ORIGINAL ARTICLE

Coping Strategies and Help Seeking Behavior among Women with Symptoms Of Postpartum Depression in Selangor

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ABSTRACT

Introduction: Most women with postpartum depression (PPD) remain undiagnosed and untreated, despite the adverse effects known to be felt by women and children. The aim of this study was to examine the coping strategies and help seeking behavior used by women having symptoms of postpartum depression. **Methods:** Using a mixed-method study design, the researcher used the Edinburgh Postnatal Depression Scale (EPDS), Brief COPE and General Help Seeking Behavior (GHSQ) inventories for the quantitative approach, while the qualitative approach was conducted by a semi-structured interview based on the topics listed. A total of 30 respondents participated in the quantitative study while seven respondents were chosen for the qualitative study. **Results:** Data analyses identified coping strategies with domains of emotion-focused and religion-focused subscales as the main coping styles, while help seeking behavior identified that families were the main groups of people that were sought by them. **Conclusion:** Women with symptoms of postpartum depression tended to cope with their mental health issues by strengthening their spiritual bonds and with help and support from their family members.

Keywords: Postpartum depression, emotion-focused coping, religious coping, help seeking, mental health.

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INTRODUCTION

The postpartum phase is an important phase as it involves the transition of life, which involves not only the new mothers, but also their spouses and family members. This transition process requires good adaptation skills for new routines and roles, in addition to other aspects such as social support and physical well-being. Needs that are not properly met will gradually lead to a more serious condition, called postpartum depression. Postpartum depression is a term applied to the depressive periods that may occur after childbirth until one year after delivery (1,2).

Postpartum depression could be contributed to by few aspects, including physiological, psychological and sociocultural factors (3). Sudden hormonal changes can contribute to maternal emotional instability after childbirth (4,5). In addition, poor health can also increase the risk of new mothers facing depression. Meanwhile, psychological factors can include stressful life events, a history of postpartum depression and problematic relationships with spouses (6,7). Stress from the family circle and acquaintances, inappropriate cultural practices during confinement (3) as well as inefficient care during confinement are the sociocultural factors that can lead to the occurrence of postpartum depression. Emotional disorders during postpartum periods are mainly categorized into three classes, namely the postpartum blues, non-psychotic postpartum depression and psychotic postpartum depression (8). The postpartum blues are the condition of increased emotional reaction and are experienced by about 60% to 80% of women who have just given birth (9). Starting from three to five days after birth, this condition is contributed to by several factors, such as adaptation to the breastfeeding process, and can last up to two weeks (10). On the other hand, non-psychotic postpartum depression is a condition with symptoms that occur for more than two weeks. Symptoms may include anhedonia, disorders in sleep and eating, exhaustion, erratic focus, as well as suicidal thoughts (11). With this condition, there are thoughts among these mothers to endanger themselves or their own children. Postpartum depression involves the presence of delusions, hallucinations, paranoia and disorganized thought process and occurs within six weeks after birth (12). With more severe symptoms than non-psychotic postpartum depression, mothers who are experiencing this phase may be at risk of hurting their baby. At this stage, there is significant risk of suicide and also infanticide (13,14). Therefore, it is important for mothers that experience irregular emotional changes during postpartum to have good and appropriate coping

mechanisms in order to avoid negative impacts towards themselves, their babies and other family members.

Coping strategies are used when an individual deals with stressful circumstances that are demanding, challenging, threatening and/or have a potential for harm or loss and involve cognitive and behavioral processes (15,16). Each individual has their own way of coping in order to manage life issues. The differences in these coping styles are caused by the diverse personalities between one individual and another. Efficient coping styles can help mothers to recover from a challenging phase and move on without stress (17). However, in order to improve, it is difficult for mothers to act on their own without the help of those around them. Coping alone does not ensure a good psychological adjustment towards a new role in life (18). Thus, having a trusted group of people for them to seek help from is important and these people can significantly help them to recover.

Consequently, another aspect that would help mothers to progressively heal is the ability and courage to ask for help. Help seeking behavior was defined as the act taken in order to fulfill one's need to be healed or cured (19). It involves communication with others to get help in terms of understanding, advice, information, treatment and/or general support in response to stressful problems or experiences (20). Previous reports stated that numbers of factors have influenced mothers from helping themselves to recover from the symptoms of postpartum depression (21,22,23). Sociodemographic factors such as economic status or birth experience, perceived severity, perceived susceptibility, perceived barriers like poor healthcare system or social stigma and perceived threat contributed to the actions taken by mothers, either to ask for assistance or not (24). In most cases, mothers tend to shut down their emotional pain as they thought they are just too fragile, or nobody will understand them. So, it is important to have adequate knowledge on postpartum matter, along with mutual understanding, tolerance and assistance between mothers and their partners or families.

