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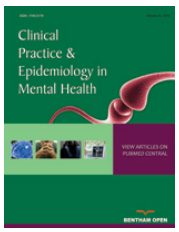

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RESEARCH ARTICLE

The Malaysian Women's Experience of Care and Management of Postnatal Depression

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Abstract:

Objectives:

Early detection and intervention for Maternal Postnatal Depression (PND) are imperative to prevent devastating consequences for mothers, babies, and families. However, there are no guidelines that explicitly focus on the management of PND in Malaysia. Consequently, it is unclear whether women with PND are receiving proper care and treatment. Therefore, this study aimed to explore Malaysian Women's experience in managing PND symptoms.

Methods:

A qualitative study was conducted among 33 women attending Maternal and Child Health (MCH) clinics in Kuala Lumpur. Data were obtained through a face-to-face semi-structured interview and analysed using framework analysis.

Results:

The women considered PND as a personal and temporary issue. Therefore, professional care was deemed unnecessary for them. Additionally, all Malay women considered religious approach as their primary coping strategy for PND. However, this was not the case for most Indian and Chinese women.

Conclusion:

The findings of this study indicated that women did not acknowledge the roles of Healthcare Practitioners (HCPs) in alleviating their emotional distress.Also, they perceived PND as a personal problem and less serious emotional condition. It is due to this perception that the women adopted self-help care as their primary coping strategy for PND. However, the coping strategy varied between different cultures. These findings underscore the importance of HCPs' proactive action to detect and alleviate PND symptoms as their attitude towards PND may influence Women's help-seeking behaviour.

Keywords: Postnatal, Depression, Health care practitioners, Women, PND symptoms, Mothers.

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1. INTRODUCTION

Postnatal Depression (PND) is a public health concern affecting 4% to 63.9% of new mothers [1]. PND refers to a depressive illness that often begins two to three weeks after birth and may last for a year. The aetiology of PND is associated with the reduction of oestrogen and progesterone, and epigenetic and neuroendocrine changes, which influence neuroinflammation [2]. A woman can be diagnosed with PND when she has at least five out of nine PND symptoms for not less than two weeks. These symptoms include depression, loss of interest, lack of energy, insomnia or hypersomnia, concentration difficulty, constant hesitation, change in body weight or appetite, lethargic, suicidal ideation or attempt, feeling of being unworthy and sense of guilt [3, 4]. Early detection and intervention of PND are imperative to prevent devastating consequences for mothers, babies, children, and spouses [5, 6]. Children's misbehaviour and negative emotions are a few examples of these devastating consequences.

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Additionally, PND has been associated with increased suicide attempt and thoughts of self-harm [7, 8]. Given these harmful effects of PND, a proper treatment (*e.g*. counselling or medications) is necessary. Nevertheless, most studies reported that PND women did not seek professional help [9 - 11].

Inadequate awareness, stigma, and cultural influences have been identified as common obstacles for women worldwide. For instance, women could not perceive the depressive symptoms as problematic due to a lack of depression literacy [10, 12, 13]. Meanwhile, stigma has been established as a barrier to help-seeking for PND women [9 - 11, 14, 15]. Women were also reported to be ashamed and humiliated about their PND symptoms. Specifically, they worried that the symptoms would make them feel vulnerable and fear that their child may be taken away by social services [11, 13, 14]. In a certain culture (*e.g*. Asian), women are not widely aware of PND symptoms. Therefore, they do not view PND symptoms as an illness, and neither try to be sensible about the symptoms in other ways [13]. For immigrant mothers, cultural factors hindered them from seeking help due to the feeling of being viewed differently from other mothers who are citizens of the country [14].

While women globally recognised the obstacles to seeking help, disparities remain in dealing with PND across cultures. Compared to other racial or ethnic groups, Asian women were less likely to discuss professional help when describing their PND experience. Instead, they spoke more on practising self-help and getting social support [16, 17]. Reasons for these cultural variations might be due to the Women's belief on whether PND is a maternal mental disorder or not. According to Williams and Healy [13], a patient's belief in health and illness may vary depending on various factors (*e.g*. context and culture). It is evident that the manifestation of mental illness has been interpreted in different ways across cultures, and that individuals should be treated accordingly [18].

Two models related to illness behaviour were used in this study to understand Women's belief in health and illness. The models were (i) Leventhal's self-regulatory model of illness behaviour [19] and (ii) Theory of Planned Behaviour (TPB) [20, 21]. Leventhal's model explained patients' beliefs and expectations about an illness or somatic symptom. Illness beliefs refer to an individual's implicit and common-sense belief in the illness. On the other hand, dealing with illness is defined as a problem-solving activity. As people with physical or mental disabilities recognise the changes in their health status, they will not only be willing to learn the cause and nature of the illness,but they will also be inspired to return to their normal state. The journey to the normal state involves three phases: (i) problem identification and interpretations, (ii) problem management, and (iii) efficacy evaluation of the coping strategy adopted [22]. TPB concerns the connection between belief and behaviour. The theory comprised four elements relevant to illness behaviour: (i) attitude towards behaviour, (ii) subjective norm, (iii) perceived behavioural control, and (iv) behavioural intentions [22]. According to TPB, the first and second elements may directly determine the behavioural intention. On the other hand, perceived behavioural control is an independent determinant of behavioural intent. This hypothesis forms the foundation of TPB recommendation regarding the transformation process from attitudes to behaviour, which includes the creation of intention [23].

