Women's Perceived Barriers to Mental Health Help-Seeking for Post-Partum Depression: Insights from Mabvazuva Estate in Goromonzi District, Zimbabwe.

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ABSTRACT

The purpose of this study was to examine the perceived potential barriers and challenges to mental health help-seeking for post-partum depression in women. Data were collected by means of in-depth interviews from a convenient sample of 15 women who have experienced post-partum depression. Participants were queried as to the symptoms of post-partum depression, possible coping mechanisms, if they had any support for their mental health, what they perceived to be the barriers or hindrances to seeking help for their mental health, the advice they would give to other women going through the same experience. The participants were also asked about the solutions they would recommend addressing these problems. Findings from the research revealed that the greatest perceived barriers to seeking help were lack of knowledge about PPD, inability to distinguish between depression and the emotional maladjustment that comes with becoming a parent, difficulty determining the severity of depressive symptoms, unawareness of the services that are available and the advantages of those services. Additionally, unfulfilled expectations for motherhood, extreme vulnerability, shame, and guilt, as well as the experience of stigma associated with both mental health problems and the idea that having PPD implies failing as a mother were also identified as potential barriers to seeking help. All the respondents indicated that there was indeed lack of support for women experiencing postpartum depression. There was also a consensus on the most prevalent symptoms for post-partum depression including but not limited to depressed mood, social withdrawal, loss of appetite, insomnia, severe anxiety and panic attacks and loss of energy. When asked what advise they would give to other women struggling with post-partum depression, most of the respondents indicated recommending professional help as opposed to suffering in silence. In addition, most of the women expressed a preference for integrated strategies that included all facets of society and lessened the burden of postpartum mental illness on women. Better treatment rates for depression and potential improvements to the general health of women who are of a childbearing age could result from knowing what discourages women from seeking or receiving care for depression related to childbirth and what kind of treatment they prefer.

Keywords: Post-partum, Depression, Childbirth, Women, Perceived, Mental Health

INTRODUCTION

According to Fisher et al. (2012), postpartum depression (PPD) remains one of the world's most significant maternal health issues. Postpartum depression (PPD), a serious maternal health concern, is defined as the presence of subsyndromal or major depression in the first year after the birth of a child, O Hara, and McCabe (2013). The duration is usually limited, with symptoms including feelings of sadness, guilt, constant worry, anxiety, and insomnia, loss of interest in usual events, sleep challenges, fatigability, problems of appetite, and difficulty in coping with daily activities, Sulyman et al (2016). In fact, PPD is often described as a thief that steals motherhood!

Despite the numerous developments in the management of PPD that have taken place in recent years, it is still a deeply underdiagnosed condition. Nylen et al, (2010) reports that affecting approximately 900,000 U.S. women annually, only about 6% of women suffering from postpartum depression seek psychological help. In 2014, a US survey answered by 1400 women revealed that 40% of those with symptoms of depression did not seek help. According to O'Mahen and Flynn (2008), a set of studies has identified several barriers that women perceive as preventing them from seeking professional help for their emotional problems, namely knowledge, attitudinal and practical/structural barriers.

Concerning knowledge barriers, women report having a poor recognition of depressive symptoms (Buist et al. 2005), including difficulty in distinguishing between the emotional maladjustment associated with the transition to parenthood and depression (Bilszta et al. 2010) and difficulty in assessing the severity of depressive symptoms (McCarthy and McMahon 2008). This poor recognition of symptoms may lead to difficulties in identifying help needs (Goodman and Tyer-Viola 2010). Moreover, women also report having scarce knowledge of the available services, treatment options and their benefits (Henshaw et al. 2013).

Women have reported that unfulfilled expectations of motherhood, feelings of shame, guilt, and extreme vulnerability, in addition to the stigma attached to mental health issues and the belief that having PPD means one is a bad mother, are obstacles to getting the practical and structural support for their mental health (Edwards & Timmons, 2009). Similarly, a Swedish narrative study of 22 mothers conducted in 2005 observed that they did not consult health services for fear of being perceived as weak or bad mothers. Therefore, these findings provide support for stigma and a lack of awareness as contributors to the under-reporting of PPD by women.

