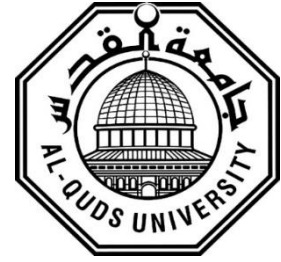


Deanship of Graduate Studies

Al-Quds University



**Lived experiences of women with postpartum depression
in the West Bank/Palestine: A descriptive Phenomenology**

Marah Mohammad Mousa Sabateen

M.Sc. Thesis

Jerusalem – Palestine

1446 / 2024

**Lived experiences of women with postpartum depression
in the West Bank/Palestine: A descriptive phenomenology**

Prepared by

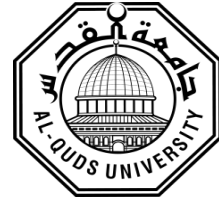
Marah Mohammad Mousa Sabateen

B.Sc. Midwifery, Al-Quds University - Palestine

Supervisor: Dr. Maha Nahal

**A thesis submitted in partial fulfilment of the requirements for
the Master's degree of Maternal Child Health Nursing Deanship
of Graduate Studies- Al-Quds University.**

1446 / 2024



Thesis Approval

Lived experiences of women with postpartum depression in the West Bank/Palestine: A descriptive phenomenology

Prepared by: Marah Mohammad Mousa Sabateen

Registration No: 22112426

Supervisor: Dr. Maha Nahal

Master thesis submitted and approved date: 16/12/2024

The names and signatures of the examining committee members are as follows:

1. Head of Committee: Dr. Maha Nahal
2. Internal examiner: Dr. Salam Elkhatib
3. External examiner: Dr. Aidah ElKaissi

Signature:

Signature:

Signature:

Jerusalem-Palestine

1446/2024

Dedication

To the most beautiful soul in my world, my eternal healer, Fatima

To all warriors of mental health who silently bear their struggles,

To those with no shoulder to lean on,

To mothers battling emotions beyond their control,

To children born from the womb of suffering,

To the soul of my beloved aunt, Fadwa,

To the seekers of freedom, our martyrs, whose sacrifices illuminate our path,

To myself—for every tear I shed, every time I stood back up and persevered,

To my family: my mother, father, brother, and sisters,

To my grandmother, Sitti Fatima, my eternal companion and guide,

To my friends, the healers of my soul: Marah, Hala, Walaa, and Dana,

To my friends enduring the darkness of imprisonment—you are deeply missed,

And finally, to Jerusalem, our steadfast university and everlasting capital.

Marah Mohammad Sabateen

Declaration

I certify that this thesis which is submitted for the degree of master is the result of my own research, except where otherwise acknowledged, and that this study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Name: Marah Mohammad Mousa Sabateen

Signature: 

Date: 16/12/2024

Acknowledgmentt

I would like to express my deepest gratitude to my thesis supervisor, **Dr. Maha Nahal**, for her unwavering support, continuous encouragement, and the trust she placed in me. I am profoundly grateful for her guidance, whether in her office or welcoming me into her home during my research journey. Her boundless patience, expertise, and nurturing approach were instrumental in completing this thesis.

I also wish to thank all the professors at the School of Nursing who guided me throughout my academic journey. Their wisdom and encouragement have been invaluable. My heartfelt thanks also go to the women who graciously participated in this research, trusting me with their stories and generously giving their time.

I am forever indebted to my family, my rock of spiritual support. To my mother, for her endless sacrifices and unwavering care, and to my father, for his warmth and those precious cups of coffee at Fajr prayer. Special thanks to my sisters—Malak, Noor, Yasmin, and Rua’a—for their constant advice and guidance, and to my brother, Mustafa, my twin in childhood and forever companion.

My gratitude extends to **Hala** and **Marah**, whose presence on this master’s journey was angelic. They truly embody the essence of support, kindness, and friendship. Finally, I am deeply thankful to my colleagues and everyone who contributed to the completion of this study. Your kindness and assistance will never be forgotten.

Marah Mohammad Sabateen

Abstract

Introduction: Postpartum depression (PPD) is a significant problem at the childbearing age, posing a critical challenge to global maternal health. Addressing PPD aligns with global strategies to improve maternal outcomes and reduce preventable morbidity and mortality. The high prevalence of PPD, which affects 10–15% of mothers annually, requires much effort to address such a problem with emphasis on psychosocial assessments during the postpartum period. In the Palestinian context, there is a notable gap in research exploring the experiences, needs, and emotions of women during this vulnerable time.

Aim: To explore the lived experiences of women with postpartum depression in the West Bank Palestine.

Methodology: A qualitative descriptive phenomenological design was used to explore the experiences of women who were previously diagnosed with postpartum depression after childbirth. A total of 12 women were recruited from mental health clinics affiliated with the Palestinian Ministry of Health. A semi-structured interview was used to collect the data from the participating women after giving verbal informed consent. The thematic analysis method was used to analyze the data. The sociodemographic characteristics of the participating women were analyzed by the Statistical Package for Social Sciences (SPSS 26). The study was conducted over 14 months, from June 2023 to December 2024.

Result: The lived experiences of women with postpartum depression were profoundly challenging and could be understood through four major themes and 12 subthemes. The first theme, Trapped in Negative Feelings, captures the emotional turmoil these women faced, including feeling trapped in negative emotions during pregnancy and childbirth, toward motherhood, their baby, and themselves. This pervasive negativity shaped their perception of their experiences and relationships.