In Malaysia, PND has not been formally assessed and detected within the primary healthcare settings [24]. Since there are currently no guidelines that explicitly focus on PND management, it is unclear whether PND women receive proper care and treatment. Malaysian citizen consists of 53.3% Malay, 26.0% Chinese, 7.7% Indian, and 13.0% of ethnic populations in Sabah and Sarawak [25]. Given the wide range of cultural and ethnic backgrounds, Malaysia offers an opportunity to understand Women's experience of managing and coping with PND across cultures. Moreover, Women's perceptions and beliefs on PND and its management are yet to be explored. Such exploration is beneficial for Healthcare Practitioners (HCPs) to promote collaboration with PND patients and improve clinical outcomes. Therefore, this study aimed to explore the Malaysian Women's experience with care and management of PND symptoms.

2. METHODS

2.1. Study Design

This qualitative study used the face-to-face semi-structured interview to explore how women coped with PND, the reasons for seeking or not seeking professional help, and what interventions they perceived would be helpful in the future. The interview was conducted among 33 women (from three cultural backgrounds: Malay, Chinese, and Indian) attending Maternal and Child Health (MCH) clinics in Kuala Lumpur. Healthcare services offered within MCH clinics include antenatal, postnatal, and childcare. Almost all women in Malaysia give birth in a hospital, where they will be looked after by nurse-midwives, medical doctors and/or obstetrician. Nurses working in MCH clinics provide care for postnatal women through eight home visits (1^{st}, 2^{nd}, 3^{rd}, 4^{th}, 6^{th}, 8^{th}, 10^{th}, and 20^{th} postnatal days) and one clinic visit (30^{th} postnatal day). Postnatal mothers are also given a scheduled appointment for the child's health (2^{nd}, 3^{rd}, 5^{th}, 6^{th}, 9^{th},12^{th} postnatal months) [26].

2.2. Participants

Purposive sampling was used to recruit the participants based on the following inclusion criteria: (i) women aged 18–45 years, (ii) at 6–52 weeks after the last childbirth during the screening stage, (iii) Malaysian by nationality, (iv) had been staying in Malaysia after the last childbirth and until the time of the interview, (v) scored three or more in the Patient Health Questionnaires (PHQ-2) and/or scored 12 or more in Edinburgh Postnatal Depression Scale (EPDS) and/or self-identified and/or being referred by a head nurse in charge, and (vi) sufficiently fluent in Malay or English language to participate in the interview.

2.3. Measures

In this study, both PHQ-2 and EPDS were used to screen participants with PND symptoms due to the expectation that the EPDS would capture the depressive symptoms which were

not asked in the PHQ-2. The EDPS consists of ten specific questions on PND symptoms, whereas the PHQ-2 consists of two short questions on general depressive symptoms: 'little interest or pleasure in doing things' and 'feeling down, depressed or hopeless' [27-,29].

2.4. Procedures

Participants who fulfilled the inclusion criteria were invited for the interview session, which was conducted either at their homes, or in a private and quiet room at the respective clinic, or at any other location that the participants preferred. The interviews were recorded and transcribed verbatim. A topic guide was used, and field notes were written and maintained immediately after each interview session to reflect the participants' emotions and non-verbal communications. Among the questions asked within the topic guide were the participants' family situation, cultural background, current emotional status, factors influencing help-seeking behaviour, reasons for seeking or not seeking help, and perceptions of what might improve emotional well-being.

In Malaysia, the Malay language is used as the formal or official language. There were three different cultures with different mother-tongue languages involved in the interview session. Given that Malay is the formal language in Malaysia, most Malaysian women could converse and express their experiences well using the Malay language. Also, the ability to converse in either the Malay or English language was one of this study's inclusion criteria. Furthermore, this criterion was included to optimise communication between the researcher and participants. While there are some differences in the postnatal practices across these three main cultures in Malaysia, there are also several common postnatal practices shared by these cultures. For example, although all cultures recognised the postnatal as a "confinement" period (where both newly delivered mothers and baby are expected to remain house-bound after childbirth), this period varies from one culture to another. In Malaysia, it is common for newly delivered mothers to be taken care of by their mother or mother-in-law [27]. As a means of avoiding any health problems, the newly delivered mothers are often advised to consume certain herbs, apply heat, and massage [27].

2.5. Data Analysis

The interview data were analysed using a framework analysis, which comprised of three stages. Firstly, six transcripts were chosen to develop a thematic framework (consisting of initial themes and initial categories). The thematic framework was then applied to all transcripts. Secondly, the connection and similarities between one theme to another were identified. Thirdly, the dataset was reviewed to analyse the degree of consistency between the phenomena and the final themes. The final themes were developed within consensus among the research team. The credibility and confirmability of the findings were verified.

2.6. Ethical Consideration

All participants were informed that their participation was voluntary and that refusing to participate or withdrawing from the study would not affect their care in any way. Pseudonyms were used throughout data collection, data analysis, and dissemination of findings [32]. The permission to conduct this study was approved by the School Research Ethics Committee (SREC), University of Stirling, and the Malaysian Medical Research Ethics Committee (MREC).

3. RESULTS

A total of 33 women (10 Malay, 12 Chinese, and 11 Indian) were interviewed by the first author. Table **1** shows the participants' characteristics. Three themes emerged from the interview data.

Table 1. The characteristics of women with postnatal depression.

