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# Postpartum depression: perception, management, and help-seeking barriers in a Palestinian context: a qualitative study

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## Abstract

**Background** Postpartum depression (PPD) is a global concern that adversely affects the well-being of mothers, their children, and their families. It is particularly prevalent in low- and middle-income countries, where limited research has been conducted. This study aimed to examine the perspectives of mothers regarding PPD and identify their health-seeking behaviors and barriers in a Palestinian context.

**Methods** This study utilized a qualitative approach involving three focus group discussions (FGDs), with a total of 17 mothers in three different regions of the Bethlehem governorate, Palestine. A phenomenological orientation was used to explore the participants' experiences.

**Results** Regarding mothers' perceptions of PPD, not all mothers perceived PPD as a mental disorder; some considered it a result of envy. Risk factors for PPD include a lack of practical and emotional support from the extended family and husband, an unpleasant childbirth experience, or a lack of preparation for motherhood. Seeking help from family members was the first option for all participants; sometimes, it was the only method they considered. The extended family may have control over the decision-making process for help-seeking behavior. Mothers may not seek professional help to avoid acknowledgment of their condition or due to shyness, fear of negative reactions from others, lack of personal free time, family misperceptions of PPD, and the underestimation of psychological therapy. However, when mothers seek help, they prefer venting sessions that include receiving advice, and they refuse to take psychotropic medication.

**Conclusion** In Palestine, PPD is often misunderstood and poses a significant barrier to seeking professional treatment. Addressing this challenge demands a holistic approach extending beyond mere medical interventions, given the complex social and cultural circumstances confronting Palestinian mothers. Vital steps include implementing regular PPD screenings, establishing a culturally suitable referral system, and actively combating the societal stigma surrounding mental health disorders.

**Keywords** Postpartum depression, Risk factors, Mothers' perception, Help-seeking behaviors, Barriers, Cultural context, Stigma

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## Introduction

Postpartum depression (PPD) is a global health issue, affecting about 11.9% of mothers worldwide [1]. Its prevalence was high, around 19%, in low- and middle-income countries [2]. For example, in the Arab region, PPD prevalence was 12.6% in Palestine [3] and 12.8%, 25%, and

28% in Lebanon, Jordan, and Syria, respectively [4–6]. PPD serves as an umbrella encompassing many mood disorders that occur post-childbirth. It includes a wide range of symptoms: eating and sleep disturbances, irritability, fatigue, guilt, feelings of worthlessness, sadness, concentration difficulties, impaired daily functioning, and loss of interest [7]. If PPD is left undiagnosed and untreated, it can lead to devastating consequences, such as infanticide and suicide [8, 9], with maternal suicide recognized as a cause of maternal mortality in the UK [9].

PPD not only affects mothers but has lasting impacts on families, especially on the growing child [10]; who rely heavily on maternal interaction during this critical developmental stage. Children of depressed mothers exhibit long-term adverse developmental outcomes, lower self-esteem, diminished academic performance, and delayed motor development compared to non-depressed mothers [9].

Although PPD is a prevalent and significant public concern [10], many mothers worldwide tend not to disclose their suffering. They may hesitate to seek professional help for PPD due to various reasons. These reasons include a lack of knowledge about PPD, myths surrounding it [11], the stigma associated with mental health struggle [12, 13], mothers' perception of PPD as a sign of maternal failure, or the fear of being labeled as inadequate mothers [12, 13]. In addition, many mothers lack a trusted support network [12], or prioritize their caregiving responsibilities over addressing their mental health needs [12, 13].

Cultural and contextual factors also play a critical role in help-seeking behaviors. For instance, in the Arab region, some mothers turn to traditional practices, such as seeking guidance from religious figures, reading the holy Quran, consuming specific herbal foods, or using special bathing materials to manage PPD [14].

The social and belief specificities of each culture affect mental disease, mental disease expression differs between Western and Eastern nations [15]. The majority of studies about PPD worldwide were accomplished based on Western diagnostic and standards methodology and by negligence to specificities in the non-Western nations [16]. A systematic review of PPD across different cultures revealed that culture significantly influences its prevalence and help-seeking behaviors. Non-western culture has less tendency for help-seeking behaviors and has specific postpartum practices that are most likely ineffective [16].

Studies on PPD in the arab world revealed unique beliefs [14, 17], such as the perception in the Arabian Gulf that mothers are vulnerable to supernatural forces, such as jinn, due to puerperal discharge (bleeding) [14]. Consequently, many people attribute PPD to these forces rather than recognize it as a mental disorder [14]. Additionally, there is a cultural practice observed in Arab communities where mothers are advised to rest for 40 days after childbirth and rely on the assistance of family members -especially their mothers, mothers-in-law, sisters, and sisters-in-law- during this recovery period [17], Some mothers in Arabic regions, such as Egypt, may experience negative criticism from those around them for giving birth to a girl, which can even lead to divorce [16]. In Jordan, giving birth to a boy enhances a mother's social reputation [18].

Understanding PPD in light of these traditional practices is vital for better context-specific knowledge; It is important to acknowledge that understanding cultural norms, local beliefs, and people's perceptions of PPD in a specific context plays a significant role in shaping effective management and help-seeking behaviors of PPD [14, 17].

Studies on PPD perception have identified additional features of PPD [13, 14], for example, it revealed some behavioral disturbances accompanied by PPD, which could be neglecting the growing baby [14]. It also showed that mothers experiencing PPD often perceived it as a sign of inadequacy, leading to a fear of being labeled as a "bad mother "compared to seemingly well-adjusted mothers. For many, the negative judgment attached to being labeled as a bad mother is more distressing than the label of depression itself [13].

Despite Palestine's high fertility rate, total fertility rate of 3.9 [19] and PPD prevalence of 12.6% [3], research on maternal mental health remains limited. Few studies specifically examined the perception of PPD, help-seeking behaviors, and associated barriers in the Arab region. This study seeks to address this gap; this study aims to explore the perception of PPD from the perspective of Palestinian mothers, identify the perceived risk factors and protective factors for PPD, and identify their help-seeking behaviors in managing PPD and their barriers to accessing help, to articulate a local understanding of PPD tradition and the nature of PPD in the Palestinian context. These findings aim to contribute to a body of knowledge that will inform effective and culturally sensitive strategies for managing and supporting PPD, both locally and across the Arab. Additionally, this research serves as a foundation for more specialized studies in the future, aiming to better understand and address maternal mental health in context-specific ways.

## Methodology

### Study design

This study utilized a qualitative approach and a phenomenology orientation, which is an interpretive qualitative research approach that aims to study individuals' lived

experiences through their own perspectives [20], to explore the perspectives of Palestinian mothers on PPD. Three focus group discussions (FGDs) were conducted, with 17 mothers in total.

## Participants/ sample selection

### *Sampling method and settings*

A purposive convenience sample was used. In terms of settings, two FGDs were conducted in two primary health care clinics, a town clinic and a city clinic at Bethlehem governorate, while the third was conducted in a community foundation in a camp within Bethlehem governorate.

