



Effectiveness of Psycho-Spiritual Therapy on Postpartum Depression Among Women of the FCT Baptist Conference, Nigeria

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ABSTRACT

This study investigated the effectiveness of psycho-spiritual therapy on postpartum depression among women attending churches within the FCT Baptist Conference, Abuja, Nigeria, and examined the prevalence of PPD, its associated risk factors, and the availability of psycho-spiritual services. Methods: A single-group pretest-posttest design was employed. From an accessible population of 630 postpartum women across eleven rural and urban church associations, a sample of 245 was determined using Yamane's (1967) formula and selected through stratified and simple random sampling; 183 valid responses were analysed. Data were collected using the Edinburgh Postnatal Depression Scale (EPDS) and the Psycho-Spiritual Wellbeing Scale (P-SWBS), and analysed using descriptive statistics, simple and multiple linear regression, and a paired-samples t-test at the .05 level of significance. Results: Postpartum depression was prevalent among participants: 134 respondents (73.2%) reported some degree of depressive symptomatology (mild to severe), and 93 respondents (50.8%) met the stricter EPDS cut-off (≥ 13) for probable postpartum depression. Financial stress, childcare responsibilities, marital challenges, and low social support were significant contributors ($R^2 = .413$, $p < .001$). Access to psycho-spiritual services was significantly associated with lower PPD ($R^2 = .236$, $p < .001$), and a paired-samples t-test confirmed a statistically significant reduction in depressive symptoms following the therapy intervention, with mean scores declining from 25.81 (SD = 5.46) before therapy to 15.38 (SD = 4.81) after therapy, $t(182) = 22.364$, $p < .001$. Post-intervention psycho-spiritual wellbeing was also significantly associated with lower depression scores ($R^2 = .272$, $p < .001$). Conclusion: Psycho-spiritual therapy can be an effective component of a holistic response to postpartum depression within faith-based communities. Structured counselling, prayer, fellowship, mentoring, scriptural encouragement, and appropriate referral pathways are recommended.

Keywords: postpartum depression; psycho-spiritual therapy; women; faith-based intervention; pastoral counselling; FCT Baptist Conference; Nigeria

Introduction

Postpartum depression (PPD) is increasingly recognised as a serious global public health problem affecting mothers, infants, families, and the broader society (O'Hara & McCabe, 2013; World Health Organization [WHO], 2022). The WHO (2022) estimates that approximately 10–15% of new mothers globally develop PPD, with markedly higher prevalence in low- and middle-income countries where social, cultural, and economic conditions heighten maternal mental health vulnerability. In Nigeria, reported prevalence rates range from 14% to over 40% depending on region and socioeconomic conditions (Adeyemo, 2020). Chinawa (2016) reported a prevalence of 20% among postpartum women in Nsukka, and a more recent hospital-based survey in the same city similarly found elevated rates among nursing mothers (Anosike et al., 2024); further Nigerian studies have reported rates as high as 23.5% in Gombe and 43.4% in Bauchi State, linked to socioeconomic hardship, poor maternal support systems, and limited mental health services (Laima et al., 2025; Mohammed, 2025).

PPD is particularly consequential for women within faith-based communities such as the FCT Baptist Conference, Abuja, who often balance childcare, household demands, religious commitments, and economic activity simultaneously. Although faith communities are often assumed to provide strong emotional support, women within them may still experience significant psychological strain, and symptoms may be misread as spiritual weakness rather than a genuine mental health condition, a misattribution that discourages help-seeking and contributes to underdiagnosis (Iheanacho et al., 2021).

Medically, PPD is classified in the DSM-5 as a major depressive episode with peripartum onset, with symptoms typically beginning during pregnancy or within four weeks of delivery, though they may persist for months if untreated (American Psychiatric Association, 2013). It is distinguished from the milder, self-limiting postpartum blues and from the rare but serious postpartum psychosis. PPD arises from an interaction of biological, psychological, and social factors, hormonal shifts, sleep deprivation, emotional stress, cultural expectations, and inadequate social support (O'Hara & Wisner, 2014), and carries downstream effects on mother–infant bonding and child developmental outcomes (Letourneau et al., 2012).