Emotional issues that were tackled early on with appropriate coping strategies and significant support helped mothers to navigate through the postpartum phase better. Lack of prevention or treatment will not only affect the mothers, but also might cause emotional and psychological deficit to their children as well. In view of this issue, this study aimed to examine the coping strategies and help seeking behavior of mothers with symptoms of postpartum depression in order to understand them better during the postpartum phase.

MATERIALS AND METHODS

Study Design and Samples

This study was conducted between December 2019 and April 2020 around the district of Selangor, Malaysia. This is a mixed-method study, applying convergent parallel designs that run both data collections together. Both data sets were analyzed separately, before the analysis of the results were interpreted in parallel. Quantitative data was collected using a set of questionnaires, while qualitative data was collected by semi-structured interviews. Sampling for quantitative data was calculated as below to determine the sample size (25).

$$n=\frac{z^2_{1-a/2}P(1-P)}{d^2}$$

p = Expected proportion in population based on previous studies or pilot studies
d = Absolute error or precision that was decided by the researcher.

(The value of p was obtained from Doucet & Letourneau, 2009.)

$$n=\frac{1.645\ (0.4(1-0.4))}{0.15^2}$$

= 29
= 30 (rounded)

Based on the calculation above, the sample size for quantitative data was 29 respondents that was rounded up to 30. Meanwhile, the qualitative sample were recruited from the quantitative pool. The information received was then sorted and categorized into suitable and related themes. Sampling was achieved by two methods, purposive sampling and snowball sampling. Respondents were recruited via social media and existing networks for the quantitative survey. The respondents were asked to leave their contact details upon agreement to participate in a follow up interview (qualitative phase). Inclusion criteria for sampling were mothers between the ages of 20 and 40 years old living and working around Selangor and who had experienced emotional issues such as feeling worthless, hopelessness, and irritable after the childbirth. This study is exempted from ethics approval as the study is derived from an undergraduate level of study. It is not compulsory for the undergraduate students to apply research ethics here at the faculty. However, prior to data collection, the supervisor had done a thorough review for the whole process of this research.

Instrument

This study used a set of validated self-administered questionnaires. The survey form was divided into four sections, demography, Edinburgh Postnatal Depression Scale (EPDS), Brief COPE (Coping Orientation to Problems Experienced) and General Help Seeking Behavior (GHSQ). The demography form included questions about age, ethnicity, relationship status, education level, career and household income as well as questions on delivery history.

The EPDS inventory is a self-report tool containing ten

items was developed (26) to determine postpartum depression through self-diagnosis. This inventory has been widely used around the world, including translated versions in various languages. The Bahasa Melayu translation (27) was tested with good validity (Cronbach's alpha, 0.86) and reliability (split half = 0.83). The score was calculated by summing up the scale marked by the respondents, with item 10, which asked about suicidal thoughts, given deeper attention. Next, COPE is designed to evaluate the differences in coping strategies taken by each individual. This test tool was simplified to 28 (28) from the original COPE test tool (29). COPE categorized the items into 14 subscales, with two questions for each scale. The reliability Cronbach alpha version of the Malay language translation is 0.83 (30). This inventory was analyzed by calculating the total mean score by each domain, and further by the mean score of each subscale. The last instrument used was GHSQ, a simple inventory that divides items into two parts, namely stressful life and suicidal thoughts. Through this inventory, respondents were asked to number on a scale a list of trusted groups to assist them if they were faced with the two situations above. The tendency of help seeking towards particular groups was determined by the computed mean score.

RESULTS

Quantitative Data

Based on Table I, the majority of respondents (43.3%) were aged 36–40 years and almost all respondents were Malay and Muslims (96.7%). Only one respondent (3.3%) was a single mother. Most of the respondents had education up to bachelor degree level (40%), while respondents with masters degrees and above shared the same percentage with respondents with education below Malaysian Certificate of Education (SPM) (13.3%). For career status, the majority of the respondents were working mothers, with a total of 8 (26.7%) respondents who were not working. Household income was recorded in the range RM4 000–RM10 000 and the range RM1 050–RM3 999 was the highest frequency (40%), representing the B40 (bottom tier income earners) and M40 (medium tier income earners) groups as the majority income values.