ID	Cultural Background	Age	Education	Occupation	Parity	Duration After Childbirth (Months)	PHQ-2 Score (/6)	EPDS Score (/30)	Place of the Interview	Language Used
PT2	Malay	33	High School	Salesgirl	4	4	2	12	Clinic	Malay
PT3	Indian	30	High School	Driver	3	9	3	17	Home	English
PT4	Malay	34	High School	Housewife	3	1	2	8	Home	Malay
PT5	Chinese	39	High School	Store assistant	2	10	1	15	Home	Malay
PT6	Malay	29	High School	Housewife	4	11	3	12	Home	Malay
PT7	Malay	28	University	Housewife	1	2	2	13	Clinic	Malay
PT8	Chinese	35	University	Purchaser	1	2	1	14	Workplace	English
PT9	Indian	24	High School	Housewife	3	12	3	19	Home	Malay
PT10	Malay	28	High School	Housewife	1	9	4	11	Home	Malay
PT11	Malay	36	High School	Housewife	3	2	-	7	Clinic	Malay
PT12	Chinese	31	High School	Admin Staff	3	2	3	11	Clinic	Malay
PT13	Malay	33	University	Housewife	3	3	2	14	Clinic	Malay
PT14	Chinese	42	High School	Housewife	4	12	3	11	Preferred location	Malay
PT15	Chinese	31	High School	Businesswoman	2	5	2	15	Home	Malay
PT16	Chinese	30	High School	Housewife	1	5	2	13	Clinic	Malay
PT17	Chinese	26	High School	Policeman	1	2	6	12	Preferred location	Malay

(Table 1) contd.....

ID	Cultural Background	Age	Education	Occupation	Parity	Duration After Childbirth (Months)	PHQ-2 Score (/6)	EPDS Score (/30)	Place of the Interview	Language Used
PT18	Chinese	25	High School	Clinic Assistant	4	5	4	16	Home	Malay
PT19	Malay	23	High School	Housewife	3	11	3	11	Clinic	Malay
PT20	Indian	28	High School	Housewife	1	4	2	13	Home	Malay
PT21	Indian	34	High School	Housewife	2	3	4	12	Home	Malay
PT22	Chinese	24	High School	Housewife	1	7	3	11	Home	Malay
PT23	Malay	34	University	IT Executive	2	3	3	18	Home	Malay
Fatiha	Malay	33	High School	Housewife	4	4	2	12	Home	Malay
PT25	Indian	41	High School	Housewife	5	5	3	10	Home	Malay
PT26	Indian	28	University	Housewife	2	7	2	10	Preferred location	English
PT27	Indian	25	High School	Admin staff	1	12	1	16	Clinic	English
PT28	Chinese	34	High School	Businesswoman	2	3	2	13	Clinic	English
PT29	Indian	29	High School	Housewife	1	6	0	12	Home	Malay
PT30	Indian	30	University	Bank Officer	2	6	3	15	Home	English
PT31	Chinese	29	High School	Admin staff	2	12	1	14	Home	Malay
PT32	Chinese	26	University	Housewife	1	6	3	16	Clinic	Malay
PT33	Indian	21	High School	Housewife	1	1	3	9	Home	Malay
PT34	Indian	33	High School	Health Assistant	2	10	0	5	Workplace	Malay

3.1. Surviving Strategies

In describing their coping strategies, none of the participants reported that they received any help from HCPs. Instead, they mentioned that the following coping strategies helped manage their emotional distress: positive thinking, mental preparedness, talking to family members and friends, receiving physical and practical support, and practising religious rituals and diversional activities. These strategies were seen as valuable in controlling their reactions towards stressors, as stated below:

"There's only one way: we've to think positively. If [we] always think negative, always crying, thinking of committing suicide, self-blaming, and all that, those negative feelings will come. We've to control our minds and emotion" (PT24, Malay).

"So that's why I said this [pointing her head] should be prepared, put in all the data so you can survive. If you think you can't, that could be an issue; your mentality couldn't handle it, it all [depends] on yourself" (PT25, Indian).

The participants' descriptions above indicated that they preferred to share their emotional distress with a trusted person, especially those who had some level of mothering experiences, such as friends, female family members, and neighbours. This non-professional personnel was perceived as reliable individuals to provide advice and support. However, some women reported that they sought information online, although its effectiveness was unknown:

"I went online to search [on] how to reduce stress. They said if you're too stressed, look at [the] blue colour. It will reduce the stress" (PT15, Chinese).

Although the religious approach was also mentioned by three Chinese participants (one Buddhist and two Christians) and an Indian participant (Hindu), it was significant that all the Malay participants (all Muslims), repeatedly addressed it as an effective way to cope with their emotional distress. Prayers, reciting the Holy Book (Quran), and remembrance of God were commonly agreed as keeping them calm:

"I did *dhikr* [reciting Arabic verse to remember God], and it helped me to relax. That's all I did" (PT7, Malay).

While the two Chinese Christian participants perceived reading the Bible and singing a religious song as keeping them 'near with God', an Indian participant stated that a special Hindu prayer could bring a positive mood in Indian mothers.

"I felt relaxed a bit. It's because of the power" (PT21, Indian).