The second theme, Insecurity with the Surroundings, highlights a deep sense of vulnerability and mistrust. This insecurity manifested within the family environment and extended to interactions with the healthcare system, where support was often perceived as inadequate.

The third theme, Trapped in Sociocultural Pressure, reflects the societal and cultural challenges these women endured. They faced cultural obstacles, gender-based discrimination, and socio-economic burdens, all of which compounded their struggles and reinforced feelings of isolation and helplessness.

The final theme, Self-Awareness, and Recognition, reveals a gradual journey toward understanding and managing their condition. Women began to recognize postpartum depression as an illness requiring treatment, developed strategies to cope with their symptoms and shifted their focus to self-care and personal needs.

Together, these themes paint a comprehensive picture of the emotional, social, and cultural complexities of postpartum depression, offering valuable insights into the experiences of affected women.

Conclusion: This study provided valuable insights into the lived experiences of women with postpartum depression. It highlights the emotional, psychological, and sociocultural challenges they faced. It explores the multifaceted nature of postpartum depression in the Palestinian context and its impact on women's struggles with negative emotions, insecurity, and societal pressures. These findings underscore the urgent need for early assessment of signs and symptoms of PPD by qualified healthcare providers to consider the culturally sensitive interventions, enhanced mental health awareness, and support systems to address the unique needs of women during the postpartum period. This study contributes to bridging the research gap in this area and calls for further exploration of this phenomenon to improve maternal mental health outcomes.

Keywords : Lived Experiences, Post-Partum Depression (PPD), Descriptive phenomenology.

Table of Contents

Declaration.....	I
Acknowledgmentt.....	II
Abstract.....	III
Table of Contents.....	V
List of Figures.....	VIII
List of Tables.....	IX
List of Annexes.....	X
List of Abbreviation.....	XI
Chapter One.....	1
1.1 Introduction.....	1
1.2 Background.....	1
1.3 Problem statement.....	3
1.4 Significant of the study.....	4
1.5 Aim of this study.....	5
1.6 Objectives.....	5
1.7 Research Questions.....	5
1.8 Definitions of Terms.....	5
Literature Review.....	6
2.1 introduction.....	6
2.2 Mechanisms of Postpartum Depression.....	6
2.3 Depression among Women.....	7
2.4 Symptoms of Postpartum Depression.....	8
2.5 Treatment of Postpartum Depression.....	8
2.6 Risk factors for PPD.....	9
2.7 Risk factors of Postpartum Depression among Arabian women.....	10
2.8 Postpartum Depression Consequences.....	11
2.9 Women's experience of Postpartum Depression.....	12
2.10 Summary.....	12
Chapter Three.....	14
Methodology.....	14
3.1 Introduction.....	14
3.2 Study Design.....	14

3.3 Target population.....	15
3.4 Context of the study.....	15
3.5 Sampling methodology.....	15
3.6 Sample size.....	16
3.7 Inclusion criteria.....	16
3.8 Exclusion criteria.....	16
3.9 Instrument of the study (semi -Structured Interview).....	17
3.10 Data Collection.....	18
3.11 Data Analysis.....	18
3.12 Phenomenology and Lived Experience.....	20
3.13 Ethical consideration.....	20
3.14 Rigor of the study.....	21
3.14.1 Credibility.....	21
3.14.2 Confirmability.....	21
3.14.3 Dependability.....	22
3.14.4 Transferability.....	22
3.14.5 Methodological Rigor.....	22
Chapter Four.....	23
Results.....	23
4.1 Introduction.....	23
4.3 Themes and subthemes of the women's experiences.....	25
4.3.1 Theme one: Trapped in negative feelings.....	25
4.3.2 Theme two Insecurity with the surroundings.....	29
4.3.3 Theme three: Trapped in the sociocultural pressure.....	33
4.3.4 Theme four: Self-awareness and Recognition.....	35
Chapter Five.....	38
Ecological model.....	38
5.1 Introduction.....	38
5.2 Ecological Model Definition.....	39
5.3 Factors Influencing Postpartum Depression.....	39
5.3.1 Individual-level.....	39
5.3.2 Interpersonal relationship-level.....	40
5.3.3 Socio-culture level.....	41
5.3.4 Community-level reactions.....	41
5.4 Using an ecological Model to Empower Women during PPD experience.....	42
Chapter Six.....	44
Discussion.....	44
6.1 Introduction.....	44
6.2 Theme one: Mother trapped in negative feelings.....	45

6.2.1 Trapped in negative feelings toward pregnancy and childbirth.....	45
6.2.2 Trapped in negative feeling toward Motherhood	46
6.2.3 Trapped in negative feelings toward the baby	47
6.2.4 Trapped in negative feelings toward self.....	48
6.3 Theme two: Insecurity with the surroundings	49
6.3.1 Insecurity within the family	49
6.3.2 Insecurity with the health care	50
6.4 Theme three: Trapped in the sociocultural pressure.....	51
6.4.1 Facing Cultural obstacles.....	51
6.4.2 Facing Gender-based discriminations.....	52
6.4.3 Facing socio-economic burden	53
6.5 Theme four: Self-Awareness and Recognition.....	53
6.5.1 Recognizing Postpartum Depression as an Illness and Treatment.	53
6.5.2 Developing experience in Managing their signs and symptoms.	54
6.5.3 Focusing on self needs.....	54
6.6 Strength of the Study	54
6.7 Limitations of the study	55
6.8 Conclusion	56
6.9 Recommendation	57
Reference	59
Appendix.....	69
A- The Questioner.....	69
B- permission letter.....	72
c- Ethical approval letter.....	73
الملخص.....	74