### *Recruiting the participants*

FGD participants were recruited at the time of the Bacille Calmette-Guerin (BCG) vaccine for their babies, for infants aged 2 weeks to 1-month-old, because primary healthcare clinics offer the vaccine on a specific day each week, resulting in a high attendance of recent postpartum mothers. Besides, this time was deemed suitable for screening for PPD. Women who attended the clinic for their babies' vaccinations were invited to participate in the FGD. The FGD took place in a private room in the clinic between 9–10 am. This was the time when women registered and waited to vaccinate their babies. The participants of the third FGD were invited by the community foundation employees in the camp utilizing the snowballing approach to identify women who gave birth during the last 6 months."

### *Inclusion criteria*

Women who gave birth within the last six months, regardless of the number of previous births, and mothers aged 18 or older were eligible to participate in the study.

### *Exclusion criteria*

Mothers under the age of 18, mothers who required the presence of relatives to participate in FGDs, and those who gave birth more than six months ago were not eligible.

The eligibility criteria were established to ensure that participating women could freely reflect on their perceptions of PPD and to avoid recall bias.

## Data collection

The FGDs occurred in different locations within Bethlehem governorate, including a camp, a city, and a town. Data were collected during FGDs via audio recording and note-taking. No FGD was repeated. More information about them is shown in Table 1.

**Table 1** Properties of the FGDS

| Group | 1 | 2 | 3 |
|---|---|---|---|
| Location | **Camp** | **City** | **Town** |
| Duration of FGD | 60 min | 50 min | 45 min |
| Date of FGD | 19-Jan-23 | 23-Jan-23 | 30-Jan-23 |
| Number of participants | 4 | 8 | 5 |

### *Duration of data collection*

All FGDs were conducted in January 2023. Each FGD lasted approximately 50 min.

### *The research team and reflexivity*

FGDs were conducted by a female researcher, the corresponding author of this article; the interviewer is also one of three researchers who conducted the data analysis. The interviewer has a master's degree in Community and Public Health and has received training through university courses, which provided her with sufficient background to conduct qualitative research. The interviewer works as a nurse at another facility. A non-participant, also a nurse, was present with the researcher during the FGDs to facilitate the process and to take notes.

### *Relationship with participants*

No prior relationship was established between the researchers and participants before the study. The study goals were only explained to participants before the interview.

### *FGDs guide*

FGDs were conducted with probes about (1) Palestinian mothers' thoughts about PPD and its symptoms, (2) possible PPD risk factors and protective factors from Palestinian mothers' point of view, (3) when, how, and where to seek assistance, (4) Possible barriers for help-seeking behaviors (Annex A). A small questionnaire about the mother's demographic and obstetric information was used (mother's age, residential area, level of education, employment status, parity, and date of last childbirth) Annex B.

## Data analysis

The FGDs data were analyzed based on the thematic analysis described by Braun and Clarke [21], which includes the researcher familiarizing with FGDs data, creating initial codes and themes, reviewing others' themes, defining the final theme, and writing up the manuscript [21]. Three researchers independently participated in the data analysis. Data was analyzed manually; no software was used to manage the data. Field notes were taken into consideration during data analysis. All results obtained from three FGDs were

analyzed. Data saturation was detected post the final FGD, the third one, when the data became repetitive and did not add unique insights. The transcripts were not returned to participants for comments or correction. Analysis steps are as follows:

> The first step: the researcher's thoughts and field notes were written immediately after each FGD, and then the researcher prepared and organized the raw data by manually transcribing the FGDs.
> The second step: the three researchers read all the data and developed ideas and impressions from participants' sayings independently. Further notes are written.
> The third step: The researchers agreed and wrote a list of dimensions, which mainly seem like sub-research questions. Each of these dimensions includes many themes, sub-themes, and codes. The themes and sub-themes were derived entirely from the data. These themes were identified through careful data collection and analysis.
> The fourth step: the phrases were colored based on their related topic, and the related phrases were set together in a table that includes 4 columns (phrase, codes, sub-theme, and theme).
> The fifth step: the coding process, takes place by finding the most descriptive words for each highlighted phrase in the adjusted columns; this step is done by the three researchers independently, then, the researchers categorize codes into sub-themes and then related sub-themes grouped into themes cooperatively.
> In the sixth step, all three researchers rearranged codes and sub-themes in this step, and the results were written up. Note that there is no significant disagreement among the three analysts.

#### Ethical considerations

The ethical approval was obtained from the research ethics committee at the Institute of Community and Public Health/Birzeit University. Also, approval for implementing the study was obtained from the Palestinian Ministry of Health and the clinics involved. Written informed consent was obtained from participating mothers after the researcher explained the objectives of the FGD to them. The researcher informed mothers that participation is voluntary and they can withdraw anytime. All FGDs were tape-recorded after obtaining consent from all participants. Notes were also taken by data collectors manually.

#### Techniques to Enhance Study trustworthiness and rigor

The researcher ensured the trustworthiness of this study through multiple criteria.

1. Credibility was established in several ways. A conceptual framework was developed and continuously used throughout the research process. Themes were supported with direct quotes, data saturation was ensured, which was observed when themes began to repeat, no additional themes emerged, and the research questions were sufficiently answered. To enhance the credibility of data collection and analysis, the prolonged engagement was ensured through the person conducting and participating in data analysis of FGDs was from the same area as the participants and had a background in their culture and norms, facilitating the collection of contextually relevant responses. additionally, field notes were taken and documented in detail immediately after each FGD to ensure accurate and useful data for analysis.
2. Dependability was maintained by providing sufficient details about the study process, allowing for potential replication.
3. Confirmability was achieved by minimizing researcher bias in presenting results. This was achieved through investigator triangulation, where multiple researchers were involved in data analysis. In this study, three researchers conducted the analysis, and an independent reviewer performed a peer review of methods, themes, results, and interpretations; as this study was a part of a master's thesis and was examined by academic reviewers. Other potential biases were documented in the reflexivity section.
4. Transferability was addressed by describing the context of the speakers in detail.

To further increase rigor and trustworthiness, the sample from Bethlehem Governorate was purposively selected to include participant mothers from diverse backgrounds, including those from camps, villages, and cities. However, a sample including only one governorate in Palestine, it is considered a convenience sample. This limitation is acknowledged in the study, clarifying that the study results are not generalizable.

Ethical considerations were carefully addressed in the study design, ensuring no prior relationship between the researcher and FGD participants. During focus group discussions (FGDs), trust was built with participants; researchers emphasized the confidentiality of collected information. Participants were informed that voice recordings would be deleted immediately after

transcription. Additionally, women were advised to speak without mentioning names or attributing statements to specific individuals.

## Results

In this study, we conducted three focus group discussions (FGDs) with a total of 17 participants to explore postpartum depression (PPD) perception and help-seeking behavior characteristics in a Palestinian context.