Although all the Malay participants described the religious approach as a helpful strategy, most Chinese participants reported that religious activities were neither applicable to them, nor effective in reducing emotional distress. There was no apparent reason for its non-effectiveness, but it seemed to be related to the deepness of their belief and consistency of their religious practice. Most participants also used diversional methods, such as playing with children, listening to music, cooking, eating, walking, exercising, reading books, browsing the internet, and watching television. It was clear from the participants' explanations that their strategies to improve their PND experience were using self-help methods rather than seeking help from HCPs.

3.2. Barriers to Help-seeking

The analysis of participants' descriptions indicated that their help-seeking behaviour was more likely to be influenced by their perceptions of the roles and responsibilities of HCPs and their feelings about the reaction of HCPs to their emotional distress. Most participants believed that the roles and responsibilities of HCPs were largely related to physical health and medical advice, but not emotional well-being. They also believed that their emotional distress was a personal problem and a less serious emotional condition. Below is a conversation

between the interviewer and a participant:

Interviewer: How do you think they can help you in terms of reducing your stress?

PT30 (Indian): I don't think so. They are more on the medical line; I don't think they will help in psychology.

It was also because of the perception below that they had doubts about disclosing their emotional distress to the HCPs:

"You can share with them, but it doesn't mean they will understand. Some will just listen to you. Some can give you advice, but not all are relevant, are they?" (PT12, Chinese).

Most participants seemed to think that their emotional distress was a personal issue that required no treatment from the HCPs. This thinking has kept them from realising that what they are experiencing was PND. This way of thinking seemed to be an important barrier to help-seeking as participants thought that emotional distress was only temporary and would get better over time. On the other hand, others thought that their PND experience had resulted from family problems. Therefore, they considered PNDas personal matters. Below are the participants' descriptions on this matter:

"I think I can handle it. It's just a disturbance. I think it's just a temporary disturbance, a temporary disturbance. I don't think it's very severe" (PT7, Malay).

"That's not their problem, they can't settle it because that's my family's problem" (Jayanthi, PT27, Indian).

On the other hand, some participants appeared to believe that the HCPs had provided sufficient healthcare services, thus they should not demand more. The participants were used to following routine care, such as baby's assessment, immunisation, antenatal education, and postnatal physical assessment. Therefore, they believed that they should not request care beyond the routine check-ups, as stated below by one of the participants:

"I think they've given us sufficient enough. They taught us about baby's food matters and how to handle the baby. That was sufficient. I think everything is okay. Whatever they offer is already sufficient so far" (PT30, Indian).

Apart from that, some participants associated unreadiness to seek help with their past experiences in the healthcare settings and perceptions of HCPs' behaviours. The HCPs were perceived as giving a brief, simple, and unsatisfying advice when they were approached. Some participants' experiences indicated their lack of confidence in the HCPs due to various incidences, such as the nurse's inability to explain the purpose of Hepatitis B vaccination, irrelevant description of the baby's position during vaccination, unprofessional attitudes when questioned about family planning, derogatory expressions, and less focus in their care. Almost all participants thought that no particular attention had been given to maternal emotional well-being. Rather, HCPs were seen to focus only on family planning, breastfeeding, and child development. Below are the participants' descriptions on this matter:

"They didn't ask about me, not at all. They only asked about my baby" (PT34, Indian).

"The nurses didn't ask like: "[Do] you have any problem?" They just ask about my baby's health, and then they asked about family planning, that's all, nothing on emotional things" (PT20, Indian).

Other participants described that the help-seeking process was difficult, particularly when one responded to their call for help. During the routine postnatal clinic and home visits, almost all participants felt that the HCPS did not pay particular attention to maternal mental health. Instead, the HCPS were seen to emphasise issues related to family planning, breastfeeding, and baby's health and growth. Below are the participants' descriptions on this matter:

"The nurses didn't ask like, do you have any problem? They just ask about my baby's health, and then they asked about family planning, that's all, nothing on emotional things" (PT20, Indian).

"I don't think they asked me before, never! I don't remember" (PT26, Indian)

The participants also mentioned that the settings and infrastructure in most of the clinics were not suitable to talk about their problems. Generally, a consultation room is shared by two nurses. However, in the two selected clinics, the consultations were conducted in an open space, where at least two nurses performed consultations with mothers and children. At the same time, many of the participants appeared to express their frustrations about the mistreatment of their emotional distress, a few participants felt that the HCP's roles were limited by a large number of patients in the clinics. For instance, a participant stated that the HCPs were rushing to finish the consultation session because there were too many mothers attending the clinic, making it difficult to ask about their emotional health:

"They were less talking because of too many patients. It's not easy to ask about that" (PT18, Chinese).

3.3. Desired Care

Existing literature suggested that there is less emphasis on the emotional aspects in the process of disease recognition and understanding PND within Malaysian primary healthcare setting [24]. There is also less attention to primary prevention such as training of HCPs working within MCH clinics that could enable them to screen for PND, to deal with cases, and to provide public education, awareness programmes and screening activities [24].Without such specific training, antenatal or postnatal women with any mental health issues (including PND) are commonly referred from MCH clinic to the psychiatric unit in the hospital. When it is required, they are then treated within the same psychiatric setting as patients with general depression and other psychiatric problems.

Consistently, participants in this present study believed that the accessibility of professional support would help improve their emotional well-being in the future. As stated below, participants repeatedly spoke of counselling and telephone-based support as alternative ways to share their feelings:

"For the counselling part, I guess they can give us support, motivation, can't they?" (PT13, Malay).