List of Figures

No	Figures	Page
3.1	Ecological Model adopted from Heise (1999)	47

List of Tables

No	Tables	Page
3.1	Semi structured interview Guide.	17
4.1	Distribution of the frequency and percentages of the sociodemographic characteristics of the participants.	24
4.2	Themes and subthemes of the women's experience with postpartum depression.	25

List of Annexes

No	Annex	Pages
A	Questionnaire (Arabic)	69
B	permission letters	72
C	Ethical approval letter	73

List of Abbreviation

Abbreviation	Definition
WHO	World health organization
MDGs	Millennium Development Goals
ACOG	American Congress of Obstetricians and Gynecologists
PPD	Postpartum Depression
PPB	Postpartum blue
PMOH	Palestinian ministry of health
SSRIs	Selective serotonin reuptake inhibitors
MMD	Major depressive disorder
MDE	Major depressive episode
UK	United Kingdom
USPSTF	United States Preventive Services Task Force

Chapter One

1.1 Introduction

This chapter provided an overview of postpartum depression (PPD) among the affected women. It included the rationale for conducting this research and the significance of the study. It also identified the varied definitions of postpartum depression and addressed the cultural and social contexts of Palestinian society.

1.2 Background

Maternal health refers to women's health during pregnancy, childbirth, and postnatal period. Protecting women's safety through all stages of pregnancy and childbirth is a global priority (Ricci, 2024). Pregnancy and birth can be risky for women, and complications can result in injury, disability, or even death. In recent years, high levels of maternal mortality have increased the focus on the promotion of maternal health care (WHO, 2021; Hoyert, 2020). One of the greatest global strategy goals is to improve antenatal, postnatal, and maternal outcomes while ending preventable maternal morbidity and mortality is one of the most critical challenges in the Millennium Development Goals (MDGs).

However, attention to maternal mortality must be accompanied by improvements along the continuum of care, including the psychological aspect (Bohren et al., 2015). Maternal mortality is a significant issue worldwide, with rates varying between countries. For example, in Ireland, maternal mortality was reported as zero per 100,000 live births, while in Colombia, it was approximately 51 deaths per 100,000 live births (Elflein, 2019). These disparities may be linked to inequalities in healthcare access and the quality of services. Enhancing access to maternal care, improving psychological support, promoting breastfeeding, and addressing systemic issues in the healthcare system are crucial steps toward reducing maternal mortality and improving overall maternal health.

Strategies to eliminate racial and socioeconomic disparities and improve the quality of maternal care include increasing access to maternal services, enhancing breastfeeding rates, and fostering cultural changes within medicine (WHO, 2021). In the Palestinian context Kneoma et al. (2022), reported that the birth rate was 28.2 per 1000 births, and the fertility rate was 3.5 per woman, which is considered a moderate fertility rate.

The postpartum period begins soon after delivery and lasts for 6 weeks duration, or after the mother's body returns to pre-pregnant status. This stage is crucial for the mother due to the numerous physical, social, and psychological changes that she passes through during pregnancy and childbirth. The social impact of the mothering role, the huge responsibilities brought by childbirth, and the hormonal changes are well-known causes of PPD (Toncoglaz, 2020). Concerning Psychological health, mothers may experience a range of emotions, from joy and elation to anxiety, stress, or even postpartum depression. Healthcare providers need to assess the mother's mental health status during this time and provide appropriate support and treatment if required (Fowles ER, 2012).

Intensive postpartum care is crucial for the mother's physical and emotional well-being and can contribute to their health. This may include regular check-ups with a healthcare provider, support with breastfeeding, and access to emotional and social support resources. Despite the WHO recommendation about postpartum care which indicates that four visits to the postpartum clinics are essential for women in the postpartum period, only 60% of women were found to seek post-partum care (McKinney et al ,2018). This situation is similar in Palestine, as it is reported in a study that only one-fifth to one-third of the women attended the postnatal care clinics after birth (Dhaher et al., 2008).

Psychiatric issues remain one of the greatest challenges for the healthcare sector, therefore a proper physical and psychosocial assessment should be done for the mother, especially regarding postpartum depression PPD. It is important to note that PPD appears usually after the first week of the child's birth and disturbs the mother's emotional and functional status. It is also defined as an extended period of emotional distress and affects approximately 10–15% of adult mothers yearly after delivery (Toncoglaz, 2020). However, recovery from PPD can take a long time and may require ongoing support from healthcare providers, family, and friends (Di Mascio et al., 2008; Negron et al., 2013).

The serious symptoms of postpartum depression usually last 2 to 12 weeks, and full recovery may take 6 to 12 months or more (Dennis, 2003). Overall, while postpartum depression can be a frightening and challenging experience for most mothers with postpartum depression, mothers can make a full recovery and resume their normal lives when they get appropriate treatment and support (Dennis, 2003). The chance of having another episode of PPD in future pregnancies is about 1 in 2, but the risk can be reduced when following accurate therapeutic measures(Rasmussen et al., 2017) Therefore postpartum depression might not be diagnosed early and this might hurt the mother and the child (Smith-Nielsen et al., 2016).