### General characteristics of the study participants

As shown in Table 2, the ages of the participants ranged from 20 to 41 years old. Out of the 17 participants in the study, 5 live in camps, 7 live in towns or neighboring villages, and 5 live in cities. Only one mother was employed. They all gave birth during the last 6 months, and their parity ranged from one to seven children. Six out of 17 participants ever suffered PPD as reported by them, while only three out of 17 mothers were ever screened for PPD before. It is important to note that during these FGDs, the mothers discussed their psychological experiences during their current and previous births.

The analysis of the FGDs revealed several key themes that provide a comprehensive understanding of PPD in the Palestinian context from the mothers' points of view, as seen in Table 3. The themes identified are related to PPD mothers' perception, screening and identification of PPD, its protective factors and risk factors, its management, and help-seeking barriers. These themes are discussed in detail below, with illustrative quotes from the participants to support the findings.

**Table 2** Focus group discussions (FGDs) participants' general characteristics

| Characteristics ($n=17$) | # |
|---|---|
| 1st FGD (city) | 8 |
| 2nd FGD (town) | 5 |
| 3rd FGD (camp) | 4 |
| Area of living | |
| City | 5 |
| Village/town | 7 |
| Camp | 5 |
| Range of age (years) | 20–41 |
| Last Birth | 3 days- 6 months |
| Range of parity | 1-7 children |
| Level of education | |
| Secondary school (Tawjihi) | 8 |
| Bachelor degree | 9 |
| Employment status | |
| Employed | 1 |
| Unemployed | 16 |
| Self-Reporting previous PPD | |
| Yes | 6 |
| No | 11 |
| Ever Screened for PPD | |
| Yes | 3 |
| No | 14 |

### Postpartum depression perception in the Palestinian context

Mothers' perceptions and their families and the community's perceptions were identified as the main themes related to PPD perception in the Palestinian context that would have a misperception and a wrong belief.

1. Mothers' perception

1.1 From FGDs, it was found that all participant mothers had heard about PPD before, and some mothers had a good perception and understanding of it.They emphasized that evil spirits do not cause PPD.

*"I know it's a mental illness, and we never suspected it to be magic." A mother- from a camp.*

However, during the FGDs, it was revealed that some mothers were aware of the time of onset of PPD, which could occur antenatally.

*"Mothers are more sensitive in the pregnancy and post-childbirth periods, so, she is at higher risk to develop depression in these periods." Many participant mothers -from camps, cities, and villages.*

1.2Meanwhile, a few women became aware of PPD only after they were affected by it.

*"When I was depressed, I was suffering, but I didn't know that this was depression." Two participant mothers, one from a camp and another from a village.*

1.3The misperception of PPD was identified. A participant mother defined it as a marital problem.

*"Depression is a marital problem that increases after childbirth because the husband can't bear it". A participant mother- from a camp.*

**Table 3** FGDs themes and sub-themes

| Dimensions | Major theme | Sub-theme | Codes |
|---|---|---|---|
| PPD Perception | Mothers' perception | Good understanding of PPD | Mental illness post chilbirth |
| | | Misunderstanding of PPD | Marital conflict |
| | | Delayed undersanding of PPD | Knowning about PPD post being affected |
| | Mothers' families and their community's perception | misperception | Supernatural forces: magic of separating couples or envy |
| | | | Pre-marriage illness |
| | | | Ignorance of each mother's experience |
| | | Stigmatization | React negatively toward depressed mother: labeling\ avoiding interaction with her |
| Screening and identification of PPD | Insufficient screening process | Insufficientof PPD screening test | PPD Diagnosis by chance |
| | | Mispractice during PPD screening | No privacy nor credibility |
| PPD Protective factors | The Extended family support | Peer supports | Mother of mother support, sisters support |
| | | Emotional support | Insurance, motivation |
| | | Practical support | Housechores, childcare, prevention of complications, free time for mother |
| | | Informational support | Guiding the mother, giving advice |
| | Baby and mother-related factors | Physical | Ability to breastfeed her child |
| | | Spiritual | Being a believer mother and feeling close to God |
| | | Adjusting to the new baby's | The mother internalization of the baby's needs through passing of the first three months; better sleeping, eating, emotional expression |
| Risk factors | Unsupported extended family | Missing emotional support | A lonely mother, No venting, negative comments about the mother or her baby |
| | | Missing practical support | No help in household chores, child rearing, nor cooking |
| | | Extended family control over decision-making | Extended family members control over the decision of breastfeeding and help-seeking- behaviors |
| | | Visitors engaging in unwanted behaviors | kissing the newborn, visiting at inappropriate times, or staying for extended hours |
| | husband negative reaction to baby sex mismatch | Marital problems | Threatening to marry another woman |
| | Baby and mother-related factors | Unpleasant childbirth experience | Pain, preterm baby, baby admission to ICU, grumpy child |
| | | Unexpected life changes | Lack of preparation for motherhood and childrearing |
| PPD management | Mode of management | Preffered Venting session | Crying, talk comfortably with others including mothers, husband, sisters, and professionals |
| | | Seeking professional help | online professional session |
| | | traditional therapy | Religious person (Al-Shiekh) |
| | | Spiritual therapy | Reading the Holy Quran by mothers themselves, prayer, supplication |
| | | Psychotic medication stigma | Refusal of pharmacological therapy |
| | Characteristics of PPD management | Delayed professional help | High threshold help-seeking behaviors |
| | | | Reluctance in seeking specialized help |
| | | The high Impact of Professional Interventions on maternal mental health | Talking with a qualified psychologist may help depressed mother greatly |
| | Help-seeking barriers | Mother related barrier | The avoidance of PPD acknowledging |

**Table 3** (continued)

| Dimensions | Major theme | Sub-theme | Codes |
|---|---|---|---|
| | | | Negative attitude toward mental disorders:Shyness, personal weakness, taboo subject |
| | | | Mother's fear of other negative reactions toward them |
| | | | No free time for mother to pursue therapeutic session |
| | | | low expectations of the professionals help |
| | | Family and community-related barriers | Misperceiving or underestimating the mother's psychological suffering or psychological therapy |
| | | | Extended family control over decision-making regarding help-seeking behavior |
| | | Health professionals and health settings barriers | no clear channel of care |
| | | | Unpleasant previous experience |

2. Mothers' families and the community's perception

2.1 Study results indicated that mothers' families and their communities have misperceptions about PPD.

2.1.1 Participant mothers reported that their families and communities may misperceive PPD as a result of supernatural forces, such as a magic of separating couples or envy.

*"When I was depressed postpartum, my family and my family-in-law thought that magic of separating couples was done to me". A mother who had been confirmed diagnosed with PPD as reported by her.*

*"People say about a depressed mother who I know that she is envied or bewitched." Three participant mothers, each from different residential areas: camp, town, and city*

2.1.2 Some families justified PPD as a pre-existing illness in women that occurs before marriage and is unrelated to pregnancy or childbirth.