Faith-based and psycho-spiritual responses to PPD have shown promise elsewhere. Meta-analytic evidence indicates that psychotherapy adapted to clients' religious or spiritual beliefs produces psychological and spiritual outcomes at least as good as, and in some respects better than, standard secular treatment (Captari et al., 2018), and structured religiously-integrated cognitive behavioural therapy has produced meaningful reductions in depression among religious clients (Pearce et al., 2015). Among mothers specifically, qualitative work has documented that church participation and spiritual practice provide relief from stress, a sense of being valued, and protection against self-harm during postpartum depression (Keefe et al., 2016). Despite this,

comparatively little research has examined structured psycho-spiritual intervention combining counselling, prayer, scriptural engagement, and fellowship specifically among postpartum women in Nigerian church settings, and evidence from the FCT Baptist Conference in particular has been absent from the literature.

The present study was informed by three complementary theoretical perspectives: Attachment Theory (Bowlby, 1969), which explains the role of supportive relationships in emotional stability during the postpartum transition; the Biopsychosocial Model of Health (Engel, 1977), which frames PPD as arising from interacting biological, psychological, social, and spiritual factors rather than biology alone; and the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984), which explains PPD as emerging when perceived demands exceed available coping resources, and positions psycho-spiritual therapy as strengthening both problem-focused and emotion-focused coping. Together, these frameworks provided the conceptual basis for examining whether structured psycho-spiritual therapy could measurably reduce postpartum depression among women of the FCT Baptist Conference.

Purpose and Objectives of the Study

The purpose of the study was to determine the effectiveness of psycho-spiritual therapy on postpartum depression among women of the FCT Baptist Conference, Nigeria. The specific objectives were to:

- Determine the prevalence of postpartum depression among women of the FCT Baptist Conference;
- Identify major factors associated with postpartum depression among the participants;
- Examine the availability and role of psycho-spiritual services within the participating faith communities; and
- Determine the effect of psycho-spiritual therapy on postpartum depression among the participants.

Methodology

Research Design

The study adopted a single-group pretest- post-test design to evaluate the effect of psycho-spiritual therapy on postpartum depression. All 183 participants were assessed on postpartum depression using the EPDS prior to the intervention, received a structured psycho-spiritual therapy intervention comprising prayer support, counselling, scriptural encouragement, and fellowship-based emotional support, and were reassessed on the same measure afterward. Psycho-spiritual wellbeing (P-SWBS) was also assessed at the post-intervention stage, alongside the post-intervention EPDS, to examine whether the degree of psycho-spiritual wellbeing attained was itself associated with residual depressive symptoms. This within-subjects comparison forms the basis of the effectiveness analysis reported under Effect of Psycho-Spiritual Therapy on Postpartum Depression, below.

Population, Sample, and Sampling Procedure

The accessible population comprised 630 postpartum women, who had given birth within the preceding twelve months, drawn from eleven Baptist church associations (five rural, six urban) across the six Area Councils of the Federal Capital Territory (FCT), Abuja. The sample size of 245 was determined using Yamane's (1967) formula for finite populations at a 5% level of precision: $n = N / [1 + N(e)^2]$, where $N = 630$ and $e = 0.05$, yielding $n \approx 245$. A stratified random sampling technique was used, with strata defined by rural and urban church association; proportionate allocation was applied within each stratum, followed by simple random sampling (balloting without replacement) to select individual respondents from church fellowship records. Inclusion criteria required participants to be 18 years or older, literate, and active members of a participating church association who had given birth within the previous 12 months; women with pre-existing severe mental health disorders, a known history of substance abuse, or childbirth more than a year prior were excluded. Of the 245 questionnaires distributed, 183 were properly completed and analysed (74.7% response rate).

Instruments

Data were collected using two standardised instruments. The Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987) is a 10-item screening instrument scored 0-3 per item (total range 0-30), with higher scores indicating greater depressive symptomatology and a cut-off of 13 commonly used to indicate probable PPD; the EPDS has demonstrated Cronbach's alpha coefficients of .80-.87 in prior research. The Psycho-Spiritual Wellbeing Scale (P-SWBS), adapted from the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982), is a 20-item instrument measuring prayer life, relationship with God, emotional stability, hope, inner peace, forgiveness, coping, and perceived spiritual support on a 5-point Likert scale, with reported reliability coefficients of .88-.95 in the source literature (Bufford et al., 1991).