As shown in Table II, most of the respondents had 2 or 3 children (46.7%), with the highest frequency of symptoms appearing with the first child (46.7%). Table II also shows the high frequency of 21 (70%) women who experienced the occurrence of symptoms in the first month after birth, synonymous with during the confinement phase. Only one person recorded the presence of symptoms when the child was 6 months old, and two other respondents stated uncertainty about the duration of the symptoms.

Based on Table III, the emotion-focused coping recorded a mean of 26.20 with a standard deviation of 7.17 for the five domains, which each recorded almost equal mean values, except for the humor domain and the religion domain. The humor domain (mean = 3.37)

Table I: Respondents Demography Data

	Frequency	Percentage (%)
Age (years)		
Below 20	0	0
20–29 (mean 24.5)	10	33.3
30–35 (mean 32.5)	7	23.3
36–40 (mean 38)	13	43.3
Race		
Malay	29	96.7
Indian	1	3.3
Religion		
Islam	29	96.7
Hindu	1	3.3
Relationship status		
Married	29	96.7
Not Married	0	0
Single Mother	1	3.3
Education level		
Masters and above	4	13.3
Degree	12	40.0
Pre-university	10	33.3
SPM and below	4	13.3
Career		
Working	22	73.3
Not Working	8	26.7
Household income		
Above RM 10 000	4	13.3
RM4 000–RM10 000	12	40.0
RM1 050–RM3 999	12	40.0
Below RM1 050	2	6.7

Table II: Childbirth and depressive symptoms data

	Frequency	Percentage (%)
Number of children		
1	7	23.3
2–3	14	46.7
4–5	7	23.3
More than 5	2	6.7
Symptoms occurred on (?) child		
1	14	46.7
2	7	23.3
3	7	23.3
4	1	3.3
5	1	3.3
Period of occurrence (after delivery)		
Below 4 weeks	21	70
5–8 weeks	6	20.1
20–24 weeks	1	3.3
Not sure	2	6.6

Table III: Mean Score of *Brief COPE*

Mean (sd)		Mean	
Emotion-focused coping	26.20 (7.17)	C.Positive	5.73
		C.Emotion	5.43
		C.Humor	3.37
		C.Accep-tance	5.43
		C.Religion	6.23
Problem-focused coping	16.60 (4.33)	C.Informa-tion	5.43
		C.Active	5.47
		C.Planning	5.70
Dysfunction coping	23.10 (4.35)	C.Substance	2.10
		C.Behavior	3.10
		C.Denial	3.47
		C.Venting	4.90
		C.Distract	5.57
		C.Self blame	3.97

was evaluated with the items "I've been making jokes about it" and "I've been making fun of the situation". The religion domain was evaluated with the items "I've been trying to find comfort in my religion or spiritual belief" and "I've been praying or meditating". The problem-focusing coping recorded an average value of more than 5 for the three domains belonging to the category, making a mean value of 16.60 (sd = 4.33). Dysfunction coping (mean = 23.10, sd = 4.35) for six domains recorded mean values with a relatively wide range. The substance use domain recorded the lowest overall (mean = 2.10), while the self-distraction domain recorded the highest mean for dysfunction coping (mean = 5.57).

Based on Table IV, it is clear that mothers who experience depressive symptoms are more likely to trust groups of people that are close to them, such as intimate partners and close family members compared to those with related expertise such as mental health specialists or doctors. Spouses recorded the highest mean scores (5.40) and (5.27) for both types of situations. Other groups that were close to the respondents, namely friends, parents and relatives or family recorded almost equal mean values.

Table IV: Mean Score for *GHSQ*

Group of People	Emotional Conflict (min)	Suicidal Thoughts (min)
Partner	5.40	5.27
Friends	4.60	4.13
Parents	4.90	4.46
Relatives/Family members	4.47	4.07
Mental health professionals	3.63	3.90
Hotline	2.43	2.70
Doctors	3.23	3.77
Religious leaders/scholar	3.00	3.53
Do not seek help	2.07	1.83
Other groups	1.60	1.53

Apart from the help of experts, it was also found that the hotline approach was not favorable among respondents for seeking help during the depressive symptom phase. On the other hand, although referring to other groups of people had a low mean value, there were some respondents who named groups that they referred used other than those listed in the inventory. The groups for assistance listed by the respondents a Syarie' lawyer, instrumental assistance such as watching videos or reading books and spiritual help by praying to God. This group or type of aid is listed as an additional alternative to the existing list in the inventory.