*"My in-laws do not know what postpartum depression is and nor that every mother is at risk of experiencing what happens to me. They talked about me and that I was mentally ill before marriage". A mother who had been confirmed diagnosed with PPD as reported by her- from a camp.*

2.1.3 Mother's family may ignore the uniqueness of each mother's childbirth experience.

*"'People around me said, "Why are you complaining? All women give birth; it's not just you,'" said a participant mother from a camp.*

2.2Women explained that their communities tend to stigmatize depressed mothers, through labeling these mothers as unsound and mad persons.

*" If you tell someone that you are depressed and want to receive treatment for depression, they will treat you like mad, and they will be afraid of you, and they will start to talk that you are bewitched, they will isolate you and not come to you." A participant mother – from a village.*

A participant's mother from a city labeled her depressed cousin as "mad," saying, "When my cousin is depressed postnatally, she becomes so mad that she wants to harm her baby."

Or through reacting negatively toward depressed mothers, like avoiding interaction with them.

*"We are a community that labeled depressed ones as crazy, and they used to say "Don't go to her" participant mothers– from a village and a city*

**Screening and identification of PPD**

1. Based on the results of the FGDs, we identified a lack of sufficient diagnosis of PPD among Palestinian mothers, which may be attributed to the insufficient screening process.

    1.1 Only 3 out of 17 mothers were offered and filled out the PPD screening (EPDS); we recognized that the diagnosis of PPD among two depressed participants was due to chance in light of a lack of recognition among the mother and her surroundings regarding the presence of PPD.

*"The nurses in the clinic knew about my illness when my mother took my son, age one year and a half, to vaccinate him in the clinic, and on the next day my mother-in-law took my other son ages 1 month to vaccinate him, at this point, the nurses got curious and ask my mother-in-law about me, then my mother-in-law told the nurse that I am suffering at home and couldn't take care of my children, at that time, the nurse recognized that I may have depression so they give me an urgent referral to the psychiatrist". A participant who had a confirmed diagnosis of PPD as reported by her.*

*"When I was depressed, I didn't love my daughter, nor care for her, I didn't know that I had depression, but my mother's friend, when she saw me by chance, told my mother that I have postpartum depression, and I didn't know that I was going through this depression" Another participant mother—from a camp.*

1.2Additionally, Mispractice during PPD screening was reported, a mother who did fill out the screening reported that it invaded her privacy and undermined her credibility. This is because the questionnaire was filled out orally in the presence of other mothers in the same clinic, causing her to lose credibility in her responses and compromising her privacy.

*"The nurse used to have us fill out the questionnaire orally and loudly, within earshot of other mothers in the same clinic. The nurse's inappropriate behavior could impact the mother's credibility in her responses and potentially expose her if she is experiencing depression. I would prefer if the questionnaire could be filled out privately, just between me and the nurse, without the presence of other mothers." A participant mother – from a city.*

**Protective factors against PPD from the perspective of Palestinian mothers**

1 The Extended family support was reported as a protective factor against PPD, As we found from FGDs, many mothers emphasized the importance of the **emotional, practical, and informational support** received from their family members, including their husbands, mothers, sisters, mother–in–law, and sisters-in-law.

    1.1 especially support provided by the mother of women, which was considered as peer support, because her mother underwent the same experience, childbirth. So, most FGD participants consider their mothers the most supportive family members because the mothers of women can help women psychologically and understand their feelings.

*"I feel that I want someone who I can talk to and who can contain and understand me, my mother is the right person for this issue because my mother feels like me and she was going through the same experience that I went through. My husband does not understand me, even the pain he cannot feel it." A participant's mother – from a village.*

    1.2 The emotional support received from their family member can be through giving her insurance. *"When my mother, mother-in-law, or husband is present beside me at home, I feel safe." Three Participant mothers, each from a different residential areas.*

    1.3 And informational support received from their family member, through inspiring and motivating her for a better future.

*"When the baby was young, his sleep was difficult and needed frequent care and changing diapers, my family members used to tell me that this is a period that will pass away, tomorrow (refer to future) the baby's sleeping hours will be programmed, and the baby will be better, so I programmed myself with their words, and they helped me to understand my baby better". A participant mother – from a camp.*

    1.4 While practical support can be through helping the mother in her duties of caring for her children and household chores,

*"When people around me helped me with the household chores and cared for my girl, I felt a sense of relief and burden lifted off me." A participant mother – from a city.*

*Besides, the presence of family members around the mother can prevent PPD complications. "My mother used to stay with me all the time, for fear that I would harm my girl or myself." A participant who had a confirmed diagnosis of PPD as reported by her.*

*Additionally, having dedicated time and space for the mother to pursue her own interests and desires contributes to her well-being.*

*"Things that protect the mother from depression are that she does what she loves and makes time for herself". A participant mother – from a city.*

2 Baby and mother-related factors
As reported by mothers in the FGDs, certain factors related to the mother and her baby have a positive impact on her mental well-being after childbirth.

*2.1 These factors can be physical, such as her ability to breastfeed her child "The ability to breastfeed naturally enables the mother to interact better with her child, breastfeeding strengthens the bond between the mother and child and alleviates feelings of inadequacy or guilt, as well as the mother doesn't need to make any extra effort to prepare milk." A participant mother – from a village.*
*2.2 Spiritual factors, such as being a believer and feeling close to God, may help the mother feel better "It is normal for a mother to feel good feelings postchildbirth, and if she is close to our God, God gives her support". A participant mother – from a village.*
*2.3 Another protective factor against PPD, as reported by participant mothers, is the mother's adjustment to the baby's needs, which occurs after the age of three months. After the first three months, the child starts to sleep and interact better, allowing the mother to develop a deeper understanding of her growing child. "In the first three months, there was little interaction with the child, and it felt like they were just a passive presence. But after three months, you begin to establish a bond, understand the baby's needs. You become accustomed to their sleep patterns, diaper changes, and feeding cues. As time passes and the initial three months are behind you, everything falls into place more smoothly." A participant mother – from a city.*

**Factors that worsen mother's mental status post-childbirth, from the perspective of Palestinian mothers**

1. Extended family-related factors. A lack of support from both the mother's side and the in-laws can significantly influence a mother's experience of PPD. This includes:

1.1 A lack of practical support, such as the loss of assistance with household chores and childcare.

*"When you give birth, you can't do your house chores or care for your child in the same time. Seeing the house untidy and not clean makes me feel depressed. I feel better when my family helps with the house chores and childrearing," said a mother from a village.*

1.2 A lack of emotional support from the extended family, the loss of outlets for expressing emotions, and being alone at home.

*"Unable to vent makes you depressed." Many participant mothers were from different residential areas: camps, towns, and cities.*

1.3 Extended family control over decision-making. The extended family control over decision-making against the mother's will and depriving the mother of her autonomy in her affairs and those of her children hurt the mother's mental well-being. For example, a husband's family controlled the decision of giving the child breastfeeding from someone other than its mother against its mother's will. However, other forms of their control over decision-making will be seen in the help-seeking section.