"Maybe by advising, maybe sometimes, you know, maybe giving a call or asking the mother: [How] you're doing, [is] the baby right? That would make the mother share their problems" (PT26, Indian).

There was also a suggestion for an extended health education session and a support group intervention led by a nurse. This group serves as a platform for the HCPs to share their vast experience of dealing with postnatal mothers. Below is a comment from a participant regarding this matter:

"I hope the nurses or doctors can give more information regarding becoming a first-time mother. This is our first baby, we know nothing, do we? It's because sometimes when they advise us, it seems that they expect us to know everything. Of course, we wish we could be given more information. If they could conduct any seminar for the first-time mother, that would be great! Or they can give advice when we visit the clinic for check-ups. We need more and more advice. I wish they can do that" (PT7, Malay).

A participant also proposed the need for a more thorough assessment from HCPs:

"I guess their advice is okay, but maybe should be more details. I mean a longer time with the patients, right? No rushing" (PT23, Malay).

4. DISCUSSION

It was evident from the participants' accounts that PND was considered as a personal problem that is only temporary and less serious emotional condition. As such, the participants believed that no professional care was required when they have PND. Although there is evidence suggesting that financial issues, cultural factors, and stigma of mental illness may pose a barrier to help-seeking [9, 31 - 33], these factors were not explicitly discussed by the participants. Instead, their discussions were mainly related to the misunderstanding that PND requires no professional care and how they perceived the roles of HCPs in caring for their emotional health. For example, several participants often felt that the HCPs did not give particular attention to their emotional health. As a consequence, they preferred practising self-help methods to professional care. Consistently, it was suggested that help-seeking was shaped by Women's ability to recognise the PND symptoms, reactions (experienced or anticipated) of others, and the organisation of services [33].These findings could be explained by understanding the concept of 'perceived duty' and 'culpability' [34].

The term 'perceived duty' refers to an individual perception of the roles and obligations of a service [34]. In this study, alleviation of emotional distress was not regarded as part of HCPs' duty. Instead, the HCPs were seen to focus on physical health. It was due to this perception that made the participants believed that the HCPs were incapable of resolving their emotional distress. Although some participants considered caring for emotional health is part of HCPs' duty, the help-seeking process was challenging because they observed that the HCPs focused more on physical health (*e.g*. family planning, breastfeeding, and baby's growth). Therefore, their emotional health needs were left unattended. There was evidence that the HCPs saw physical health as the main focus of health care in Malaysia [35]. Therefore, less attention was given to managing maternal mental health disorders within their clinical practice [35]. For example, antenatal and postnatal women are not routinely screened for depression within the MCH clinics, although the international guidelines for diagnosing mental disorders (i.e. DSM-5) have been widely used within the psychiatric settings in Malaysia [36]. Without a specific policy on screening and care for maternal mental health disorders, antenatal or postnatal women with any mental health disorders (including PND) may be overlooked and probably underdiagnosed within MCH clinics in Malaysia.

On the other hand, the term 'culpability' refers to whether a service is to 'blame' when it fails to meet its obligatory duties or does not do things within the scope of duties [34]. Most women in this study tended to cope with the adverse experience in healthcare due to abrupt HCPs intervention and reaction to their grievances and implied that this should not have happened. For example, a few participants noted that they initially wanted to seek professional help, but they changed their minds after realising that the HCPs did not attend to their emotional needs. However, some participants seemed to accept the HCPs' failure to address their emotional health. They justified that the HCPs were overwhelmed with patients in the clinic and that they had received what they expected from the healthcare services (*e.g*. baby's immunisation and postnatal physical assessment).

The participants' view of the HCPs' roles and responsibilities resulted in them to adopt self-help care as their primary coping strategy for PND. Interestingly, self-help care methods varied between different cultures. While all the Malay participants addressed the usefulness of religious activities in coping with PND, this strategy was not widely discussed by the Indian and Chinese participants. This finding is consistent with the previous studies reporting that faith and religion are valuable tools in dealing with depressive symptoms [13, 37 - 40]. Additionally, religious participation was reported to protect women from depressive symptoms, specifically by assisting them to overcome the challenges of early motherhood [41]. Although the Indian and Chinese participants did not provide particular reasons for perceiving religious approaches as nonhelpful, this perception may be related to their religiosity. For instance, previous studies found that religious or spiritual beliefs effectively reduced depressive symptoms [42], especially among religious patients and those with high religiosity [43, 44].

Cultural variability could affect the perception of illness and possible strategies for treatment and management. Each woman may experience PND differently [12]. For instance, Asian women commonly associate cultural and tradition factors to PND, especially when they feel powerless to reject traditional rituals imposed on them by their female caregivers, causing them to feel tense, stress, and emotional distress [12, 45]. In Malaysia, women appear to acknowledge PND as "emotional disturbance" or "changes" after giving birth. They explained such changes through three interrelated cues: emotional (feelings experienced by the women when they felt down or depressed), behavioural (the way that a woman acted

or conducted herself, and how she responded to others), and physiological (alterations in the body function recognised by the women) changes [46]. Findings from this present study reported that the Indian and Chinese women acknowledged the PND symptoms based on emotional changes, whereas the Malay women acknowledged the PND symptoms based on emotional and behavioural changes. There is evidence that women from different cultures could not perceive the "emotional disturbance" as problematic due to limited knowledge of PND [46]. These findings could explain why the women in this present study did not acknowledge professional help as a mean to reduce their PND experience.