It is obvious that women during the postnatal period are getting less concerned for their physical or psychological health, and limited attention has been given by the Palestinian Ministry of Health (PMOH) to women in the postpartum period. Studies about Palestinian women in the postpartum period, and exploring their needs and feelings are still lacking in the Palestinian context (Hammoudeh, 2021). Moreover, the women's experiences with the physical and psychosocial changes during the postpartum period are still not well understood. Therefore, this study is going to explore the lived experiences of Palestinian women with postpartum depression after the last childbirth and who recovered from the PPD at least 6 months ago.

1.3 Problem statement

Postpartum depression is an important issue that emphasizes the need for early diagnosis and treatment to protect the affected women and to prevent serious complications. It has a serious impact on the medical, psychological, and well-being of the affected women. Further, PPD has influences upon the health of the newborn and the whole family members. In Palestine, particularly in the West Bank, despite the progress achieved in promoting maternal Health (WHO, 2021), there is an obvious gap in the available data about maternal morbidities, particularly in the data related to PPD. The limited availability of data and research on this serious problem makes it difficult to understand the feelings and experiences of women with PPD. Therefore, describing the women's experiences with postpartum depression after their recovery from the condition, and exploring the emotional and psychosocial effects of postpartum depression upon the mother and the family's health is essential.

This study is the first study in Palestine to concern women in the postpartum period using a qualitative approach. Most of previous studies adopted a quantitative approach that focused on the prevalence and estimation of risk factors, but the mother's voices and experiences were not explored. Therefore, studying the experiences of mothers with a previous history of PPD is worth studying, to understand the phenomenon of living with PPD to promote women's health and improve the care provided for mother and their families.

1.4 Significant of the study

Maternal health is the most vulnerable period that reflects the quality of care and follow-up provided for women in childbearing (The Lancet, 2016). Since perinatal outcomes are strongly related to maternal health conditions during pregnancy, childbirth, and the postpartum period, there is an important need to develop maternal health programs in Palestine. However, in a quick review of the available services in this context, data revealed a shortage in the programs that highlight the psychological needs of women after birth (Palestinian Annual Report of Health,2018). This shortage in the available services for the psychological conditions of the mothers is expected to adversely affect the health of women and the entire family and society.

Few studies have been conducted in Palestine related to postpartum depression among women. One of these studies was about the Prevalence of Postpartum Depression in Nablus Governorate-West Bank which was 17% of all pregnancies (Ayoub et al., 2017). Another study was conducted in Bethlehem about the prevalence of depressive symptoms among women (Qandil et al., 2016). It was reported that Palestinian women are more likely to develop Postpartum Depression due to low health services, socioeconomic status, and the Israeli occupation (Qandil et al., 2016), Another significant study by Khatib et al. (2023) explored the effectiveness of integrated psychological interventions in reducing postpartum depression among Palestinian women. The findings revealed significant differences between the intervention and control groups before and after the intervention. Before the intervention, the prevalence of depression was 20.5% in the control group, demonstrating the need for comprehensive support programs to address this issue.

This study is expected to be one of the first qualitative studies on postpartum depression in the West Bank of Palestine. It identified many issues related to Palestinian women's experiences with PPD, the main risk factors associated with PPD, and the provided services. The results of this study could be used by stakeholders to implement interventions for detecting PPD in its early stages and to prevent the undesirable consequences of such a serious disorder. Since PPD is still a neglected phenomenon and is not well recognized as an important issue in Palestine, a clear understanding of the condition, its causes, risk factors, and physical and psychosocial consequences is important.

The results of this study are expected to suggest policies that aim to reduce the burden of PPD upon the mother and family members. Building an intensive program and preparing and training qualified healthcare providers are needed to recognize the causes of PPD and identify where the change in practice can be and needs to be made.

1.5 Aim of this study

This **study** aims to explore the lived experiences of women with postpartum depression in the West Bank of Palestine.

1.6 Objectives

1. To explore women's experiences with PPD in the West Bank of Palestine.
2. To recognize the availability of health care services for women with PPD.
3. To come out with recommendations based on the findings of the study

1.7 Research Questions

- 1- What is the lived experience of women with postpartum Depression in Palestine?
- 2- How do Palestinian women perceive their daily life experiences with PPD?
- 3- What are the available services offered for women with PPD in Palestine?

1.8 Definitions of Terms

- 1. Postpartum depression (PPD):** A complex mix of physical, emotional, and behavioral changes that happen in some women after giving birth, according to the DSM-5, a manual used to diagnose mental disorders, PPD is a form of depression that begins within 4 weeks after delivery. The diagnosis of postpartum depression is based not only on the length of time between delivery and onset but also on the severity of the depression (Stewart & Vigod, 2019).
- 2. Lived Experience:** Refers to a representation of a given person's experiences and choices and the knowledge they gain from these experiences and choices (Parsell et al., 2024).
- 3. Qualitative methodology:** Provides a framework for empirical material (data) collection and analysis that enables researchers to gather empirical information in its entirety. The empirical materials are not substantively reduced or represented numerically (Jennings, 2005).
- 4. Descriptive Phenomenology:** Descriptive phenomenology is a qualitative research approach rooted in the philosophical traditions of Edmund Husserl. It aims to explore the lived experiences of individuals to understand the essence of a phenomenon as experienced by those who have lived through it. It is used to help in uncovering how individuals perceive, interpret, and make sense of their experiences in their everyday lives and how human beings experience a certain phenomenon (Deakin University,

Chapter Two

Literature Review

2.1 introduction

This chapter provides an overview of postpartum depression (PPD) It synthesizes findings from previous studies to provide a comprehensive understanding of PPD, focusing on its implications for mothers and their children. The chapter also examines the mechanisms underlying PPD and its associated complications, offering insights into how this condition affects both psychological and physical aspects of postpartum life, also it provides insights into the complexity of PPD within Arab societies and its broader implications for women's health.