Qualitative Data

Coping Strategies

A total of seven informants were involved in the qualitative data collection process. All respondents were from the Malay ethnicity group, Islam practitioners and resident in Selangor. The analysis found that emotion-focused coping was the main action taken by the informants in managing their emotions, followed by problem-focused coping. For emotion-focused coping, mothers choose to gain emotional support through (i) strengthening divine value and (ii) storytelling, sharing and expressing. While through problem-focused coping, mothers shared their tendency to (i) increase their knowledge and information.

(i) Strengthening divine values

Spiritual aspects helped them a lot in staying composed while handling their unstable emotions. The belief of the existence of God who will always help them became a source of strength when they began to feel affected by those symptoms.

"*… Non-stop prayers to Allah. Because once you realize you have lost your sense, a sense of danger, you have to go back to Allah as fast as possible. If not, I'll lose myself. That is why the pillar of religion is the most important, if you lose your composure, you could return quickly to God. We won't feel alone, we trust that we have God. Allah is with us. "* (Informant 5)

Dependence on Allah in dealing with these symptoms was supported by other respondents who said:

"*I quickly istighfar, it's like, I don't know how I came to my senses, suddenly comes the feeling of guilty." ... "I tried (to control), like us Muslims, we read the Al-Quran, pray, du'a, asked Allah to strengthen me and all that.*" (Informant 6)

"*Maybe when thinks about Allah... we will think not to commit suicide because our religion forbids it. That's it for me to survive… Holding on to Allah but sometimes I do blame Allah for putting me in this situation. But when I sleep and woke up again... I seek forgiveness for thinking like that. "* (Informant 7)

According to the respondents, the practice of religious rituals or worship such as dhikr and istighfar shielded against doing things unexpectedly. In fact, one respondent stated that if her religious beliefs were not strong enough, she might really lose herself during the period of depressive symptoms.

(ii) Storytelling, sharing and expressing
In addition to the spiritual aspect, respondents also stated that sharing problems by sharing stories with people they trusted was frequently practiced to cope with the symptoms of postpartum depression. Four out of seven informants stated that storytelling helped them to clear away things that were on their minds, as stated by the first informant:
"*Usually with my husband. Even with my mother-in-law, I would diligently talk to her. My mother-in-law is okay. So, I just talk. I'm used to talking with my friends, good friends. First I share with my husband, then with my good friends. So, when everything is okay, laugh it off.*"

For other informants, sharing showed that the people around them were concerned about the condition they were experiencing. Especially for the 3rd respondent, even though her friends tried not to hurt her more by asking any question, she thought it was sadder when nobody asked about her condition. According to the 3rd informant:
"*Talk about this. (Often) with my husband. I'm more frustrated if people don't ask anything, pretending not knowing. I'm okay, I can talk about this.*"

Informants clearly describe that, through sharing and expressing, they could remove the feeling of burden that was lingering in their hearts. In this way, they did not feel trapped by their own feelings, but at the same time were able to get through the difficult phase. Some respondents also stated that talking about the emotions they were experiencing was the best way to keep themselves from being overwhelmed by the symptoms of postpartum depression.

(i) Increase knowledge and information
3 out of 7 informants stated that through the searching of knowledge, they are able to cope well. According to them, this problem-focused coping is done through reading relevant sources or watching informational videos to provide more insights to them about the situation they were experiencing.

According to the 3rd informant:
"*Yes it (reading) was very helpful. I did read a lot on that (maternal information), I also searched on what to do after childbirth, and mostly said that after giving birth, don't be alone, talk (with others), don't supress (emotion), and then don't be carried away by the emotion.*"

This statement is further supported by the 5th and 6th informant:
"*When I read it was like "Oh I'm experiencing this thing" so I realize that I am in that situation. I don't talk to other people, so when I read, read other people's blogs who share their experiences, I feel that I'm not alone. When I read that, "Oh there are other people who are worse, I'm just ok, not so bad" "Alhamdulillah I (experienced) just for a short time*" (Informant 5)

"*And I followed ig (instagram) 'Confinement Lady', (the page) talked about this issue, this PPD, when I read there, there are many more mothers who have worse experiences. (The page) was quite famous at that time. That's why I followed the page. And when I read it, oh, (there's people who experienced) worse. To the extent that they already held knife" ... "I kind of like to google the blogs of mothers whom, international blogs, read their experiences, how do I handle my child alone*"
(Informant 6)

For the informants, through the method of learning and increasing their knowledge, they gained new information on how to deal with their unstable emotions at during challenging moments. Through reading, especially exploring the experience of others, they are able to take precautions steps so that they will not lose their self-control during the symptom occurrence phase.