*"Once, I was trying to breastfeed my two-day-old son, but no milk came out. My husband's family took the baby from me and gave it to my sister-in-law to breastfeed him, and she did; I felt suffocated. They didn't ask for my permission, and I would disagree that my sister-in-law breastfed my son." A participant mother – from a camp.*

1.4 Extended family negative talk about the mother or her child may make the mother feel incompetent and guilty

*"A word from those around us can make us upset; for example, someone comes and says "Why do you feed your baby artificial formula, thus his immunity will be low; this milk is what makes him sick" I try not to think about these negative talks, then someone else comes and says the same thing Instead of motivating me, they make me feel guilty and go backward." A participant mother – from a village.*

1.5 visitors engaging in unwanted behaviors, such as kissing the newborn, visiting at inappropriate

times, or staying for extended hours. These factors were mentioned as burdens on the mother's physical and mental well-being.

*"When I returned from the hospital, my in-laws came and stayed in my room all day. I was in pain, felt drowsy, and needed to rest, which made me feel worse," a participant from a camp.*

*"The visitor used to kiss the neonate, and I don't like this behavior; my child had low immunity." Two participant mothers- from a camp and a town.*

2. Husband's negative reaction to the baby sex mismatch

A husband's negative reaction to the baby's sex mismatch, leading to marital problems and threats of marrying another woman, negatively impacts his wife's mental well-being.

*"When we know the sex of the baby, many problems with my husband start, it's really suffering..... My mother-in-law told me he wanted to get married to have boys". A mother of 6 girls who had confirmed diagnosis with PPD.*

3. Baby and mother-related factors

Women reported several factors related to the baby and the mother that might worsen their mental status, including:

3.1 The childbirth experience, including pain associated with childbirth, having a preterm baby, and baby admission to intensive care units (ICU) worsens the mother's mental status.

*"I was depressed, maybe because I was in pain, I gave birth via cesarean section and had painful stitches. Nevertheless, although I am in pain, I used to go to the hospital because the baby was admitted to ICU" A mother of a preterm baby.*

Postnatally, another risk factor for PPD is a grumpy child.

*"When I see my baby sleeping and relaxed, I feel happy and relaxed, but when he starts crying and I don't know what to do, I start crying." Many participant mothers were from different residential areas: camps, villages, and cities.*

3.2 Lack of preparation for motherhood and childrearing was another important factor mentioned by the mothers; post-childbirth, the mother sees themselves in front of new roles and responsibilities toward their growing children.

*"Facing a huge and unexpected responsibility post-childbirth and no one prepared you for this responsibility makes the mother feel depressed, especially for us in Palestine. No one comes to tell you that there is a course on how to become a new mother, a course on modern childrearing, or how to deal with a child." A participant mother – from a camp.*

## PPD Management

1. Mode of management

During the FGDs, participants revealed that their preferred help-seeking behaviors varied, including venting their feelings and seeking advice or consultation, while some mothers refused pharmacological treatment. However, other PPD management options available in Palestine could involve seeking help from charlatans or religious figures or engaging in spiritual rituals.

1.1 Venting sessions

crying or speaking comfortably and frankly with others.

*"Nothing can relieve my unpleasant feeling and comfort me except crying" a participant mother – from a camp.*
*"I feel that I need someone to talk with, and complain to him, someone who can understand me, give me support" many mothers in FGDs.*

1.2 Seeking professional help

Based on the findings from the FGDs, some mothers believed that the specialized person could guide them on the right pathway to overcome their unpleasant feelings.

*1.2.1 However, some mothers prefer seeking specialized help through online psychological support sessions.*

*"I wanted a specialized person to guide me on the right path, comfort me, and tell me what is right. So, I tried to seek help from a specialist on social media who provides sessions. I was sure that the specialist would assist me in overcoming my unpleasant feelings." A mother who had felt depressed before.*

*Mothers prefer this mode of help-seeking behavior to avoid spatial presence in such clinics. "Seeking guidance and support for postpartum depression online enabled you to ensure that no one would witness you going to a psychological clinic" A mother – from a camp.*

*1.2.2 Based on FGDs, among those who report accepting professional help, they preferred seeking help from a psychologist or social worker to seeking help from a psychiatrist.*

*"The social worker improves the mother's sense of psychological expression, they talk to each other like this, and the term of a social worker is kinder than a doctor, and the image of the mother is better if she go to a social worker." A mother – from a village.*

1.3Seeking help from traditional therapy (charlatans and religious persons (AlShiekh))

FGDs showed that seeking help for PPD through traditional therapy, like charlatans and religious persons, is found in the Palestinian context. A mother reported a significant deterioration in her mental status by seeking help with this method, and it was obstructing and delaying the correct treatment and management to take place.

*"My family and my family-in-law thought that magic of separating couples was done to me, so they took me to the Sheikh (religious person) against my will, going to the Sheikh was one of the most important obstacles in my treatment, as I took a long time in treatment with the Sheikh without any benefits, as he used to read the holy Qur'an to me; it was a terrible period, as I did not bear these rituals of treatment" A participant who had a confirmed diagnosis with PPD as reported by her.*

As the previous quotes showed, the extended family also has control over the decision-making of help-seeking behaviors.

1.4Refusal of Pharmacological treatment

The mothers could talk thoroughly about their negative feelings, discomfort, and suffering, but they didn't prefer to take psychiatric medications.

*"The right treatment for postpartum depression wasn't through psychiatric medication, but through being heard, unfortunately, no one heard me, but they described a psychiatric medication to me" A participant who had a confirmed diagnosis of PPD as reported by her.*

Women may not acknowledge the positive effects of psychiatric medication despite its well-established benefits for maternal mental health. For example, a participant mother in the FGDs with a confirmed diagnosis of PPD reported that when she stopped taking her psychiatric medication, her unpleasant depression symptoms returned. However, the same mother also emphasized elsewhere that the medication had no effect.

1.5Spiritual rituals

Mothers may tend to relieve their mental discomfort by reading the Holy Quran by themselves, prayer, and supplication especially if mothers believe that their mental suffering is a result of envy.

*"A depressed mother may say, what I faced may be due to envy, so the mother will read the holy Qur'an, pray, and invoke God to relieve her suffering". A mother – from a city.*

2. Characteristics of PPD management

2.1 As FGDs showed, help-seeking behaviors could be delayed; a high threshold characterized it. Women expressed that neither they nor their surroundings were aware that they were experiencing PPD and abnormal behavior that needed treatment. They resumed help-seeking behaviors when the daily living of the entire family was impaired as a result of the mother's PPD or when the mother started to hurt her children or herself.

*"People surrounding me recognized I was not okay when I became completely helpless; I couldn't take care of my house or my children, I was restless," A participant who had a confirmed diagnosis of PPD as reported by her, from a village.*

*"Around me, felt something was wrong when I tried to harm my children and myself" Another participant who had a confirmed diagnosis of PPD, as reported by her, from a camp*

In addition, mothers did not intend to seek help in case of mild to moderate daily life impairment, for example, two participant mothers emphasized that they have severe sadness, helplessness, and the inability to complete the house tasks, but they were patient and did not think about asking for help yet.