2.2 Mechanisms of Postpartum Depression

The underlying physiological mechanisms of PPD mostly are linked to the great fluctuation seen in the steroidal hormones during pregnancy and in the postpartum period (Saraswat et al., 2021). Pregnancy is marked by the great levels of estrogen, progesterone, and corticosteroids, which drop at the time of delivery. Therefore, women with a predisposition to depression tend to develop symptoms after the drop in estrogen levels, this theory is known as estrogen withdrawal state (Frokjaer, V. G., 2020). The drop in estradiol during the postpartum period affect the activity of neural circuits in the brain, explaining mood alterations seen in this period. Surprisingly, neurological studies show that women in the postpartum period have reduced volume of the brain, and the brain gets back to its normal volume 6 months postpartum.

Additionally, neuroplasticity function decreases during the postpartum period, mainly in the hippocampus area of the brain (Blankers et al., 2024). This could explain the alterations in neurological functions seen in this period. Neuroscience studies suggest that serotonin levels are altered in the synapses, with decreased serotonin receptors in the anterior cingulate cortex and temporal cortex (Vahid-Ansari & Albert, 2021).

All these studies point to altered neurological function as an underlying cause. It is believed that sleep disturbances observed in the postpartum period are explained by the decline of progesterone levels. The sleep disruption observed could be a major contributor to the development of PPD (Baattaiah et al., 2023). Studies suggest that the disrupted sleep pattern of the mother may be a risk factor for infant sleep disturbance as well, persistent infant sleep disturbances may also be related to maternal depression (Feldman, 2009; Payne, 2019).

2.3 Depression among Women

Around 12-20% of the population is affected by major depressive disorder, considered to be the leading cause of disability worldwide (Pearlstein T, 2019). Unfortunately, women are more prone to major depressive disorder, and more likely to have comorbid anxiety. Latest studies show that depression affects women mostly during reproductive years. This is explained by alterations in the level of hormones, like cortisol, estrogen, and progesterone. Therefore, research has been done to track these hormones as biomarkers of the development of depression. (Brummelte S, 2016) .

Postpartum depression is defined as the development of depression in the postpartum period. Essentially, should be distinguished from major depressive disorder (MDD) as PPD occurs during physiologically stressful periods. Additionally, women with PPD tend to have more comorbid psychological disturbances like anxiety (Anokye , 2018).

The diagnosis of PPD requires the woman to meet the criteria of MDD for at least two weeks. Symptoms vary between sleep abnormalities, loss of appetite, anhedonia, decreased energy, emotions like guilt and worthlessness, inhibited concentration, and suicidal ideation. The diagnosis of PPD could be challenging, as many of the mentioned symptoms occur in the postpartum period. Risk factors linked to social status, include previous episodes of depression, stressful life events, lack of social support, anxiety within pregnancy, poor marital relationship, economic instability, and young mother age.

Weak risk factors include unwanted pregnancies and obstetric complications. Evidence still lacking regarding other factors like environmental status (Fitelson, 2010; P., 2009). Depression during pregnancy known as antenatal depression is very common, affecting around 12% of pregnant women, mostly during the last two trimesters. While postpartum depression incidence ranges between studies, this could be explained due to the variations in the diagnostic tools used. The greatest risk factor known to be linked to the development of PPD is previous history of depression, either antenatally or before pregnancy. Attention to the diagnosis of PPD is so crucial as it affects the mother, the child, and the whole family. Mothers untreated with PPD have six times higher incidence of MDD later (Gavin, 2005; Banti, 2010).

2.4 Symptoms of Postpartum Depression

According to The American Psychiatric Association (APA,2013), postpartum depression (PPD) is defined as the occurrence of a major depressive episode (MDE) within 4 weeks after delivery. A major depressive episode is defined with symptoms including mood lability, anxiety, irritability, feeling overwhelmed, and obsessional worries or preoccupation often about the baby's health, feeding, and bathing safety. Major depressive episode is diagnosed with typical symptoms of 2 weeks duration, with impairment in functioning. Suicidal thoughts are extremely common, affecting about 20% of women with PPD (Stewart & Vigod, 2019). Those women might have thoughts or intent to harm their child, those thoughts need to be distinguished from obsessional symptoms in which the woman has a thought or an image of harming herself or her child but is highly distressed by this thought or image and has no intent to act on it (Lawrence et al., 2017).

2.5 Treatment of Postpartum Depression

Treatment of PPD starts with promotion through education and motivating help-seeking behaviors, this would lead to the discovery of symptoms early and ensuring properly timed management. (Dennis & Chung-Lee, 2006). Different randomized control trials were done for the treatment of PPD, and the two cornerstones of treatment are psychotherapy and medical management. Research proved the evidence was mostly related to cognitive behavioral therapy for short- and long-term benefits for patients with PPD, while interpersonal psychotherapy was found to promote relationships and social functioning (Hayes, 2004; Klier et al., 2001; O'hara et al., 2000). Treatment of women affected with PPD must focus on the psychological status of the mother and their relationship with the environment surrounding. Interpersonal psychotherapy is identified to be the most superior psychotherapy for patients with PPD.