Findings of this study somewhat support Leventhal's model [19] and TPB [20, 21]. According to the Leventhal's model, people with an illness construct a representation of the problem through five dimensions: (i) identity (the label given to the diagnosis and the symptoms experienced), (ii) perceived cause of the illness (biological and/or psychosocial factors), (iii) timeline (beliefs about how long the illness will last), (iv) consequences (patients' perceptions of the possible effects of the illness on their life), and (v) curability and controllability (patients' beliefs about whether their illness can be treated and cured, and the extent to which its outcome is controllable). Although this study's findings did not explicitly discuss all the five dimensions of the Leventhal's model, at least two elements were addressed in this study (i.e. the element of timeline and curability and controllability). The women in this study viewed PND as a less serious and temporary condition, how they dealt with the distress and addressed their beliefs about whether their emotional distress can be treated and cured. In reference to TPB, it can be understood that some underlying factors influenced the Women's help-seeking style, particularly when intentions do not appear to result in behavioural changes. For instance, the findings indicated that their desire to pursue medical assistance was hampered by their negative experience and unwelcoming HCPs attitude and response towards their complaints.

CONCLUSION AND IMPLICATION FOR PRACTICE

This qualitative study showed that women did not regard the alleviation of emotional distress as part of HCPs' roles and responsibilities. Instead, women considered PND as a personal problem and less serious emotional condition. It was due to this perception that women adopted self-help care as their primary coping strategy for PND. The coping strategies were found to vary between different cultures. Religious coping strategies were only applicable to Malay women but not others. It is noticeable that the existing strategies (including the introduction of routine assessment) have not yet changed women's help-seeking behaviours relating to depressive symptoms in the postnatal period [47]. For this reason, women need to be provided with the tools to self-assess their mental health, both by having detailed information on symptoms and having an accessible resource where they can monitor their emotional health (*e.g.* health monitoring application). An improved interface between maternity and mental health services is needed, accompanied by improved HCPs interactions. Meaningful change may require empowering women's self-assessment and monitoring, and public health messages to improve recognition of PND symptoms by women and their families [33].

The findings of this study also underscore the importance of HCPs' proactive action to detect and alleviate PND symptoms, as their attitude towards PND may influence Women's help-seeking behaviour. For that reason, training HCPs to assess and recognise PND may help identify women at risk of developing PND and may find it challenging to obtain assistance and support [48]. It was remarkable that variations exist in coping strategies across women from various cultural backgrounds in Malaysia. Given that the religious approaches were reported as effective by the Malay women, it is worth including religious activities in their healthcare plan. As reported by the women in this study, there is also a need for counselling, extended health education session, and a nurse-led support group intervention. These proposed interventions were found to be particularly helpful to women, as they do not only provide support but also contribute to Women's empowerment through awareness of postnatal care and PND management [49]. While further research is needed to test the effectiveness of these interventions, there is no doubt that HCPs should be able to not only recognise the Women's emotional needs but also to manage PND despite the limited resources they had within their healthcare practice.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The permission to conduct this study was approved by the School Research Ethics Committee (SREC 14/15)(Paper No 8), University of Stirling, United Kingdom and the Ethics Committee of Malaysian Medical Research (MREC), Malaysia (NMRR-14-598-20853).

HUMAN AND ANIMAL RIGHTS

No animals were used in this research. All human research procedures followed were in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013.

CONSENT FOR PUBLICATION

All participants were informed that their participation was voluntary and that refusing to participate or withdrawing from the study would not affect their care in any way.

AVAILABILITY OF DATA AND MATERIALS

The data sets used during the current study can be provided from the corresponding author [N.A], upon reasonable request.

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CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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REFERENCES

[1] Arifin SRM, Cheyne H, Maxwell M. Review of the prevalence of postnatal depression across cultures. AIMS Public Health 2018; 5(3): 260-95. [http://dx.doi.org/10.3934/publichealth.2018.3.260] [PMID: 30280116]

[2] Payne JL, Maguire J. Pathophysiological mechanisms implicated in postpartum depression. Front Neuroendocrinol 2019; 52: 165-80. [http://dx.doi.org/10.1016/j.yfrne.2018.12.001] [PMID: 30552910]

[3] Yang R, Zhang B, Chen T, Zhang S, Chen L. Postpartum estrogen withdrawal impairs GABAergic inhibition and LTD induction in basolateral amygdala complex via down-regulation of GPR30. Eur Neuropsychopharmacol 2017; 27(8): 759-72. [http://dx.doi.org/10.1016/j.euroneuro.2017.05.010] [PMID: 28619359]

[4] Mughal S, Siddiqui W. Postpartum Depression Stat Pearls. Treasure Island, FL: StatPearls Publishing 2019.

[5] Scottish Intercollegiate Guidelines Network. Management of perinatal mood disorders: a national clinical guideline SIGN guideline, No 127. Edinburgh: Scottish Intercollegiate Guidelines Network 2012.

[6] National Institute of Mental Health. Depression. Bethesda: U.S. Department of Health and Human ServicesNational Institutes of Health 2013.

