. There is a significant mean difference in religious orientation in male and female prisoners of North Khorasan Province.
2. There is a significant mean difference in vitality in male and female prisoners of North Khorasan Province.

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3. There is a significant mean difference in mental health in male and female prisoners of North Khorasan Province.
4. There is a relationship between extrinsic religious orientation and mental health and vitality of North Khorasan Province prisoners.

This study attempts to find an answer to this question that if there is a significant relationship between religiosity (religious orientation) and mental health and vitality among the male and female prisoners of North Khorasan Province.

Methods

This descriptive and analytical study was done on 130 prisoners (males & females) by using correlation method. The survey was carried out using a correlation method. Multivariate regression and. Pierson's correlation coefficient were employed to meet the research hypotheses. According to the purpose of this study, the method applied to this research is of correlation kind and field research type. Three religiosity questionnaires were used (Religious Orientation Scales, developed by Allport) to measure mental health and vitality. Participants of this study are all male and female prisoners of North Khorasan Province in 2014. The sampling method used in this research is cluster sampling. As per gathered information, the total number of the participants is 200. 130 questionnaires were distributed among the male and female prisoners of North Khorasan Province and gathered in accordance with the number of participants. The questionnaires were distributed, and the obtained data were analyzed using descriptive and inferential statistics.

Results

In 13 (21%) out of the 60 participants were diploma holders and 30 participants (at three groups each composed of 10 participants) were at elementary level in terms of reading and writing. The least number of participants (8 participants), representing 13.2% of the whole, were illiterate. 9 participants, representing 15% of the whole, also had university degrees.

Most of the female prisoners were at elementary level in terms of reading and writing. To be specific, from 60 participants, 23 of them, representing 32.9% of the whole, were at elementary level when it comes to reading and writing, and 13 of them, representing 18.6% of the whole, had elementary school degree, 12 (17.1%) were illiterate, and only one of them, representing 1.4% of the whole, had college degree. 22 male prisoners 36.7were workmen, 11 (18.3%) were jobless, 7 (11.7%) were retired, 9 (15%) were students, 8 (8.8%) were clerks, and only two of them, representing 35.3% of the whole, were bosses. 28 (40%) of female prisoners

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were workwomen just like male prisoners. Also 14 (20%) of them were jobless, 11 (15.7%) were students, and 8 (11.4%) were housewives. 15.4% of the participants were married, 31.4% were unmarried, 12.9% were divorced and 2.9% were widowed. 70% of the male prisoners had private property, 13.3% were tenants, and 11.7% had no stable place of residence.

To meet the first hypothesis, Pierson's Correlation Coefficient was used and the results are shown in Table 1.

Table 1: Multiple correlation coefficients of religious orientation and mental health and vitality by step method

Model	Predictor variable(s)	MR	RS	R	F	Significance level
1	Mental health	0.435	0.506	0.085	18.07	0.001
2	Vitality	0.247	0.061	0.056	12.56	0.001

As it can be seen from Table 1, the results of multiple regression analysis by step method show that both of the two predictor variables (mental health and vitality) have a significant role in predicting religiosity or religious orientation. In other words, in the best predicting (Model 2), multiple correlation coefficient value (MR) for linear combination of predictor variables (mental health and vitality) and religious orientation equals 0/435, showing almost good relationship between predictor variables and religious orientation. Coefficient of determination value (RS) equals 0/506, implying that 506% of religious coefficient variance is explained by mental health predictor variable and % of which by vitality. Variance analysis indicators (F-test) also showed the significance of regression and linear relationship between the variables (P=0/001). It was revealed that regression model with predictor variables and the criterion variable is almost well qualified, and changes explained by the model are real rather than being random or by chance. In addition, predictor variables could predict religious orientation changes, and with the possibility of more than 99% these variables contribute in predicting the criterion variable changes.

In order to meet the Second hypothesis, the linear regression test was used, and the results are presented in Table 2.