*"I am very sad and helpless, always I feel lost, don't know what to do, and sometimes I cannot take care of the house and the baby together. I need practical help, but I never thought of asking for psychological help". A participant mother – from a village.*

*2.2 Professional help for PPD is characterized by a high impact; Based on a participant's experience and as reported by her, a single professional and appropriate intervention can significantly impact a mother's mental well-being. "I benefited a lot when a psychologist came to the hospital and talked to us while I was staying there with my baby who was admitted to the neonatal ICU. After only one session, my psychological condition improved a lot, and I am currently excellent." A mother who had felt depressed before.*

2.3 All participants unanimously agreed that the first line of seeking help is their family members, especially from mothers and their husbands.

*"The first choice of help is my husband, then my mother, if their support isn't enough, I will ask for help privately by going to a private psychiatrist" A participant mother – from a city.*

*"I will not seek help for postpartum depression from outside my family, because the problem will grow" many participant mothers*

## 3. Barriers to professional help-seeking behaviors

Barriers that impede mothers from seeking needed help for their PPD symptoms can be classified into three subthemes as follows; maternal barriers, family and community barriers, and health professionals' barriers.

*3.1 Maternal barriers, including:*

*3.1.1 The avoidance of PPD acknowledgment impeded mothers from seeking the necessary help they needed; seeking professional help would require them to acknowledge the existence of PPD, which some mothers believe that PPD may accompany them throughout life if they choose to acknowledge it.*

*"If you seek help from your family, you can stay on the right path, and things are easier. However, if you decide to go to a doctor, it may indicate that this mental distress will stay with you for the rest of your life." A participant mother – from a village.*

*3.1.2 Mothers' negative attitude toward mental disorders, based on FGDs results, a mother felt shy about PPD.*

*"Shyness can prevent a mother from seeking treatment, I will not ask for help because I may feel strange." A mother – from a village*

And other mothers looked at PPD as a **taboo subject** that prohibits people from uttering it to others. All these negative attitudes toward PPD prohibit mothers from seeking needed professional help.

*"I am mentally tired, and this is the first time I talk about it in front of someone, I used to not talk about it in front of others, I used to talk about it only between myself and myself." A mother – from a camp.*

*3.1.3 Mother's fear of other negative reactions toward them if they seek professional help is considered an obstacle to seeking professional help*

*"If I got depressed postnatally, I would not ask for help. Because our problem is with people's view of us, and we are a small community, we know each other and talk to each other, we think a lot about people's view of us." A mother – from a city.*

*3.1.4 Many FGDs participants reported that they did not have free personal time to meet their needs; they used to take care of their children. "I was so busy with my baby; it never occurred to me to ask for help". Two participant mothers from a village and a camp.*

*3.1.5 Mothers had low expectations of professional help.*

*"People and a doctor advised me to visit a counselor unit in our primary health centers during this post-childbirth, but I didn't go. I told the doctor that I didn't want to see the counselor. All my mental suffering due to the sex of the baby, what could she do to help me with this matter?" A mother – from a camp.*

*3.2 Family and Community Barriers, including:*

*3.2.1 Misperceiving or underestimating the mother's psychological suffering, as well as the value of psychological therapy, by mothers' families' impaired help-seeking behaviors*

*"I will not go to psychological therapy, even if the health professional offered a private, secret, and confidential session, because people around me will blame me for going to therapy, for example, when I told my mother-in-law I am psychologically tired, she said " No, you are ok, why you are complaining". A mother – from a camp.*

*"My family and my family-in-law thought that the magic of separating couples was done to me, so they took me to the Sheikh against my will" A participant who had a confirmed diagnosis with PPD.*

*3.2.2 As the previous quote shows, family misperceptions, combined with their control over decision-making, are a real barrier to seeking professional help for PPD*

3.3 Health professionals and health settings barriers

Based on the discussion with mothers, mothers stated many barriers to seeking help related to health professionals and health settings, which are as follows:

*3.3.1 Mothers were unaware of any local mental health services to seek help from if they experienced depression.*

*"I did not think to ask for help, from whom do I want to ask for help" many participant mothers.*

*4. Unpleasant past experience, for example, a mother reported that the psychologist blamed her for her depressed feelings.*

*"When I visited the psychologist before, she used to ask questions and talk like any family member, she told me "Why do you feel down, look around, many people are worse than you and their mental health is better, why do you want to work when you still gave birth a while ago, instead of thinking in yourself, think about your son, thank your God that your family is around you instead of being upset" but this is not what I want to hear" A mother – from a camp.*

*"For example, when I went to this specialist, she began to tell me, "Why did you give birth your children followed each other, why did you give birth to this seventh child, why do you give birth after 6 years of childlessness?" I mean, the questions are not good, the specialist increase my depression and make me feel guilty and I am the cause of the problem". another mother – from a camp.*

## Discussion

To the best of our knowledge, this study is the first study in the oPt, and one of the few within the Arab world to offer a comprehensive understanding of mothers' perspectives on postpartum depression (PPD), their help-seeking behaviors, and the obstacles they face. Notably, it actively engaged mothers as key stakeholders, fostering their meaningful participation in the research process, to ensure active mothers' involvement in PPD prevention, diagnosis, and treatment.

This study revealed that not all mothers or their families had a timely and accurate understanding of PPD. Some families attributed PPD to supernatural forces, such as magic or envy, or saw it as a pre-existing illness in women unrelated to pregnancy or childbirth. Stigmatization of depressed mothers was common in this community. Study findings indicated that loneliness, lack of support from husbands and extended family, inability to breastfeed, an unpleasant childbirth experience, or lack of preparation for motherhood could negatively impact a mother's mental well-being postpartum. Conversely, the study highlighted the protective role of support from women's mothers and peers against PPD. However, PPD in this community was characterized by a high recognition threshold. However, help-seeking behaviors are heavily influenced by the perceptions of the mother and the perception of her extended family, who often hold significant control over the decision-making process. For all participants, seeking help from family members was the first and sometimes the only option they considered. Many participants were hesitant to seek professional help due to the stigma surrounding PPD, underestimation of psychological suffering and the effectiveness of therapy, unclear pathways to accessing care, or a lack of personal time for the mothers. The preferred help-seeking behaviors are venting sessions, seeking advice, and online consultations, while a significant number were reluctant to take psychotropic drugs.

### PPD perception

Consistent with existing studies conducted in Western culture, our findings support the notion that the mother's experience with PPD is not only influenced by her understanding of PPD but also by the awareness of her husband and family members [13]. These results highlighted the significance of considering the broader support network surrounding a mother in understanding and addressing PPD. In addition, similar to the findings in the Arabian Gulf region [14], we encountered the presence of strange myths and beliefs related to supernatural forces that impact the well-being of mothers after childbirth. In the Arabian Gulf, there is a myth called "um AlSibyan," meaning the mother of sons, which is believed to influence maternal well-being negatively. This myth aligns with the concept of "The magic of separating couples" found in our study when describing PPD, highlighting the existence of supernatural forces affecting postpartum women [14].