The World Health Organization reports that of the 13% of women suffering from PPD after giving birth, the prevalence is closer to 20% in developing countries, according to the National Institute of Health and Care Excellence (2014). In Africa, studies on the magnitude of postpartum depression remain scanty, Nakku, Nakasi & Mirembe (2006). The few existing studies estimate the magnitude to be 15 to 25 percent, Villegas et al (2011). In Ethiopia, for example, the period of postpartum confinement, which ranges from 40 days to three months, may be a barrier to help-seeking for women experiencing mental distress (Berhane et al, 2001).

In addition, in a qualitative study from rural Ethiopia key informants expressed the view that women would be exposed to attack by evil spirits and shamed if they left their home during the postpartum period. Moreover, an additional barrier to obtaining help from formal health care services was identified when mental distress was attributed to the escalation of preexisting problems, such as poverty and marital instability, rather than a disease (Hanlon, Whitley, Wondimagegn, Alem and Prince, 2009). As a result, mental healthcare is provided only when women seek it, or when health professionals identify symptoms worthy of clinical attention. Therefore, access to intervention is dependent on women's help-seeking behaviours and their ability to communicate with health professionals about their post-partum depressive symptoms (Brown and Limley, 2000).

Furthermore, studies from sub-Saharan Africa have reported higher rates of PPD exceeding 30.0% in South Africa, Nigeria, and Zimbabwe, with substantial within-country heterogeneity (Gelaye et al, 2016). Within Zimbabwe, for example, PPD ranged from 16.0% to 34.2% across different settings between 1995 and 2015, according to research by January, Burns and Chimbari (2017). A recent review on depression in Zimbabwean women showed that significant risk factors for PPD include socio-economic difficulties, history of experiencing adverse events and intimate partner violence, January et al. (2017). According to Chibanda (2023), one of the major causes of PPD is an abusive relationship which make circumstances leading to pregnancy and delivery very stressful.

However, as Cindy-Lee Dennis (2007) points out, no research has looked at postpartum depression help-

seeking barriers in detail. There is also evidence to suggest that although the prevalence of PPD is projected to be higher in Africa than the global mean prevalence, there is still a paucity of data available in many African countries (McKay et al, 2011). Hence the current research becomes pertinent as it will provide new insights and fresh perspectives into the barriers to women's help seeking for post-partum psychological distress.

1.2 Objectives of the study

- To examine the barriers to mental health help-seeking in women with postpartum depression.
- To establish ways that positively influence attitudes towards mental health help-seeking in women experiencing post-partum depression.
- To suggest strategies for improving the mental health of women with post-partum depression.

MATERIALS AND METHODS

- **Research Approach**

The qualitative research approach served as the foundation of this research. Lincoln (2000) states that qualitative research focuses on understanding social events by the interpretations that individuals assign to them, and it investigates objects in their natural environments. Thus, the main objective of the qualitative research paradigm was to investigate respondents' perceptions and feelings (Belotto, 2018). Notably, this paradigm guarantees an understanding of women's perceptions on mental health help-seeking attitudes towards post-partum depression.

- **Research Design**

The researchers' goal in this study was to characterise the phenomenon under investigation as precisely as possible while clinging to the truth and facts, avoiding any preconceived notions. Hence, a phenomenological design was appropriate for the current study as it allowed the researcher to interview the participants which were women from Mabvazuva Estate in Goromonzi District. According to Welman and Kruger (1999, p. 189) as cited in Zaheer et al., (2021) "the phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved. In the current study the researcher attempted to describe the perceived barriers and challenges to mental health help-seeking for post-partum depression in women.

- **Population and Sampling Techniques**

The women residents of Mabvazuva Estate in Goromonzi District, Mashonaland East Province, made up the study's population. A total of fifteen women were chosen using purposive sampling. When a researcher chooses a certain group of individuals who are pertinent to the study, this is known as purposeful sampling (Harwell, 2011). The participants in the selection were women who had an experience with post-partum depression.

- **Data Gathering Instrument**

The method of gathering data used in this research was in-depth interviews. According to Mataruse (2021) in-depth interviewing is a qualitative research method that entails conducting in-depth one-on-one interviews with a limited number of participants to get their opinions on a certain idea, initiative, or state of affairs. Interviews were preferred because they allow one to gather rich information and draw more detailed conclusions than other research methods, taking into consideration nonverbal cues, off-the-cuff reactions, and emotional responses. Furthermore, in-depth interviews have the potential to be very insightful, and as a

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result provide extremely valuable outcomes.