Table 2: Multiple regression coefficients of intrinsic religious orientation, mental health and vitality by step method

Model	Predictor variable(s)	Non-standardized coefficients		Standardized coefficients	T	P
		B	Standard error	β (beta)		
1	Mental health	0.86	0.122	-0.422	-2.86	0.008
2	Vitality	1.13	0.152	-0.052	-3.7	0.001

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The above regression coefficients imply that in the best predictor model (like test results for the first subsidiary hypothesis), mental health (β=-0/226, P=0/001) and vitality (β=-0/031, P=0/008) are capable of predicting intrinsic religious orientation. As Table 1.2 shows, the t-test value and its significance level determine the impact of mental health and vitality variables on predicting the intrinsic religious orientation. Accordingly, part of the first subsidiary hypothesis is confirmed. It means that there is a multiple relationship between mental health and vitality and religious orientation, and these variables can predict the religious orientation of male and female prisoners of North Khorasan Province. A comparison of standardized regression coefficients (β) showed that the mental health score of -0/422 is a stronger predictor for intrinsic religious orientation, and after that, vitality with the value of just -0/052 is the second important predictor. Negative beta coefficient means the higher religiosity, the fewer symptoms, and therefore, the more mental health and the less vitality. In order to meet the third hypothesis the linear regression test was used, and the results are presented in Table 3.

Table 3: Multiple regression coefficients of extrinsic religious orientation and mental health and vitality levels by step method

Model	Predictor variable(s)	Non-standardized coefficients		Standardized coefficients	T	P
		B	Standard error	β (beta)		
1	Mental health	1.09	0.310	-0.226	-3.54	0.001
2	Vitality	1.13	0.032	-0.031	-3.70	0.001

The above regression coefficients indicate that in the best predictor model (like test results for the third subsidiary hypothesis), mental health (β=-0/226, P=0/001) and vitality (β=-0/031, P=0/008) are capable of predicting extrinsic religious orientation. As Table 1.3 shows, the t-test value and its significance level determine the impact of mental health and vitality variables on predicting extrinsic religious orientation. Accordingly, part of the third subsidiary hypothesis is confirmed. It means that there is a multiple relationship between mental health and vitality and religious orientation, and these variables can predict the extrinsic religious orientation of male and female prisoners of North Khorasan Province. A comparison of standardized regression coefficients (β) showed that the mental health score of -0/226 is a stronger predictor for extrinsic religious orientation. Negative beta coefficient means the higher intrinsic religiosity, the fewer symptoms, and therefore, the more mental health and the less vitality.

In order to meet the forth hypothesis,

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independent t-test was used, and the results are presented in Table 4.

Table 4: Comparison of mental health in male and female prisoners

Gender	Mean	SD**	T-test	*Df**	*p*
Women	11.46	0.59	12.2	60	0.001
Men	23.65	0.51			

*df=Degrees of freedom
**SD=Standard deviation

Considering the significance level of p-value, which is less than 0.05, it can be said that there is intense significant difference in the mental health of male and female prisoners of North Khorasan Province. The above mean values show high levels of mental health in male prisoners (23/65) than in female ones (11/46).

In order to meet this hypothesis, independent t-test was used, and the results are presented in Table 5.

Table 5: Comparison of vitality in male and female prisoners

Gender	Mean	SD**	T-test	*df**	*p*
Women	12.13	0.60	16.13	60	0.045
Men	18.62	0.53			

*df=Degrees of freedom
**SD=Standard deviation

As shown in Table 5, considering significance level of p-value which is less than 0/05, we can say that there is significant difference in the vitality of male and female prisoners of North Khorasan Province. The above mean values show high levels of vitality in male prisoners than in female ones.

In order to meet this hypothesis, independent t-test was used, and the results are presented in Table 6.

Table 6: Comparison of orientation level in male and female prisoners

Gender	Mean	SD**	T-test	*df**	*p*
Women	18.19	0.66	11.23	60	0.03
Men	9.36	0.53			

*df=Degrees of freedom
**SD=Standard deviation

As shown Table 6, given the significance level obtained for the test (0/03), and considering that the vale is than 0/05, it can be said that, in the alpha level of 0/05, there is a significant mean difference in religious orientation in male and female prisoners of North Khorasan

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Province, which (regarding the values of 9/36 and 18/19 for male and female prisoners, respectively)shows the high level of religious orientation in female prisoners than in male ones.