In addition, the questionnaire included two researcher-developed checklists aligned with the study's second and third objectives: a six-item checklist of candidate risk factors for postpartum depression (financial challenges, childcare stress, marital challenges, sleep deprivation, hormonal changes, and inadequate social support), and a six-item checklist of psycho-spiritual services available within participating churches (prayer sessions, pastoral counselling, women's fellowship meetings, Bible study/scriptural encouragement, mentorship by experienced mothers, and emotional support groups). Both checklists were rated on a 5-point scale (1 = strongly disagree/not available to 5 = strongly agree/consistently available) and were reviewed for content and face validity alongside the EPDS and P-SWBS items by the expert panel described below.

Validity, Reliability, and Pilot Testing

Content and face validity were established through expert review by the researcher's supervisor and two additional experts in psycho-spiritual and counselling studies, whose feedback informed revisions to item clarity and relevance. Reliability was assessed through a pilot study with 15 postpartum women who were not part of the main sample, using the split-half method with the Pearson Product-Moment Correlation Coefficient; the resulting coefficient exceeded the acceptable benchmark of .70, confirming adequate internal consistency for the main study.

Data Collection Procedure

Permission was obtained from the Research Ethics Committee of the Psycho-Spiritual Institute, Abuja, and an introductory letter from the Head of Department was presented to the FCT Baptist Conference leadership and to pastors of the selected church associations to secure cooperation. Two trained research assistants, briefed on the study objectives and ethical considerations, administered the questionnaires directly to respondents.

Ethical Considerations

Ethical approval for this study was granted by the Research Ethics Committee of the Psycho-Spiritual Institute of Lux Terra Leadership Foundation, an Affiliate of Veritas University, Abuja. Before administration, research assistants explained the purpose, procedures, and voluntary nature of the study to each respondent, and verbal informed consent was obtained. Respondents were assured of confidentiality and anonymity, informed of their right to withdraw at any stage without penalty, and no names or other identifying information were recorded on the instruments.

Data Analysis

Data were coded and analysed using SPSS (version 27) and Microsoft Excel. Descriptive statistics (frequencies, percentages, means, standard deviations) summarised demographic characteristics and answered the research questions on prevalence, risk factors, and service availability. Simple and multiple linear regression were used to test the association between identified risk factors, psycho-spiritual services, and post-intervention psycho-spiritual wellbeing, and postpartum depression, and a paired-samples t-test compared depression scores before and after the intervention to evaluate the therapy's effect directly. All hypotheses were tested at the .05 level of significance.

Results

Demographic Characteristics of Respondents

Table 1. *Age distribution of participants (N = 183)*

Age Group	Frequency	Percentage
18-25 years	48	26.2%
26-35 years	89	48.6%
36 years and above	46	25.1%
Total	183	100.0%

Table 2. *Marital status of participants (N = 183)*

Marital Status	Frequency	Percentage
Married	152	83.1%
Separated	18	9.8%
Widowed	13	7.1%
Total	183	100.0%

Table 3. Educational qualification of participants (N = 183)

Educational Qualification	Frequency	Percentage
Primary Education	21	11.5%
Secondary Education	49	26.8%
NCE/OND	44	24.0%
HND/B.Sc	56	30.6%
Postgraduate	13	7.1%
Total	183	100.0%

Table 4. Residential status of participants (N = 183)

Residential Status	Frequency	Percentage
Urban	117	63.9%
Rural	66	36.1%
Total	183	100.0%

Analysis of Research Questions

Baseline EPDS scores showed that most respondents experienced some degree of postpartum depression: 134 respondents (73.2%) fell in the mild-to-severe range overall, and 93 respondents (50.8%) met the stricter cut-off of ≥ 13 used to indicate probable PPD.

Table 5. Prevalence of postpartum depression among participants (N = 183)

PPD Level (EPDS)	Frequency	Percentage
Normal (0-9)	49	26.8%
Mild (10-12)	41	22.4%
Moderate (13-16)	56	30.6%
Severe (17 and above)	37	20.2%
Total	183	100.0%

On a 5-point mean-rating scale, respondents rated all six candidate risk factors above the acceptance benchmark of 2.50, with inadequate social support and financial challenges rated highest.