### PPD protective factors from participant mothers' perception

Our findings highlighted the importance of our social support in preventing and treating PPD, aligning with

studies conducted in Western contexts [9, 17]. The type of support Palestinian mothers need to cope with psychological distress and challenges during the postpartum period is similar to those mothers in Western cultures require [10, 12]. This support included practical assistance with child-rearing and household tasks, access to resources, emotional support to foster feelings of love and care, and informational support through guidance and advice [10, 12]. These findings emphasized the importance of providing comprehensive support to mothers in the postpartum period. Furthermore, in both our study and a study conducted in the USA [12], there was a similarity in the preferred person for disclosure among mothers. It was found that mothers in both studies preferred disclosing their feelings to their mothers. This preference stems from the understanding and empathy they receive from someone who has undergone the same experience of motherhood.

#### PPD risk factors from participant mothers' perception

According to a narrative literature review, the causes of PPD are inconsistent [22]; the development of PPD can be explained by biological theory, evolutionary theory, or psychosocial theory [22], while our study focused on assessing PPD among Palestinian mothers from a psychosocial perspective. Building on previous reviews of women with PPD symptoms, it was found that mothers often experienced a sense of loss of identity, loss of work, and confusion in the postpartum period, particularly if they had a strong professional identity before. They referred to this as "struggling with life-related to the self" [23]. This struggle was evident in our study when an employed woman described her presence at home with her child as feeling confined and missing her identity. However, consistent with prior research and supported by our study findings, experiencing loneliness and insufficient social support increased the mother's likelihood of developing PPD [9, 13, 14, 23]. In today's society, many couples miss the traditional support and assistance that their own family and in-laws would have provided because they live independently and away from their extended families. This shift can be attributed to the transition from agricultural to industrial societies [17]. So, we found that mothers living in geographically distant areas from their families [24] and migrant mothers are at a higher risk for PPD [9].

Breastfeeding and PPD have a mutual effect, meaning they impact each other bidirectionally. Depression can affect a mother's ability to pursue her activities of daily living, including nurturing and breastfeeding her child, conversely, the inability to breastfeed can worsen a mother's mental status, contributing to feelings of guilt and causing her to blame herself and feel like a bad mother. This is a common thread between Edhborg's study, Abdollahi's discussion of evolutionary theory, and our research [22, 23].

Regarding the association between baby sex agreement and the risk of PPD, a study conducted in the Emirates, an Arabic region, supports our results by highlighting that the birth of multiple girls without any boys may lead husbands to consider marrying additional women. This circumstance can result in marital conflicts, ultimately contributing to the mother's experience of depression [14]. Therefore, we can infer that the impact of a baby mismatch on the mother could be linked to the husband's awareness and reaction toward this situation.

#### Help-Seeking Behaviors

Addressing help-seeking behaviors and their barriers is crucial to ensure appropriate healthcare services to mothers considering their cultural and social context [13]. Themes relating to help-seeking behaviors in the Palestinian context have standard features with previous literature in Eastern and Western culture, which light the significance of stigma toward PPD [9, 12–14]. Based on studies conducted in Western cultures, the feelings of stigma among mothers towards PPD were often attributed to perceiving it as a sign of maternal failure [13]. Furthermore, our study revealed that the mothers' perspective on the medical model of PPD, particularly regarding refusal of medication use, aligns with mothers' views in the Western culture [13]; This similarity suggests that the cultural perception of PPD and its treatment approaches transcends geographical boundaries and highlights the importance of addressing the stigma surrounding medication as a treatment option. In addition, we observed a similarity between the seeking behavior of Arabic mothers living in Arabian golf and the Palestinian mothers in this study. Both groups tended to primarily seek help from their family members, with a lesser degree of reliance on friends, while they considered seeking professional help a last choice [14].

#### Help-seeking behaviors barriers

The causes behind Palestinian mothers' reluctance to disclose their feelings are the same as in other cultures [13, 23]. These causes include avoidance of PPD acknowledgment, considering it as a personal weakness or a failure to be a good mother [23], fear of being stigmatized or judged, finding it challenging to prioritize their mental health needs, limited awareness of available services, or having low expectations regarding the quality of care provided [13]. Similar to our study, certain conditions must be met for a mother to seek professional help, such as a non-judgmental, safe, and confidential environment

that enables them to enhance their ability to deal with their problems [13].

## Conclusion

In conclusion, our study provided unique insights into the psychological experiences of Palestinian mothers post-childbirth, revealing the underdiagnosis and undertreatment of PPD. This issue stems from inadequate recognition of PPD by both mothers and their families, poor help-seeking behaviors, the stigma associated with PPD, and insufficient screening. This study showed that lack of support and interpersonal struggles have emerged as significant contributing factors to PPD. Furthermore, it was observed that most of the participants overestimated the importance of family support as the sole and most significant factor in treating PPD while the results also indicated that some mothers' families are unaware of PPD, its symptoms, or how to address it effectively. Additionally, various methods of seeking help have been documented, including beneficial and ineffective approaches. Moreover, significant barriers to accessing professional help for PPD have been identified. These findings emphasize the immediate need for improved screening, recognition, and availability of appropriate support and treatment for PPD in Palestinian communities, considering the unique mothers' needs. In conclusion, the prevention and treatment of PPD require a comprehensive approach that goes beyond solely medical interventions, considering the challenging social and cultural circumstances faced by Palestinian mothers. It would be better for future studies to include all Palestinian governorates for improved generalizability and to conduct more focused and comprehensive studies that rely on a stronger, more reliable methodology.

### Study implication

To enhance mothers' mental health post-childbirth, several steps are essential. First, implement routine PPD screening and establish a well-defined referral system to provide confidential, effective, suitable, and high-quality treatments that are context-sensitive and take into account the mothers' preferred therapeutic approach, such as adopting a psychosocial approach. In addition, targeting interventions to high-risk groups including mothers with limited family support and those with marital conflicts can also enhance mothers' mental well-being. Beside campaigns targeted at mothers and their families to combat societal stigmatization of mental disorders.

### Study strengths

This study has several strengths. Firstly, it is unique in the oPt and is one of the few studies in the Arab world that explores cultural perspectives and provides a comprehensive understanding of PPD within an Arabic context. Which aids in a better prevention and treatment of PPD and helps prevent the uncritical adoption of Western mental health concepts. By considering the three different residential areas—city, camp, and village—the study captures diverse perspectives and experiences. In addition, the inclusion of mother participation further enhances the study's validity and ensures that the voices of individuals directly affected by PPD are heard.

### Study limitations

However, there are some limitations to consider. Firstly, the study includes convenience sampling, where all participants were recruited from Bethlehem Governorate due to its convenience for researchers. Further findings might emerge if other governorates were included. Another limitation of this study is the fact that mothers not only discussed their most recent pregnancy, which was expected to be within the last six months but also shared experiences from all their pregnancies. Additionally, during FGDs few mothers tended to judge the opinions of others, potentially hindering open and accessible conversation. Moreover, there were instances where mothers' personal experiences were reflected upon, compromising their privacy in front of other participants.