[7] Netsi E, Pearson RM, Murray L, Cooper P, Craske MG, Stein A. Association of persistent and severe postnatal depression with child outcomes. JAMA Psychiatry 2018; 75(3): 247-53. [http://dx.doi.org/10.1001/jamapsychiatry.2017.4363] [PMID: 29387878]

[8] Prenoveau JM, Craske MG, West V, *et al.* Maternal postnatal depression and anxiety and their association with child emotional negativity and behavior problems at two years. Dev Psychol 2017; 53(1): 50-62. [http://dx.doi.org/10.1037/dev0000221] [PMID: 28026191]

[9] Baldisserotto ML, Theme MM, Gomez LY, Reis TBQ. Barriers to seeking and accepting treatment for perinatal depression: a qualitative study in Rio de Janeiro, Brazil. Community Ment Health J 2019. [http://dx.doi.org/10.1007/s10597-019-00450-4] [PMID: 31512080]

[10] Silva S, Canavarro MC, Fonseca A. Why women do not seek professional help for anxiety and depression symptoms during pregnancy or throughout the postpartum period? Barriers and facilitators of the help-seeking process the psychologist. Psychol: Pract Res J 2018; 1(1): 46-58. [http://dx.doi.org/10.33525/pprj.v1i1.17]

[11] Ta Park VM, Goyal D, Suen J, Win N, Tsoh JY. Chinese American Women's Experiences with Postpartum Depressive Symptoms and Mental Health Help-Seeking Behaviors. MCN Am J Matern Child Nurs 2019; 44(3): 144-9. [http://dx.doi.org/10.1097/NMC.0000000000000518] [PMID: 31033585]

[12] Arifin SRM, Cheyne H, Maxwell M. Cross-cultural experience of maternal postnatal depression. Int J Psychosoc Rehabil 2020; 24(3) [http://dx.doi.org/10.37200/IJPR/V24I2/PR200817]

[13] Schmied V, Black E, Naidoo N, Dahlen HG, Liamputtong P. Migrant Women's experiences, meanings and ways of dealing with postnatal depression: A meta-ethnographic study. PLoS One 2017; 12(3): e0172385. [http://dx.doi.org/10.1371/journal.pone.0172385] [PMID: 28296887]

[14] Wittkowski A, Patel S, Fox JR. The Experience of Postnatal Depression in Immigrant Mothers Living in Western Countries: A Meta-Synthesis. Clin Psychol Psychother 2017; 24(2): 411-27. [http://dx.doi.org/10.1002/cpp.2010] [PMID: 26987569]

[15] Clement S, Schauman O, Graham T, *et al.* What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychol Med 2015; 45(1): 11-27. [http://dx.doi.org/10.1017/S0033291714000129] [PMID: 24569086]

[16] Edhborg M, Nasreen HE, Kabir ZN. "I can't stop worrying about everything"—experiences of rural Bangladeshi women during the first postpartum months. Int J Qual Stud Health Well-being 2015; 10(1): 26226. [http://dx.doi.org/10.3402/qhw.v10.26226] [PMID: 25595913]

[17] Shafiei T, Small R, McLachlan H. Immigrant Afghan Women's emotional well-being after birth and use of health services in Melbourne, Australia. Midwifery 2015; 31(7): 671-7. [http://dx.doi.org/10.1016/j.midw.2015.03.011] [PMID: 25912509]

[18] William B, Healy D. Perceptions of illness causation among new referrals to a community mental health team: "explanatory model" or "exploratory map"? Soc Sci Med 2001; 53(4): 465-76. [http://dx.doi.org/10.1016/S0277-9536(00)00349-X] [PMID: 11459397]

[19] Leventhal H, Meyer D, Nerenz D. The common sense representation of illness danger. Media Psychol 1980; 2: 7-30.

[20] Ajzen I. From intentions to actions: a theory of planned behaviour Action control. Springer 1985; pp. 11-39.

[21] Ajzen I. The theory of planned behaviour. Organ Behav Hum Decis Process 1991; 50(2): 179-211. [http://dx.doi.org/10.1016/0749-5978(91)90020-T]

[22] Williams B. Understanding medicine taking: models and explanationsPatient-Centred Prescribing Seeking Concordance In Practice, United Kingdom: Radcliffe publishing LTD 2007; pp. 44-62.

[23] Fishbein M, Ajzen I. Belief, Attitude, intention, and Behaviour: an introduction to theory and Research. Reading, MA: Addison-Wesley 1975.

[24] Arifin SRM, Cheyne H, Maxwell M. The context of postnatal depression in Malaysia: an overview. Mal J Nurs 2018; 10(1): 57-65. [http://dx.doi.org/10.31674/mjn.2018.v10i01.008]

[25] Khader FR. The Malaysian experience in developing national identity, multicultural tolerance and understanding through teaching curricula: Lessons learned and possible applications in the Jordanian context. Int J Humanit Soc Sci 2012; 2(1): 270-88.

[26] The Malaysian administrative modernization and management planning unit Obtaining Facilities, Welfare & Health Care. 2019.

[27] BabyCenter. Indian Confinement Practices. 2014.

[28] Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry 1987; 150: 782-6. [http://dx.doi.org/10.1192/bjp.150.6.782] [PMID: 3651732]

[29] Mitchell AJ, Yadegarfar M, Gill J, Stubbs B. Case finding and screening clinical utility of the Patient Health Questionnaire (PHQ-9 and PHQ-2) for depression in primary care: a diagnostic meta-analysis of 40 studies. BJPsych Open 2016; 2(2): 127-38. [http://dx.doi.org/10.1192/bjpo.bp.115.001685] [PMID: 27703765]

[30] Arifin SRM. Ethical Considerations in Qualitative Study. Int J Care Scholars 2018; 1(2): 30-3.