- **Data Analysis Procedure**

Content analysis was used to analyse the data. Qualitative content analysis has been defined as: a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns (Hsieh & Shannon, 2005, p.1278). According to Patton (2002, p.453), qualitative content analysis refers to any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings. So, the data was sorted using qualitative content analysis, an applied data analysis technique for qualitative academics.

RESULTS AND DISCUSSION

Post-Partum Depressive Symptoms in Women

Results from the study confirmed the insights from the literature review regarding the symptoms of postpartum depression experienced by women after giving birth. Out of a myriad of depressive symptoms experienced by women following the birth of a child, the following were identified as the most prevalent amongst the research participants:

- *Inability to sleep, called insomnia, or hypersomnia.*
- *Overwhelming tiredness or loss of energy.*
- *Depressed mood or severe mood swings.*
- *Withdrawing from family and friends.*
- *Loss of appetite or eating much more than usual.*
- *Inability to feel pleasure in normally pleasurable activities known as anhedonia.*
- *Reduced ability to think clearly, concentrate or make decisions.*

The above findings validate the examples of the symptoms of post-partum depression shared by Sulyman et al (2016) which include but are not limited to feelings of sadness, guilt, constant worry, anxiety, and insomnia, loss of interest in usual events, sleep challenges, fatigability, problems of appetite, and difficulty in coping with daily activities. In addition, when asked about how long they had experienced the symptoms stated, most of the participants highlighted a period between two weeks to one month, whilst a few stated that their symptoms had been present for over a month. Again, this resonates with Sulyman et al (2016) who stated that the duration of post-partum depression was usually limited.

Lack of Mental Health Support for Women struggling with Post-Partum Depression

Results from the study also revealed that there was a lack of mental health support for women struggling with post-partum depression. All fifteen participants responded that women who suffer from post-partum depression do not receive appropriate support for their mental health. Some participants posited;

Mine was detected late. Cultural beliefs and our society do not not fully understand the challenge which makes it hard to relate. I don't think people know of PPD and everyone including the mother focuses more on her child than herself. There are limited support structures in our society PPD is a condition that our culture has not grasped or if I can say ignorant about. Even as a mother I feel scared to share what I'm going through because I would not want to be labelled as a bad mother Most women do not speak out therefore it is difficult for family and people around to notice the change Noone really understands post-partum depression. They will think you are having "moods" then it evolves to real depression. Even the nurses and doctors may not even know that's what you are suffering from. I know I actually couldn't

understand myself who I had become Due to cultural practices and social norms/ expectations, many women do not get support in African households because they are expected to be resilient "shinga. A cry for help falls on deaf ears because some people are quick to judge " kuyema"

These findings corroborate Nylen et al s assertion that while it affects approximately 900,000 women annually, only approximately 6% of women suffering from postpartum depression seek psychological help. The above views are also consistent with O'Mahen and Flynn (2008), whose submission states that there are several barriers women perceive as preventing them from seeking professional help for their emotional problems which have been identified. Resultantly, women can only receive mental healthcare if they ask for it or when medical specialists determine that their problems need further investigation.

The Perceived Barriers to Mental Health Help-Seeking

Quite evidently, concerns regarding the perceived barriers to seeking help for their mental health were shared by the women. Below are some of the verbatim quotes from the participants,

… Not thinking that mental health requires treatment; failure to recognize or articulate a problem… Cultural & spiritual beliefs associated with mental health; Fear of being judged as an inadequate mother; Lack of knowledge; Societal stigma associated with mental health…

The above findings confirm the assertion by Edwards & Timmons (2009) that with regards to attitudinal and structural barriers, women have identified unfulfilled expectations of motherhood, shame, guilt, and extreme vulnerability as well as the experience of stigma associated with mental health problems and the notion that having PPD implies a failure as a mother as obstacles to seeking help for their mental health.

The research also established the lack of knowledge about post-partum depression among women as a hindrance to them seeking help for their mental health following the birth of a child. To this end, some of the participants stated the following,

…Lack of knowledge; The belief that only the health of the newborn baby matters are barriers to mental health help seeking…

This finding corroborates Buist et al. (2005)'s assertion that concerning knowledge barriers, women report having a poor recognition of depressive symptoms including difficulty in distinguishing between the emotional maladjustment associated with the transition to parenthood and depression and difficulty in assessing the severity of depressive symptoms. To this end, this poor recognition of symptoms may lead to difficulties in identifying help needs. Moreover, Henshaw et al. (2013) opine that women also report having scarce knowledge of the available services, treatment options and their benefits for post-partum depression.