Help Seeking Towards Trusted People

(i) Provides of support
The majority of the respondents stated that their family was the first group of people that they referred to when dealing with emotional changes in daily life. In addition, close friends were also referred to as the closest group of trusted people by the respondents. The 5th informant stated:
"*So if there is anything, I will just look for friends or close family members. The people whom I used to share my stories. Because if to share with new people, it is difficult for me to tell the story from the start. So, friends, family members already know the issues and understands.*"

This is further supported by the 2nd informant:
"*… Like me, I'm staying in the same house with my cousin, so I talk with my cousin. My cousin is also a good listener. So, it helps me to reduce my stress. Sometimes I do call my mom, because my mom stays far from me. [So I'll] call my mom, and she'll be there to support…*"

Support from trusted groups not only applied the aspect of listening and giving empathy but also the aspect of helpful assistance such as childcare and performing household chores. For informants who also had other children, support from their children also provided strength for them to go through that phase. They added that having a very strong support from family members

was one of the things that they highly appreciated in their lives, as mention by informant 3:
They (children) did a lot distract me, tell stories about other things, talk with me. So it's kind of great, Alhamdulillah. (That's why) I think family support is important. If I don't have my family support, the result might be different. I received great family support, as well as my friends support"

For them, having a very strong support from family is a blessing that they are most grateful of. With the support, mothers knew they are not alone, and the group of people they trust, trusted the them back that they will be healed.

Mixed Data Interpretation
Both the quantitative and qualitative data clearly showed the tendency of mothers to apply emotion-focused coping while dealing with depressive symptoms. With the spiritual subscale as the most dominant subscale, both data sets expressed that mothers favored spiritual practice to strengthen themselves when they were dealing with emotional issues. On the other hand, problem-focused coping is also practiced by mothers through reading and expanding knowledge, but not as often as emotion-focused-coping.

Meanwhile, help seeking behavior also recorded a consistent pattern in both the qualitative and quantitative data. Respondents and informants trusted the people in their circle the most and believed these people were more reliable in assisting them in the postpartum depression phase. Partners and parents in particular became the most important people to them and the ultimate support for them, leading to a better life. This is because of the high value of trust towards these particular groups, especially parents, for example, who have been with them since their childhood. In addition, friends and other family members were also named as the people they trusted and referred to when they were experiencing emotional instability. Nonetheless, both data findings showed a low value of trust towards other groups of people, including health professionals. These findings are a serious concern, as the women might not get the proper help from their trusted groups if they do not really have sufficient knowledge of postpartum depression.

DISCUSSION

Both the quantitative and qualitative findings of this study emphasized that emotion-focused coping was the main coping strategy practiced by mothers with postpartum depression symptoms. This finding is in line with previous finding (31) which mothers preferred emotion-focused coping over problem-focused coping. Emotion-focused coping was more effective in anticipating suicidal thoughts too, as well as acting as a shield against postpartum depressed women thinking about suicide (32). Emotion-focused coping helped mothers to sort out the feelings that lingered with them, and emotion-focused coping encouraged mothers to be more vocal about their condition. The worries that were voiced enabled not only mothers but also the people around them to be aware of their emotional instability.
Narrowing it down, the results showed that the spiritual subscale was the main subscale in the domain of emotion-focused coping. Looking from the perspective of Islam, as in this study the majority were believers, the findings of this study were in line with previous findings that examined the spiritual dependence of Muslims during stressful events (33,34). Spiritual coping styles were practiced by Muslims who faced emotional stress as, for them, religious beliefs gave more hope and encouraged self-resilience. Religious beliefs were also found to have helped mental health patients to understand the hassle they experienced as well as looking at the therapeutic approach in parallel with the Islamic principles approach (35).