Interpersonal psychotherapy is defined as treatment based on moderating functions related to interpersonal relationships. Interpersonal psychotherapy adjusts the mother's adaptation to the new maternal status and moderates the marital relationship (Wang et al., 2023). This therapy focuses on retrieving the functionality of the mother. Other patterns of psychotherapy like cognitive behavioral therapy and psychodynamic therapy could also be part of the plan of the therapy provided (Van Lieshout et al., 2022). In addition, selective serotonin reuptake inhibitors could be part of the treatment regimen provided for the patient. Precautions need to be undertaken to avoid side effects on the babies. Therefore, usually, they start with a low dose and titrate up accordingly by observing the infant for side effects (De Crescenzo, Perelli, Armando, & Vicari, 2014).

PPD is not like other medical complications of pregnancy. Therefore, the management of PPD needs to look at the multiple levels of functionality of mothers. Including self-care and their awareness of themselves. Furthermore, their awareness toward their children and

the care needs to be provided and the social and marital functions. Usually, PPD must be treated by a multi-disciplinary team that includes psychiatrists, pediatricians, obstetricians, and social workers as well (Kroska, 2020; O'Hara, 2018)

2.6 Risk factors for PPD

Risk factors for PPD include a previous history of depression, this is classified as the strongest risk factor for PPD development, increasing the odds by 20-fold. Additionally, increased age was associated with increased risk for the development of PPD (Silverman et al., 2017). Studies found that women who were found to have gestational diabetes were at higher risk for PPD (Azami et al., 2019; Shuffrey et al. (2022); Tan et al. (2024); Fischer & Morales-Suárez-Varela (2023) .Other risk factors include stressful events, problems with marital relationships, lack of social support, low socioeconomic status, decreased self-esteem, and unplanned pregnancy (Beck, 2003; Robertson et al., 2004).

A comprehensive literature search was conducted by Mehta & Mehta (2014), using PubMed and PsycINFO databases to review and identify risk factors for postpartum depression (PPD) within Asian studies. Demographic factors such as maternal age at childbirth, older age at marriage, and lower socioeconomic status were consistently linked to increased risk of PPD. Clinical factors like migration for childbirth, premarital pregnancies, and complications during pregnancy were significant contributors. Psychosocial factors, including cultural conflicts, lack of social and instrumental support, and stressful life events, further heightened the risk. Additionally, dissatisfaction with the gender of the child, particularly the birth of a girl, emerged as a notable risk factor for PPD. This comprehensive analysis underscores how a combination of demographic, clinical, and psychosocial influences contribute to postpartum depression in Asian populations.

In a multinational study, Bradshaw et al. (2022) explored risk factors associated with postpartum depressive symptoms (PDS) across diverse populations. Their analysis emphasized the significant variability in PDS related to demographic, obstetric, and cultural factors. Key findings included the higher prevalence of PDS among younger mothers, first-time mothers, and those with twin births. The research highlights the complex interplay of global influences on maternal mental health.

However, studies showed that About 60–80% of all new mothers suffer from PPB which rarely requires medication and normally subsides with support and education (Jennings, 2005), it is significant to carry out follow-up, because around 20% of these mothers are likely to progress to PPD, in general the symptoms appear within two weeks after delivery.

Several risk factors lead to the development of postpartum blues. According to Howard et al., (2014), these risk factors include a history of menstrual cycle-related mood changes or

mood changes associated with pregnancy, a history of major depression or dysthymia, a larger number of lifetime pregnancies, or a family history of postpartum depression, there is many suggestions that hormonal changes are most likely the primary cause of postpartum mood changes (O'Hara & Wisner, 2014), the pathology not well understood, while the most successful diagnostic tool is an interview, the psychiatric should exclude major depressive disorder or PPD, moving to treatment, PPB differ from any other intervention, it resolves on its own and requires no treatment other than validation, education, reassurance, and psychosocial support (Seyfried & Marcus, 2003).

Postpartum blues share with postpartum depression the presence of mood symptoms like tearfulness, but they are considered mild symptoms. Additionally, symptoms are limited in duration, only 4-10 days. The most important differentiating feature is the lack of functional impairment. (O'Hara et al., 1991) It is worth noting that PPD shares anxiety, and obsessive and compulsive features in around 30-50% of patients (Miller & O'Hara, 2020; Ross et al., 2003).

2.7 Risk factors of Postpartum Depression among Arabian women

Studies that involved the Arabian countries in the PPD investigations are numerous, and still, this topic needs to be under the scope of researchers in the Arabic areas. The prevalence of PPD in the Arabic region is around 15-25% depending on multiple factors (Alonazi, 2022), mainly the demographic features and the social characteristics of each area. The studies have detected areas with a surprisingly high incidence of PPD, the Bedouin areas of the south Palestinian areas have a PPD prevalence of 44.2% (Ayoub, 2020). Other studies which involved women from Northern Palestine have detected the prevalence to be around 22% (Wildali et al., 2024).

Risk factors for PPD in the Arabian region are different as well. The social dynamics of the Arabian community, make the social risk factors contribute more significantly than other societies. Low socioeconomic status has been defined to be the most prominent risk factor (Agrawal, 2022). The lack of education, the area of rural residencies, and the lack of employment were defined as risk factors for PPD in the Arab regions. Pregnancy-related risk factors have similarities with risk factors worldwide, but still, the social characteristics of the Arab region intervene with the risk factors involved (Ayoub, 2020).