Table 6. Mean ratings of risk factors for postpartum depression

(N = 183; decision rule: mean ≥ 2.50 = accepted)

Risk Factor	Mean	SD	Decision
Inadequate social support	3.47	0.69	Accepted
Financial challenges	3.41	0.71	Accepted

Risk Factor	Mean	SD	Decision
Childcare stress	3.35	0.75	Accepted
Sleep deprivation	3.26	0.78	Accepted
Marital challenges	3.18	0.82	Accepted
Hormonal changes	3.08	0.81	Accepted
Grand Mean	3.29	0.76	Accepted

Multiple regression analysis tested the combined statistical effect of four of these factors, financial stress, childcare stress, marital challenges, and low social support, selected as the psychosocial and interpersonal risk factors most directly addressable through psycho-spiritual intervention. Sleep deprivation and hormonal changes, although also rated highly by participants as perceived contributors, were treated as physiological correlates of the postpartum period rather than entered into the regression model, consistent with the Biopsychosocial Model's distinction between biological and psychosocial contributors to PPD (Engel, 1977). The regression confirmed that financial stress, childcare stress, marital challenges, and low social support were each significant predictors, with financial stress the strongest contributor.

Table 7. Multiple regression analysis of risk factors on postpartum depression

($R = .643$; $R^2 = .413$; Adjusted $R^2 = .400$; $F = 31.275$, $p < .001$)

Predictor	B	t	p
Financial stress	.287	4.291	< .001
Childcare stress	.241	3.612	< .001
Marital challenges	.218	3.174	.002
Low social support	.196	2.883	.004

Respondents rated all six psycho-spiritual services above the acceptance benchmark, with prayer sessions and pastoral counselling most consistently available.

Table 8. Mean ratings of available psycho-spiritual services ($N = 183$; decision rule: mean ≥ 2.50 = accepted)

Psycho-Spiritual Service	Mean	SD	Decision
Prayer sessions	3.62	0.57	Accepted
Pastoral counselling	3.48	0.68	Accepted
Women's fellowship meetings	3.44	0.73	Accepted
Bible study / scriptural encouragement	3.39	0.70	Accepted
Mentorship by experienced mothers	3.27	0.77	Accepted
Emotional support groups	3.11	0.84	Accepted
Grand Mean	3.39	0.72	Accepted

Regression analysis confirmed that access to psycho-spiritual services was significantly associated with lower postpartum depression.

Table 9. Regression analysis of psycho-spiritual services on postpartum depression**(R = .486; R² = .236; Adjusted R² = .232; F = 64.221, p < .001)**

Variable	B	SE	β	t / p
Psycho-spiritual services	-.593	.074	-.486	t = -8.014, p < .001

Effect of Psycho-Spiritual Therapy on Postpartum Depression

To directly evaluate the effect of the psycho-spiritual therapy intervention, EPDS scores before and after therapy were compared using a paired-samples t-test.

Table 10. Pre- and post-therapy postpartum depression scores (paired-samples t-test)

Measure	N	Mean	SD
Before therapy	183	25.81	5.46
After therapy	183	15.38	4.81

A paired-samples t-test showed a statistically significant reduction in postpartum depression scores following the intervention (mean reduction = 10.43 points), $t(182) = 22.364$, $p < .001$, confirming that the psycho-spiritual therapy intervention was associated with a substantial improvement in depressive symptoms.

Supplementary Analysis: Psycho-Spiritual Wellbeing and Postpartum Depression

Beyond the effect of the intervention itself, a simple linear regression examined whether participants' post-intervention psycho-spiritual wellbeing (P-SWBS) was associated with their residual level of depression. The analysis showed a significant negative association, with the model explaining 27.2% of the variance in post-intervention depression scores.

Table 11. Regression analysis of post-intervention psycho-spiritual wellbeing (P-SWBS) on postpartum depression **(R = .521; R² = .272; Adjusted R² = .268; F = 67.912, p < .001)**

Variable	B	SE	β	t / p
Psycho-spiritual wellbeing (P-SWBS)	-.684	.083	-.521	t = -8.241, p < .001

Discussion

The findings demonstrate that postpartum depression was a substantial concern among the women studied: 73.2% of respondents reported some degree of depressive symptomatology at baseline, and 50.8% met the stricter cut-off for probable PPD, rates consistent with the elevated PPD prevalence reported elsewhere in Nigeria (Adeyemo, 2020; Laima et al., 2025; Mohammed, 2025). The identification of financial stress, childcare responsibilities, marital challenges, and low social support as significant contributors underscores the multidimensional nature of postpartum wellbeing and corroborates prior Nigerian and sub-Saharan African findings linking socioeconomic hardship, marital conflict, and poor social support to PPD risk (Martins et al., 2024; Silverman et al., 2017). This pattern is consistent with the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984), which explains PPD as arising when perceived demands exceed available coping resources.