Discussion

The findings of this research are in keeping completely with the results of other researches. Gharaee et al. (2008), in a research about the relationship between mental health and intrinsic and extrinsic religion, found a significant relationship between intrinsic religion and mental health [20] but such a relationship was not reported in Bahrami and Ramezani Farani's research (2004) about the role of extrinsic religion [21]. Findings of religious orientation (intrinsic and extrinsic) in mental health and depression in the elderly revealed a significant correlation between religious orientation and mental health and depression in the elderly. Lahsaeezade et al. (2004), in a survey on the relationship between religious orientation and mental health of the immigrants based on Allport and Ross model, showed that the correlation coefficient between intrinsic religious orientation and mental health was 0.079, and between extrinsic religious orientation and mental health was -0.750. In explaining these findings, we can say that it is possible to find a positive relationship between mental health and intrinsic religious orientation since those with extrinsic religious orientation use their religious commitments as a means of gaining position, power or safety and, generally, use a kind of counsel, but those with intrinsic religious orientation make their beliefs intrinsic and live with them; however, there are some signs of extrinsic crisis in them [22]. It has been reported that intrinsic and extrinsic religious orientation have a significant relationship with the family mental health; the findings of this research confirm the assumption of Allport's theory about the relationship between mental health and religiosity as well as its relation with the family mental health. Although Iranian society has entered the industrialization process, along with these changes and developments, religious beliefs and values have maintained their role and act as a supervising power in order to control the behavior of the society members. People with stronger intrinsic religious orientation have more mental health, so religion is an important factor affecting on the attitudes and behavior of the family members [23]. Accordingly, it has long been assumed that there is a positive relationship between religion and mental health, and psychology of religion recently has provided much empirical support in this area. Having meaning and purpose in life, feeling of belonging to a noble source, hoping to gain the assist of God in a troubled life, and having

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social and spiritual support are resources that all religious people can deal with problematic life events and endure less damage psychologically [24]. The following two forms of religious creeds may affect on mental health: shaping individual behaviors, and changing one's attitude toward others. They can also improve people's overall health (by encouraging healthy behaviors, and thus improve physical health [25]. In explaining the experience of this finding in persons with intrinsic and extrinsic religious orientation of different life events, it is natural that people with internal religious event are more positive; therefore, they easily accept death as a result of lower death anxiety. God remembering is a factor for increased tolerance, coping with hardships and tensions, and increasing self-control and moral development.

With the increase of orientation and religious faith, self-control process is also improved through preventing the effectiveness of external conditions or maintaining demographic and mental health [26]. Religion, partly because of character integrity, will be a source of mental health promotion.

In explaining this finding, it can be said that people with intrinsic religious orientation (i.e. those who believe that religion is rooted in their nature), in comparison with people with extrinsic religion (i.e. those who believe in religion as a means for gaining something else are naturally responsible for their emotions. One of the most important characteristics of the people with intrinsic religious orientation is that they do not project their works and daily tasks, and accept the realities because this is related to emotional irresponsibility, leading to create anger and sadness within every human being. In other words, the reason of everybody's misery is not himself but also the others; the realities usually should not be accepted in a quiet and serene way as they happen. Therefore, given what have been told about the characteristics of intrinsic religious orientation and irresponsibility, it can be said that intrinsic religious orientation decreases the emotional irresponsibility. In general, religious orientation relies on beliefs and religious activities, and by controlling anxiety and emotional irresponsibility, helps people [27]. It is also possible that in assessing the impact of this variable on the mental health in men and women, gender variable acts as a confounding variable, and affects the relationships between these two variables. Regarding this, men and women use unequally valuable social resources, such as social capital, social (network) support, relationships and bonds and other components, which impress their mental health. The main reason of increased incidence of mental illness in women in comparison to men should be sought in their inferior social-economic status and inadequate access to the

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social and economic resources and [28] Accordingly, the existence of gender discrimination in community is an important factor in decreasing health level and incidence of more mental disorders in women than men. From this viewpoint, while social exclusion can generally affect the incidence of mental illness, this phenomenon, because of its gender discrimination, impresses women more than men and has greater consequences [29]. In this way, some of the issues about women's health are not directly related to their biological characteristics; rather they are related to social exclusions and lack of access to the valuable social resources, which women (given their limited roles) experience them during their daily lives.

The overall rate of psychiatric disorders for men and women is almost identical. However, significant differences can be found in the pattern of mental illness; more women than men are affected by socio-economic factors and life situations are at risk for mental health. Women experience more emotional distress, sexual violence, domestic violence, stress caused by their multiple roles, and sexual discrimination because of domination of emotional dimension comparing to men enjoy a dominant logical dimension [30].