The study also revealed that women's inability to identify a mental health problem also contributed to their failure to seek help. One of the participants mentioned the subsequent,

… Not thinking that mental health requires treatment and failure to recognize or articulate a problem is yet another perceived barrier to mental health help-seeking for women suffering from post-partum depression

The above response validates Hanlon et al s 2009 assertion that an additional barrier to obtaining help from formal health care services was identified when mental distress was attributed to the worsening of pre-existing problems, such as poverty and unstable marriages, rather than a disease. Resultantly, access to intervention was dependent on women's help-seeking behaviours and their capacity – or lack thereof – to communicate with health professionals about their post-partum depressive symptoms.

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Advice to Women suffering from Post-Partum Depression

When asked about what advise they would give to other women suffering from PPD or who may face the same experiences in the future, the participants had the following submissions;

… Seek professional help. Use your support system…

… Get help and don't be afraid to express yourself…

Kusungirwa

… Don't keep quiet about what you are going through, talk to someone whom you are close to and be receptive to getting help…

… Don't suffer in silence, reach out for help…

Overall, the above responses echo the importance of seeking help, that is professionally as well as getting support from the existing social structures such as family and friends. In addition, an interesting phenomenon was introduced by the respondents, that is, *Kusungirwa*. This is where by an expecting mother is sent back to her family by her husband so that she receives the appropriate support and care both pre-during and post the delivery of a child. This is done to help alleviate the challenges faced by women after giving birth especially the one in question.

DISCUSSION

The results from the study revealed that the guilt, shame, and stigma associated with PPD seem to be the greatest barriers women experiencing post-partum depression face in seeking help for their mental health. This supports a claim made by Beck (2006) that up to half of PPD cases in new mothers remain undetected due to privacy conflicts and a reluctance to disclose to close family members. New mothers are stigmatised because disclosure is thought to result in desertion and a worry of receiving insufficient support, (Beck, 2006).

It was also established that women with postpartum depression find seeking professional psychosocial support difficult but ultimately beneficial. Our findings highlight the need to increase awareness among pregnant women of the importance of PPD so that they can seek help, as asking about these symptoms by clinicians is not enough.

The study also found that the particularly vulnerable sub-populations, are women who lack knowledge and are ill-equipped to identify depressive symptoms. This includes having trouble differentiating between depression and the emotional maladjustment that comes with becoming a parent, as well as having trouble determining the severity of depressive symptoms. who are at an increased risk of not seeking care. This is in line with Bilszta et al; (2010) who state that the examples of knowledge obstacles in women suffering from post-partum depression include women having a poor awareness of depressed symptoms as well as understanding the difference between PPD induced depression and emotional instability that comes with parenthood.

The results of the study also support the need for awareness raising and educational interventions as an essential element for improving access to quality mental healthcare to women in the postpartum period. Similarly, Chibanda (2023) recommends that women with PPD should be treated rather than jailed,

…If you go to Chikurubi, there are women incarcerated for what we call infanticide. Again, you know, I'm of the opinion that these people should not be incarcerated. They need help, vanofanirwa kunge

vachinorapwa vanhu ava (They should be getting treatment.) You know when you put them in jail, you are not really helping them…

Furthermore, the study established that there is an urgent need to design and implement treatments that address the lack of information and perceived shame associated with women's lack of help-seeking behaviour for PPD, in addition to establishing new guidelines to address barriers at the health care system level. Hence, awareness of women's experiences is important to inform primary healthcare practitioners of how best to help women with post-partum distress. This finding was in tandem with Murray et al., (2014) who stated that the timely treatment of PPD has been found to enhance both maternal and infant outcomes.

The study also revealed the need for an integrated and multisectoral approach to mental health, particularly that of women struggling with post-partum depression. This means that the mental health of women with PPD will be made a priority beyond the mental health system to ensure the provision and availability of comprehensive support systems. The finding is consistent with Baskova et al (2023) who revealed that interventions aimed at reducing the stigma and increasing knowledge of PPD should be incorporated into the antenatal education of expectant mothers, particularly among women who may not have previously sought care for mental or chronic illnesses. However, an earlier study published in 2001carried out among first time mothers did not show such an influence, and rather indicated positive effect of education on the overall health awareness of women, Cankaya (2021).