The findings further indicate that psycho-spiritual resources available within the church environment, pastoral counselling, prayer, women's fellowship, scriptural encouragement, and mentoring, were associated with reduced depressive symptoms. This is consistent with qualitative evidence that church participation and spiritual practice provide mothers with stress relief, a sense of being valued, and protection against self-harm during postpartum depression (Keefe et al., 2016), and with findings that church-based platforms offer culturally acceptable avenues for addressing depression among Nigerian women (Iheanacho et al., 2021).

Most notably, the pre- and post-therapy comparison showed a substantial and statistically significant reduction in depression scores following the intervention, from 25.81 to 15.38, directly answering the study's fourth objective and supporting the effectiveness of the psycho-spiritual therapy programme. Post-intervention psycho-spiritual wellbeing was also significantly associated with lower depression scores, suggesting that the degree to which participants internalised the psycho-spiritual dimension of the intervention, and not simply their exposure to it, may matter for outcomes. These findings are consistent with broader evidence that psychotherapy tailored to clients' religious or spiritual beliefs produces outcomes at least as good as, and in some respects better than, standard secular treatment (Captari et al., 2018), and with trial evidence that religiously-integrated cognitive behavioural

therapy produces meaningful reductions in depression among religious clients (Pearce et al., 2015). Taken together, the findings reinforce the Biopsychosocial Model (Engel, 1977), PPD here reflected the combined influence of psychological, social, economic, and spiritual factors rather than biology alone, and Attachment Theory (Bowlby, 1969), insofar as the supportive relationships fostered through counselling, fellowship, and mentoring appear to have contributed to participants' emotional stabilisation.

Limitations

- The single-group pretest–posttest design lacks a control or comparison group, so the observed reduction in depression scores cannot be fully separated from regression to the mean, natural symptom remission over time, or concurrent factors unrelated to the intervention. A controlled or randomised design is recommended for future work to strengthen causal inference.
- The intervention protocol's exact duration, session count, and facilitator qualifications are not fully detailed in this report; future dissemination of this work should specify these parameters to support reproducibility.
- The researcher-developed checklists used to assess risk factors and psycho-spiritual service availability, while reviewed for content validity, have not been independently validated or subjected to formal reliability testing beyond the pilot study; future work should establish their psychometric properties more rigorously.
- The sample was drawn from one denominational conference within one geopolitical region, which may limit generalisability to other faith traditions, denominations, or regions.
- Self-report measures are subject to social-desirability and recall bias.

Implications for Practice

- Faith communities can establish structured psycho-spiritual support programmes for women during pregnancy and the postpartum period.
- Pastoral counselling should be complemented by appropriate screening and referral pathways for women with significant depressive symptoms.
- Women's fellowships and support groups can strengthen social support, reduce isolation, and promote healthy coping.
- Church-based maternal mental health programmes should address practical stressors, childcare pressures, financial strain, and marital difficulties, alongside spiritual needs.
- Collaboration between faith leaders and qualified mental-health and healthcare professionals can strengthen the safety and effectiveness of integrated care.

Conclusion

Postpartum depression is a significant concern among women of the FCT Baptist Conference. Financial pressure, childcare stress, marital challenges, and inadequate social support were identified as important associated factors. Psycho-spiritual services were significantly related to lower depressive symptoms, while the psycho-spiritual therapy intervention was associated with a statistically significant reduction in postpartum depression scores. The findings support a holistic approach in which spiritual resources are integrated with psychosocial support and appropriate professional care.

Recommendations

- Baptist churches within the FCT should establish structured psycho-spiritual support programmes for postpartum women.
- Regular counselling, prayer, fellowship, mentoring, and scriptural encouragement should be incorporated into these programmes.
- Awareness seminars should be organised to improve recognition of postpartum depression and reduce stigma around seeking help.
- Church leaders should develop clear referral and collaboration pathways with qualified healthcare and mental-health professionals.
- Further research should examine the effectiveness of psycho-spiritual therapy using stronger experimental or controlled designs and larger, more diverse samples.

Contribution to Knowledge

This study contributes evidence from a Nigerian faith-based context on the potential value of psycho-spiritual approaches to postpartum mental wellbeing. It highlights the role of spirituality, faith-based support, social connection, hope, and emotional encouragement in promoting resilience, and suggests that these resources can be incorporated into broader maternal mental-health interventions.

Conflict of Interest

The author declares no conflict of interest.

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Data Availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

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