The result of the above hypothesis is consistent with the findings of Fujita et al. [31]. Diner et al. believe that the amount of happiness is equal in men and women; however considering depression, it is not that much easy as if although men's and women's happiness is equal, depression is more in women than in men. Diner et al. explain that women experience more negative and positive emotions and the resultant of both of them makes men's and women's happiness to be seemingly equal. Furthermore, probably the strong impact of factors other than gender such as social and economic factors causes the reduction of gender role in explaining happiness and vitality since such factors impact both men and women but in different degrees. It seems that providing conditions for increasing people's vitality through improving self-esteem, physical health and physical activities, along with increasing mental health and performance development can lead to increase their happiness [32]. Along with this research, the findings of some researches in other countries have shown that attendance at religious places through different ways such as increasing faith in God, strengthening religious beliefs, praying, creating mental comfort, increasing communications and social support, increasing marital intimacy and teaching religious orders, which lead to promote physical and mental health, may cause increasing happiness [33]. It seems that the women attending the present research, as a sample coming from Iranian society,

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emphasize the impact of spirituality role in happiness.

The findings of the present research in comparing religious orientations and self-control capacity in males and females showed a significant mean difference in men and women in intrinsic and extrinsic orientations (at the level of 0.05). As if the male orientation was extrinsic, the female orientation was intrinsic. These findings are in line with the findings of Levin and Taylor (1993:16), and McCalog et al. (2000:211. For example, the same researchers also found out that women are more religious than men [34].

Unlike the mentioned researches, some findings also suggest that there is no considerable difference between men and women in terms of religious orientation. For example, Biabani et al. concluded that there is no difference between men and women in religious orientation. In this regard, Arefi, Moradi and Mohsenzadeh [35] reported that there is no difference between male and female students considering religious orientation. Given these contradictory findings in different cultures, it can be said that religious differences between men and women are a socio-cultural issue rather than reflecting differences due to gender. This finding could be explained by this fact that men (compared to women) enjoy external religious-oriented interests and social support due to the nature of their social status and occupation because they are more concerned with the economic and labor aspects of the family, while women have more internal religious-oriented interests so because of the specific social and cultural conditions, they always seek for inner peace; for example, due to higher susceptibility in case of divorce and family breakdown, they have more tendency to inter-religious beliefs as well as prying and worshipping.

Finally, it can be said in the view of Islam, God has created both man and woman as human and equal [36]. Biologists consider the physical differences between the two sexes as fundamental and profound. The physical differences between men and women include differences in the chromosome, in the reproductive system, and in hormones [37]. There are psychological differences between men and women well [38].

References

1. Garousi Farshi M, Mehryar A, Ghazi Tabatabayi M. Application of NEO Personality Inventory and evaluating new features and analysis of the factor structure among Iranian university students. Journal of Humanities of Al- Zahra University 2001; 39: 173-98. [In Persian]
2. Al Booyeh A. Meaning of life. Tehran: Islamic Sciences and Culture Academy, Springer; 2009.

[Downloaded from hehp.daneshafarand.org on 2026-11-13]

3. Safaei, Shamousi N, Ahmadi tahur M. The relationship between spiritual well-being and mental health of students. Master Thesis, Sabzevar: Sabzevar University of Medical Sciences, 2010.
4. Hartz GW. Spirituality and Mental Health: Clinical Applications. New York; Haworth Press, 2005.
5. Litwinczuk KM, Groh CJ. The Relationship between spirituality, surpose in life, and well-being in HIV-positive persons. J Assoc Nurses AIDS Care 2007; 18(3): 13-22.
6. Jalali Moghadam, M. Introduction to sociology of religion and beliefs about the great sociologist Religion. Second Edition, Tehran: Publishing Center, 2007.
7. Raffiepoor F. The anatomy of society. Tehran: Sahami Aam Publications, 2010.
8. Himmelfarb H. Measuring Religious Involvement. Social Forces 1975; 53(4): 606-18.
9. Bagheri Sh. Dialogue and understanding sociology (on measures of religiosity religious implications). Shiite Women 2008; 4(2): 24-5.
10. Sherman AC, Simonton S. Research on Faith and Health: New Approaches to Old Questions. In: Plante TG, Sherman AC, (Eds). Faith and Health: Psychological Perspectives. New York: Guilford, 2001; p: 1-12.
11. Miller WR, Thorsesen CE. Spirituality, Religion, and Health: An emerging research field. APA 2003; 58(1): 24-35.
12. Hosseini A. Principles of mental health (mental health evaluation and planning in Islam). Master Thesis, Mashhad: Ferdowsi University of Mashhad, 2001.
13. Gartner J, Iarson DB, Allen G. Religious commitments and mental health: A review of the empirical literature. JPT 1991; 119: 26-7.
14. Khodayari, Rahimi A. "The scope of psychological research in the field of religion". JTB 2001; 20(2): 12-4.
15. Khatoni A. The effect of reciting the Quran on anxiety of patients hospitalized in the cardiac intensive care unit of the selected hospitals in Tehran. Master Thesis, Tehran: Iran University of Medical Sciences, 2011. [Persian]
16. Louise CA, Maltby J, Day L. Religious orientation, religious coping and happiness among UK adults. PID 2005; 38: 1193-202.
17. Rasmussen L, Charman T. "Personality and Religious Beliefs: A Test of Flugel's Superego Projection Theory". JPR 1995; 5: 109-17.
18. Chadwick BA, Top BL. Religiosity and delinquency among LDS adolescents. SSR 1995; 32: 10-9.
19. Koening HG. Religion, Spirituality, and medicine application to clinical practice.