These risk factors include unwanted pregnancy, first pregnancy, or high number of births. Additionally, complications related to pregnancy like medical illnesses or birth-related complications are also considered risk factors. The association between an infant's gender and postpartum depression (PPD) remains inconclusive. A meta-analysis of cohort and case-control studies done by (Ye et al., 2020) suggests that women giving birth to female infants may face a higher risk of developing PPD compared to those giving birth to male infants. This highlights the need for family and social support interventions to address gender preferences and improve communication to reduce PPD risk, many studies in the Arabian countries have found a link, this could be explained by the burden and the

pressure built by society toward mothers who have given birth to female infants. Additionally, infant factors like low weight or prematurity may also contribute to the development of PPD (Ayoub, 2020; Gelaye et al., 2016).

Alharbi et al. (2014) conducted in Saudi Arabia aimed to examine the correlation between postpartum depression (PPD) and obstetric and demographic variables in Saudi females. The findings revealed that low hemoglobin levels and anemia during pregnancy were significant risk factors for PPD. Additional factors, such as maternal age, occupation, and parity, were also identified as potential contributors.

2.8 Postpartum Depression Consequences

Disruption of maternal-fetal bonding can be an important result of PPD. Therefore, this could affect the development of the child due to the disruption of their relationship with his mother (Diaz-Ogallar et al., 2024). PPD has been related to infant excessive crying and sleep problems. Infants born to mothers with PPD tend to have stress signs. Women with PPD tend to terminate breastfeeding earlier, and have less interest in engagement with the infant (Borrero et al., 2024.) Additionally, mothers may have intrusion or hostility induced by the PPD. Infants born to mothers with PPD tend to have poor social and cognitive development.

Behavioral inhibition, poor emotional function, and the development of medical and psychiatric disorders upon maturity are all observed in children born to mothers affected with depression (Lubotzky-Gete et al., 2021). PPD leads to disruption of the care provided to the child (Mustillo et al., 2011). Studies showed that women affected are less likely to commit to child wellness visits, tend to miss immunization appointments, and do not commit to caring plans provided for the children (MacDonald et al., 2024). Additionally, they tend to compromise the safety of the infants, neglect and abuse their children. PPD could affect mothers with the basic care provided like food, sleep, and safety (Ezzeddin et al., 2018). Furthermore, mothers affected tend to interact less with infant touch and play. Understanding the underlying examination of these behaviors is still lacking.

On the other side, studies have shown that women with the development of PPD during the first two weeks, have more predisposition to convert to bipolar disorder and Suicide tends to occur at lower rates in the postpartum period (Mandelli et al., 2016; Bergink et al., 2016). Although, few studies in the UK and Australia have shown that suicide was the leading cause of maternal death in these countries (Chin et al., 2022; Austin et al., 2007). Suicide was 3 times higher in women who had the experience of infant or fatal death. Suicide tends to be more violent in the postpartum period compared to other periods (de Avila Quevedo et al., 2021). Infanticide could be one of the severe complications of PPD this is due to neglect and sometimes abuse. Around 20%-30% of women who have done infanticide, commit suicide as well (Luykx, Di Florio, & Bergink, 2019).

At Palestine, a study aimed to examine the prevalence and the most probable risk factor of PDD among Palestinian women in the northern West Bank showed A total of 129 women scored 13 or higher on the EPDS, indicating a postpartum depression prevalence rate of 33.9%. The main factors associated with postpartum depression included stressful life events during pregnancy, vacuum use during delivery, low social support, and husbands' lower level of education (Wildali et al., 2024).

2.9 Women's experience of Postpartum Depression

The studies that examined the experiences of mothers with PPD have classified their emotions into three main subcategories which include the feeling of being drained due to emotional and physical fatigue, Worthlessness and failure feelings shared with the feeling that the mother is incompetent or imperfect that goes along the body image (Dooley Hussmann, 2020). Lack of agreement feelings between the expectations and the reality, the raising techniques, and lack of agreement with the mother-in-law. These experiences were linked with mothers' understanding of their status, but some women of other cultures did not understand their situation. The lack of understanding led them to be more confused. Some women described the status of postpartum depression as being crazy, while others just thought it was due to pregnancy. Irrespective of the level of understanding and knowledge, all women who suffered from PPD, described the same symptoms of loneliness, isolation, and tiredness.

Some women translated their emotional symptoms into physical symptoms of general pain. The experience of PPD also affected their perception of their babies. They had problems with their attachment toward their babies, some of the babies were not accepted due to their gender, or because they were unplanned pregnancies.

Many of the women affected linked their experiences to the bad experiences they had in hospitals in the healthcare protocols. Studies have linked the variations in the experiences due to the cultural variations seen. (Ling-ling Gao, 2010; Lorna Templeton, 2010; Haque & Malebranche, 2020; Wang et al., 2024).

2.10 Summary

Postpartum depression (PPD) is a prevalent mental health issue affecting women during the postnatal period. The literature highlights that PPD arises from a combination of biological, psychological, and social factors. Key risk factors include hormonal fluctuations, a history of mental illness, lack of social support, stress related to childcare, and socioeconomic challenges.