CONCLUSIONS

According to the study, numerous supposedly "perceived" barriers that keep postpartum depressed women from accessing mental health care are, in fact, genuine. The lack of knowledge about PPD, the failure the differentiate the emotional maladjustment associated with the transition to parenthood from depression, difficulty in assessing the severity of depressive symptoms, having scarce knowledge of the available services, treatment options and their benefits, unmet expectations of motherhood, shame, guilt, and extreme vulnerability as well the experience of stigma associated with both mental health problems as well as the connotation of PPD implying a failure as a mother, were confirmed by the participants in this study to be hindrances to seeking help for their mental health.

The study also found that women's experiences with post-partum depression symptoms are similar to the most common symptoms being insomnia, excessive sleeping, extreme exhaustion or lack of energy, depression or severe mood swings, withdrawing from family and friends, appetite loss or eating a lot more than usual, losing interest in and enjoying previously enjoyed activities, diminished ability to think clearly, concentrate, or make decisions, and hopelessness. A significant finding was also revealed in this study that women with PPD do not receive adequate care for their mental health, which makes it more difficult for them to not only deal with the difficulties of childbirth but also to get the assistance they require when needed.

Some of the most important advice that the respondents said they would give to other women suffering from PPD included seeking professional help, making use of one's existing support system, not being afraid to express oneself, "kusungirwa," ceasing to suffer in silence, and being open to receiving assistance. Furthermore, there is a pressing need to develop culturally appropriate psychological interventions and decolonize psychological approaches in the treatment of PPD, as put forward by some of the participants who suggested adopting "kusungirwa" as a coping strategy and preventative measure for PPD.

Summarily, the study revealed that the mental health of women suffering from PPD is a collective responsibility. In order to achieve this, an integrated, multisectoral approach to mental health treatment is needed. This entails giving mental health a high priority in areas outside of the mental health system, such as the physical health system, as well as in settings and policies related to employment, education, and

society.

RECOMMENDATIONS TO SUPPORT WOMEN SUFFERING FROM PPD.

The following recommendations were made based on the findings of this study:

- A target population's involvement in developing and proposing different interventions and/or solutions to address their problems is crucial in helping to identify their particular needs and re-imagining how to adequately address them.
- The provision of post-support in the form of more information and support groups, adequate support system, and counselling services.
- The availability of reasonable accommodations for working mothers in the workplace, including maternal health education & support structures. These may include the review of Maternity & Paternity Leave Policies to make them more progressive in line with the Diversity & Inclusion Agenda.
- The provision of the necessary education to help women and their partners recognize the early signs and symptoms of postpartum depression (PPD) as well as help increase women's understanding of how to meet their own needs. This can be done through awareness campaigns in clinics, hospital, antenatal care facilities, workplace, and communities.
- To raise awareness on mental health in communities, churches, workplaces to encourage seeking professional help.
- To foster integrated, multi-sectoral stakeholder engagements which guarantee stakeholder participation at all engagement levels, including in families, communities, workplaces, churches, to name a few. Because the proposed collaborations leverage resources from business, government, and nonprofit organisations, they have the potential to address systemic issues, such as structural and attitudinal barriers, and address the perceived obstacles that prevent women suffering from postpartum depression from seeking mental health help.
- To get a broader spectrum of experiences, future research should also aim to include a bigger sample size of the study population.
- In order to assure a range of perspectives on this issue, future research should likewise concentrate on securing a diverse set of participants. Diversity in terms of racial and ethnic backgrounds, gender, sexual orientation, and so forth.

LIMITATIONS AND IMPLICATIONS OF THE STUDY

While significant others are also impacted by the challenges linked with childbirth, their opinions were not considered in the study, which focused exclusively on the perceptions of women. The significant others consist of spouses, siblings, and other relatives. Furthermore, despite being a highly common occurrence in both our local and regional contexts, discussions about PPD are still frowned upon in our society due to the stigma that mental illness has in our community. Therefore, it is critical to highlight the various sectors that both influence and are influenced by women's perceptions of their behaviour in seeking mental health treatment for PPD. This will help to highlight the significance of involving actors outside of the specialised mental health system in initiatives to promote mental health and lessen the burden of mental illness.

AUTHOR CONTRIBUTIONS

Conceptualization, Mudokwani & Chirombe; Methodology, Mudokwani & Marwisa; Data collection, Mudokwani and Maziya; Collation of results, Marwisa and Maziya, Discussion and conclusions, Mudokwani, Chirombe & Marwisa.

All authors have read and agreed to the published version of the manuscript.

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