[Downloaded from hehp.daneshafarand.org on 2026-11-13]

JAMA 2007; 53(4): 262-6.

20. Gharraee V, Alibeygi N, Zanuzyan S, Akbri dehaghi A. "Internal and external investigate the relationship between mental health and religion in Kashan". SRP 2009; 22: 65-88.
21. Bahrami F, Ramadan Ferrand A. "Internal and external role of religious beliefs in mental health and depression in the elderly". JPR 2010; 6(1): 42-7.
22. Lahsaeezade AA, Azargoon Z, Moradi G. "The relationship between religious orientation and mental health of immigrants, according to Allport and Ross model: The study Qasr-e Shirin". JLH 2006; 3: 149-69.
23. Desrosiers A, Miller L. Relational spirituality and depression in adolescent girls. JCP 2007; 63(10): 1021-37.
24. Allport GW. The person in psychology: Selected essays. Boston, MA, US: BeaconPress, 1968.
25. Ardelt M, Koenig C. The role of religion for hospice patients and relatively healthy older adults. JRA 2006; 28: 214-5.
26. Delors J. Learning: The Treasure Within, UNESCO of the International Commission Pocket Edition, Publisher, translator: Tehran, Institute of Education and Training, 2001 [In Persian].
27. Ground H Comparative study of religious orientation (internal and external) mental health and irrational beliefs. Psychology and Religion 2012; 5(1): 35-6.
28. Etesaminiya H. The relationship between religious orientation and mental health and moral development. JPR 2015; 1: 115-6.
29. Fisher JR, de Mello MC, Izutsu T, Tran T. The NaNoi Expert statement: Recognition of maternal mental health in resource-costrained setting is essential for achieving the millennium development goals. Int J Ment Health Syst 2011; 5(1): 2.
30. Cash TF. "The Irrational Beliefs Test: Its relationship with cognitive behavioral trait and depression". JCP 1984; 40(6): 1399-405.
31. Fujita F, Diener E, Sandvik E. Gender differences in negative affect and well-being: The case for emotional intensity. JPSP 1991; 61: 427-34.
32. Diener E, Emmons RA, Larsen RJ, Griffin, S. The Satisfaction with Life Scale. JPA 1985; 49: 71-5.
33. Ellison CG. Religious involvement and subjective well-being. JHSB 1991; 32: 80-99.
34. Taylor F. Content analysis and gender stereotypes in children's books. Teaching Sociology 2003; 31(3): 300-11.
35. Arefi M, Moradi Omid, Mohsenzadeh, F. Religious orientation, mental health, The first Regional Conference of Young Sex and Spirituality in the Age of Communication, Educational Deputy and Research

[Downloaded from hehp.daneshafarand.org on 2026-11-13]

Organization of Sanandaj. Master Thesis, Sanandaj: University of Sanandaj, 2010.
36. Ganji H. Differential psychology. Tehran: Bahar Publications, 1996.
37. Allen LS, Richey MF, Chai YM, Gorski RA. "Sex differences in the corpus callosum of the living human being". JSN 1991; 11: 933-42.
38. Carlson K. Mental health of women. (Tr. by Savalan), Tehran, 2000. [In Persian]

[Downloaded from hehp.daneshafarand.org on 2026-11-13]