[31] Cacciola E, Psouni E. Insecure attachment and other help-seeking barriers among women depressed postpartum. Int J Environ Res Public Health 2020; 17(11): 3887. [http://dx.doi.org/10.3390/ijerph17113887] [PMID: 32486285]

[32] Bell E, Andrew G, Di Pietro N, Chudley AE, Reynolds JN, Racine E. It's a shame! stigma against fetal alcohol spectrum disorder: examining the ethical implications for public health practices and policies. Public Health Ethics 2016; 9(1): 65-77. [http://dx.doi.org/10.1093/phe/phv012]

[33] Newman TC, Hirst J, Darwin Z. What enables or prevents women with depressive symptoms seeking help in the postnatal period? Br J Midwifery 2019; 27(4): 219-27. [http://dx.doi.org/10.12968/bjom.2019.27.4.219]

[34] Williams B, Coyle J, Healy D. The meaning of patient satisfaction: an explanation of high reported levels. Soc Sci Med 1998; 47(9): 1351-9. [http://dx.doi.org/10.1016/S0277-9536(98)00213-5] [PMID: 9783878]

[35] Ng CG. A review of depression research in malaysia. Med J Malaysia 2014; 69(Suppl. A): 42-5. [PMID: 25417950]

[36] Arifin SRM, Cheyne H, Maxwell M. The context of postnatal depression in Malaysia: an overview. Malays J Nutr 2018; 10(1): 57-65.

[37] Azale T, Fekadu A, Medhin G, Hanlon C. Coping strategies of women with postpartum depression symptoms in rural Ethiopia: a cross-sectional community study. BMC Psychiatry 2018; 18(1): 41. [http://dx.doi.org/10.1186/s12888-018-1624-z] [PMID: 29422037]

[38] Rahnama P, Javidan AN, Saberi H, *et al.* Does religious coping and spirituality have a moderating role on depression and anxiety in patients with spinal cord injury? A study from Iran. Spinal Cord 2015; 53(12): 870-4. [http://dx.doi.org/10.1038/sc.2015.102] [PMID: 26123206]

[39] Kasi PM, Naqvi HA, Afghan AK, *et al.* Coping styles in patients with anxiety and depression. ISRN Psychiatry 2012; 2012: 128672.

[http://dx.doi.org/10.5402/2012/128672] [PMID: 23738194]

[40] Kapsou M, Panayiotou G, Kokkinos CM, Demetriou AG. Dimensionality of coping: an empirical contribution to the construct validation of the brief-COPE with a Greek-speaking sample. J Health Psychol 2010; 15(2): 215-29. [http://dx.doi.org/10.1177/1359105309346516] [PMID: 20207665]

[41] Mann JR, McKeown RE, Bacon J, Vesselinov R, Bush F. Religiosity, spirituality and antenatal anxiety in Southern U.S. women. Arch Women Ment Health 2008; 11(1): 19-26. [http://dx.doi.org/10.1007/s00737-008-0218-z] [PMID: 18278428]

[42] Bonelli R, Dew RE, Koenig HG, Rosmarin DH, Vasegh S. Religious and spiritual factors in depression: review and integration of the research. Depress Res Treat 2012; 2012: 962860. [http://dx.doi.org/10.1155/2012/962860] [PMID: 22928096]

[43] Berk LS, Bellinger DL, Koenig HG, *et al.* Effects of religious vs. conventional cognitive-behavioural therapy on inflammatory markers and stress hormones in major depression and chronic medical illness: A randomized clinical trial. Open J Psychiatr 2015; 5(3): 238-59. [http://dx.doi.org/10.4236/ojpsych.2015.53028]

[44] Pearce MJ, Koenig HG, Robins CJ, *et al.* Religiously integrated cognitive behavioral therapy: a new method of treatment for major depression in patients with chronic medical illness. Psychotherapy (Chic) 2015; 52(1): 56-66. [http://dx.doi.org/10.1037/a0036448] [PMID: 25365155]

[45] Edhborg M, Nasreen HE, Kabir ZN. "I can't stop worrying about everything" experiences of rural Bangladeshi women during the first postpartum months. Int J Qual Stud Health Well-being 2015; 10: 26226. [http://dx.doi.org/10.3402/qhw.v10.26226] [PMID: 25595913]

[46] Arifin SRM, Cheyne H, Maxwell M. Conceptualisation of postnatal depression in Malaysia: The contribution of critical realism in exploring the understanding of Women's and healthcare practitioners' perspectives, Opción. Año 2020; 36(26): 1918-39.

[47] Cossu G, Preti Carta MG. Treatment of mental health problems in refugees and asylum seekers. Oxford textbook of Public Mental Health 2018; pp. 7-47.

[48] Dunford E, Granger C. Maternal guilt and shame: Relationship to postnatal depression and attitudes towards help-seeking. J Child Fam Stud 2017; 26(6): 1692-701. [http://dx.doi.org/10.1007/s10826-017-0690-z]

[49] Scope A, Booth A, Morrell CJ, Sutcliffe P, Cantrell A. Perceptions and experiences of interventions to prevent postnatal depression. A systematic review and qualitative evidence synthesis. J Affect Disord 2017; 210: 100-10. [http://dx.doi.org/10.1016/j.jad.2016.12.017] [PMID: 28024220]