Religious rituals, such as praying five times a day, helped people with mental health issues to spend more time practicing their spiritual beliefs, which eventually lessens their time for other things. Moreover, the positive element of religious coping is not only for Muslims, but practitioners of other religions too (36,37,38). Emotion-focused coping was significantly related to religious practices as it provided a space for the believers to understand the meaning and purpose of the difficult phase that they were going through. Religious practices strengthened their relationship with God, with the belief that there was greater meaning to the hard times they were experiencing, and the feeling of being connected with other individuals (39). Spiritual values helped people to look around them with a positive perspective and hope, as well as contributed to internal strength that was expressed through prayers and other routines. Unlike other coping styles, spiritual practices could be carried out at any time and in any situation.

On the other hand, emotion-focused coping was also contributed by the subscale of emotional support through storytelling and the sharing of feelings. This finding was similar to a previous study (40) that found that the treatment desired by mothers who go through postpartum depression was to talk about their feelings, also referred to as 'talk therapy'. Having someone to talk to or talk therapy with a health professional were stated as the most favorable treatments. Talking to a group with the same experiences, such as their own mothers, relatives or friends who already have children is also one way of emotion-focused coping within the subscale of emotional support. Mothers sought their friends' opinions about their condition, and they chose to talk to their acquaintances to feel 'normal' (41). The sense of belonging to a group helped them to accept their condition without feeling different from other individuals. Mothers with symptoms of postpartum depression

need space to express their feelings (42) without being judged in a prejudiced way, and to be accepted by the individuals around them unconditionally.

In seeking help to treat their condition, findings showed that women with depressive symptoms were likely to seek support from groups of people that were close to them. Seeking assistance from primary groups; partners, parents, and families, are factors contributed by the culture in the society that usually preserve strong family bonds. This finding is in parallel with previous studies (40,43,44,45), in which mothers expected support to help them through the depressive phase, especially from their partner who was considered the primary source of support. For married women, their partners were considered the backbone of their daily lives. A good marital relationship could help in handling their instability of emotions as they believed that their partners were reliable enough for them to ask for help. The expected support was not only for the emotional aspects, but also in terms of physical assistance (42,46), such as acting as a motivator and facilitator by actively engaging in feeding, changing their baby's diapers, and helping with household chores. Lack of involvement or assistance by their partners made them feel as if they were a single mother without a complete family (47). With the help of their partners, mothers could have a good rest physically and emotionally.

The tendency of seeking help from family members was in parallel with previous studies (48,49). The findings presented that mothers were more comfortable asking for help from family members, especially their biological mothers and mothers-in-law (54). This behavior of help seeking was driven by a sense of comfort and trust towards the group that was very close to them. Family support was very important to support their emotions when episodes of depressive symptoms occurred (50). For single mothers, it is challenging to go through the postpartum phase without the presence of a husband, so they received more support from parents and friends than married women. This was due to the effort put in by these groups in filling the emptiness of the role, in order to support single mothers going through the postpartum phase (51).

Meanwhile, the results stated that women with emotional and mental health issues showed reluctance in seeking help from health professionals. These low findings are in line with previous findings (40,47) where some mothers reported their frustration when seeking support at a baby care clinic. Experts tried to normalize the emotions experienced by these mothers (52), but did not provide appropriate support, making the mothers feel they were misunderstood. Furthermore, the tendency to seek help was low due to the level of trust between the mothers and the healthcare professionals and how the helps offered is significant for the mother to seek treatment (53). Low dependence on health professionals can also be due to personal factors involving comfort, attachment, and trust (55). Postpartum depression caused by personal affairs such as marital relationship or socio-economic status will discourage mothers to meet health experts as they want to protect individual and family image.

CONCLUSION

The objectives of this study which were to explore the experience of postpartum depression issue and the coping mechanism, as well as help-seeking behavior were achieved through the data collection. Regardless of the result portrayed, the data might not be able to help with the generalisation due to the small number of participants. The study utilized a non-probability sampling technique; therefore, findings are not generalisable. However, the results analysed can be used for future study of postpartum depression.
The result obtained has provided significant information on coping strategies and need of support among mothers with symptoms of postpartum depression. Mothers with depressive symptoms are likely to cope by focusing on handling their emotions with the help and endless support from their family members. Religious beliefs and rituals can be seen as a constructive coping strategy. In consequence, insufficient coping mechanisms and/or deficient emotional support can cause mothers to choose to isolate themselves, and thus worsen the occurrence of symptoms. Women who face depressive symptoms may choose not to express their feelings due to lack of support, social stigma, and lack of knowledge about their condition. Thus, it is important for future mothers, as well as their partners and family members, to be educated and aware of this issue as it would help in maintaining their mental health wellness after childbirth.

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