#### Abbreviations

| | |
|---|---|
| PPD | Postpartum depression |
| FGDs | Focus group discussions |
| EPDS | The Edinburgh Postpartum Depression Scale |

## Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12884-025-07457-8.

Supplementary Material 1.

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#### Authors' contributions

This paper is part of Batoul Mattar's Academic Master thesis. BM wrote the original draft, conceptualized, created, and validated the tool, collected data, transcribed the data manually, analyzed the data, and wrote the final draft. Niveen ME Abu-Rmeileh is the principal investigator of the study. NMEAR supervised all research steps, conceptualized the study tool, and reviewed, edited, and analyzed the data. Yasmeen Wahdan reviewed and edited the paper, conceptualized the tool, and curated and analyzed the data. Maysaa Nemer reviewed and edited the paper, helped write the discussion section and proofread the final draft.

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#### Data availability

The datasets used and analyzed during this study are available from the corresponding author upon reasonable request.

## Declarations

### Ethics approval and consent to participate

The ethical approval was obtained from the research ethics committee at the Institute of Community and Public Health/Birzeit University. Also, approval for implementing the study was obtained from the Palestinian Ministry of Health and the clinics involved. Written informed consent was obtained from participating mothers after the researcher explained the objectives of the FGD to them. All FGDs were tape-recorded after obtaining permission from all participants. This study adhered to ethical principles outlined in the Declaration of Helsinki. Data collectors also took notes manually.
When conducting FGDs, the confidentiality of the information was emphasized from the researchers' side. It was explained to the participating women that the confidentiality of information from other participating women is not guaranteed. So, the researcher emphasized that women should speak without mentioning names and without attributing the speech to the speaker.

### Consent for publication

Not applicable.

### Competing interests

The authors declare no competing interests.

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### References

1. Woody CA, Ferrari AJ, Siskind DJ, Whiteford HA, Harris MG. A systematic review and meta-regression of the prevalence and incidence of perinatal depression. J Affect Disord. 2017;219:86–92.
2. Ayoub K, Shaheen A, Hajat S. Postpartum Depression in The Arab Region: A Systematic Literature Review. Clin Pract Epidemiol Ment Health. 2020;16(1):142–55.
3. Mattar B, Abu-Rmeileh NME, Wahdan Y. Postpartum depression symptoms: prevalence, risk factors, and childbirth experiences in Palestine. BMC Public Health. 2024;24(1):1357.
4. El-Hachem C, Rohayem J, Bou Khalil R, Richa S, Kesrouani A, Gemayel R, et al. Early identification of women at risk of postpartum depression using the Edinburgh Postnatal Depression Scale (EPDS) in a sample of Lebanese women. BMC Psychiatry. 2014;14(1):242.
5. Safadi RR, Abushaikha LA, Ahmad MM. Demographic, maternal, and infant health correlates of post-partum depression in Jordan. Nurs Health Sci. 2016;18(3):306–13.
6. Roumieh M, Bashour H, Kharouf M, Chaikha S. Prevalence and risk factors for postpartum depression among women seen at Primary Health Care Centres in Damascus. BMC Pregnancy Childbirth. 2019;19(1):519.
7. Thurgood S, ADM, & WL. Postpartum Depression (PPD). American Journal of Clinical Medicine. 2009;6 (2):17–22.
8. Miller LJ. Postpartum Depression. JAMA. 2002;287(6):762.
9. Dennis CL, Dowswell T. Psychosocial and psychological interventions for preventing postpartum depression. Cochrane Database of Systematic Reviews. 2013 Feb 28;
10. Chen Q, Li W, Xiong J, Zheng X. Prevalence and Risk Factors Associated with Postpartum Depression during the COVID-19 Pandemic: A Literature Review and Meta-Analysis. Int J Environ Res Public Health. 2022;19(4):2219.
11. Dennis C, Chung-Lee L. Postpartum Depression Help-Seeking Barriers and Maternal Treatment Preferences: A Qualitative Systematic Review. Birth. 2006;33(4):323–31.
12. Nordbeck M. Seeking Social Support: How Women with Postpartum Depression Navigate Cultural Stigmas that Influence How They Disclose Their Struggles. Nordbeck UWL Journal of Undergraduate Research XXV. 2022.
13. Hadfield H, Wittkowski A. Women's Experiences of Seeking and Receiving Psychological and Psychosocial Interventions for Postpartum Depression: A Systematic Review and Thematic Synthesis of the Qualitative Literature. J Midwifery Womens Health. 2017;62(6):723–36.
14. Ghubash R, Eapen V. Postpartum Mental Illness: Perspectives from an Arabian Gulf Population. Psychol Rep. 2009;105(1):127–36.
15. Bashiri N, Spielvogel AM. Postpartum depression: a cross-cultural perspective. Prim Care Update Ob Gyns. 1999;6(3):82–7.
16. Evagorou O, Arvaniti A, Samakouri M. Cross-Cultural Approach of Postpartum Depression: Manifestation, Practices Applied, Risk Factors and Therapeutic Interventions. Psychiatr Q. 2016;87(1):129–54.
17. Bina R. The Impact of Cultural Factors Upon Postpartum Depression: A Literature Review. Health Care Women Int. 2008;29(6):568–92.
18. Nahas V, Amasheh N. Culture Care Meanings and Experiences of Postpartum Depression among Jordanian Australian Women: A Transcultural Study. J Transcult Nurs. 1999;10(1):37–45.
19. Palestinian Central Bureau of Statistics (PCBS). The Palestinian Multiple Indicator Cluster Survey MICS 2019–2020. 2021 [cited 2024 Jul 20]. Available from: https://www.unicef.org/sop/reports/palestinian-multiple-indicator-cluster-survey
20. Hilde Drivenes Daland, Kari-Mette Walmann Hidle. Information literacy skills in the research process [Internet]. 2016 [cited 2024 Nov 5]. Available from: https://www.sciencedirect.com/topics/psychology/phenomenological-approach#:~:text=2.7%20The%20Phenomenological%20Approach&text='Phenomenography%20is%20an%20interpretive%20research,5).
21. Kiger ME, Varpio L. Thematic analysis of qualitative data: AMEE Guide No. 131. Med Teach. 2020 Aug 2;42(8):846–54.
22. Abdollahi F, Lye MS, Zarghami M. Perspective of postpartum depression theories: A narrative literature review. N Am J Med Sci. 2016;8(6):232.
23. Edhborg M, Friberg M, Lundh W, Widström AM. ``Struggling with life'': Narratives from women with signs of postpartum depression. Scand J Public Health. 2005;33(4):261–7.
24. Ayoub KA. Prevalence of postpartum depression among recently delivering mothers in Nablus District and its associated factors. [Nablus]: Najah University; 2014 [cited 2023 Aug 4]. Available from: https://repository.najah.edu/handle/20.500.11888/7829

## Publisher's Note