Women with PPD often exhibit symptoms such as persistent sadness, anxiety, fatigue, irritability, and difficulty bonding with their newborns. Untreated PPD can lead to severe consequences, including impaired mother-child relationships, developmental issues for the child, and long-term mental health struggles for the mother.

The research underscores the importance of early detection and intervention. Approaches such as psychoeducation, counseling, support groups, and, in some cases, pharmacological treatments are effective. The socio-ecological model is increasingly used to frame interventions, addressing PPD at multiple levels: individual (awareness and coping strategies), interpersonal (family and partner support), organizational (healthcare services), community (awareness campaigns), and societal (policy and stigma reduction).

While significant progress has been made in understanding PPD, gaps remain in addressing barriers to care, particularly for marginalized and underserved populations. There is a growing emphasis on culturally sensitive and accessible interventions to ensure equitable support for all affected women. The reviewed studies predominantly examined postpartum depression (PPD) in women across various countries, exploring its associated factors through diverse study designs, including case-control studies, systematic reviews, and qualitative and quantitative approaches. The factors linked to PPD were primarily related to social determinants, such as a prior history of depression, stressful life events, lack of social support, anxiety during pregnancy, poor marital relationships, economic instability, and younger maternal age.

Unwanted pregnancies and obstetric complications were identified as minor contributing factors. Additionally, disturbances in sleep patterns for both mothers and infants were highlighted as significant contributors.

Some studies also investigated the physiological mechanisms of PPD, focusing on hormonal changes during pregnancy and the postnatal period, as well as altered neurological functions as underlying causes. Research emphasized the importance of therapeutic management, comparing the effectiveness of psychotherapy and pharmacological treatments.

The literature underscored the role of healthcare services in addressing PPD, yet studies within the Palestinian context remain limited. Existing research in Palestine revealed a relatively high incidence and prevalence of PPD among women, with associated factors largely influenced by sociocultural and economic conditions. The complex sociocultural context in Palestine significantly affects both the causative factors and the approaches to managing PPD, warranting further exploration and tailored interventions.

Chapter Three

Methodology

3.1 Introduction

This chapter describes the methodology of this study; it describes the study design, study population, study setting, sample size, eligibility criteria, sampling process and data collection. It explores the strengths and weaknesses of each and discusses the ethical considerations concerning this study.

3.2 Study Design

The study employed a descriptive phenomenological approach to explore the lived experiences of women with postpartum depression (PPD) in the West Bank of Palestine. This methodology was chosen to uncover the essence of PPD as experienced by women, aiming to describe the phenomenon in its purest form, free from preconceived notions or external interpretations. By focusing on in-depth descriptions provided by participants, the study sought to reveal the universal essence of PPD while remaining faithful to the unique realities of the women involved.

A key aspect of this approach was bracketing (*epoché*), where the researcher intentionally set aside personal biases, assumptions, and preconceptions about PPD to approach the data with fresh eyes. This step ensured that the participants' experiences were understood as they were described, without imposing prior theories or judgments. Through phenomenological reduction, the study further analyzed participants' lived experiences, focusing on the structures of their experiences, such as the emotional, temporal, and social dimensions. The analysis aimed to answer questions such as "What is this experience like?" and "What is essential about this experience?" This approach allowed the study to remain grounded in the participants' lived realities and provided rich insights into the phenomenon of PPD within the Palestinian context.

The study used semi-structured interviews to collect data from women who were diagnosed by PPD in different governorates in the West Bank including Nablus, Bethlehem, Hebron, and Ramallah of the women who had postpartum depression after the last childbirth and recovered for at least 6 months ago.

3.3 Target population

All the women affected previously by postpartum depression and recovered 6 months ago, and aged from 18-45 years old, this criterion was selected to take advantage of participant's full experience to allow them to reflect on the meaning of their lived experience

3.4 Context of the study

Palestine has been under Israeli occupation since 1948 (Falah, 1996), marking a tragic event that has shaped the lives of Palestinians ever since. The ongoing crisis resulting from this occupation has profoundly affected various aspects of life, with women bearing a significant burden as primary caregivers in families. Women often had to take on dual responsibilities of raising children and managing households in the absence of men who were either imprisoned or had lost their lives. These circumstances have imposed unique economic, social, and psychological challenges on Palestinian women, contributing to complex mental health issues, including postpartum depression (PPD). This study was conducted in the West Bank of Palestine, focusing on Nablus, Bethlehem, Ramallah, and Hebron Governorates.

Participants were selected from private and governmental mental health clinics in collaboration with the Palestinian Ministry of Health. The interviews were conducted in the participants' homes based on their preferences, as they felt more comfortable and able to share their experiences in their private environments. This approach ensured that the participants' voices were authentically captured in a setting of their choice, promoting trust and openness. Informed consent for this study was obtained from the participating mothers and their agreement about the recording interviews was also taken.

3.5 Sampling methodology

Purposive sampling was used to explore the lived experiences of mothers who were diagnosed with postpartum depression. A total of 12 mothers interviewed, aged 18- 45 years old, collected from mental health government distributed in the West Bank specifically in Nablus, Hebron, Bethlehem, and Ramallah.

Despite the diversity in certain aspects, the sample maintained a level of homogeneity that was crucial for exploring the lived experiences of women with postpartum depression. All participants were women residing in the West Bank of Palestine who had recently

experienced postpartum depression, which ensured a shared context for the phenomenon under study. This homogeneity in the core characteristics of the participants facilitated a focused investigation into the commonalities of their experiences while still allowing room for the exploration of variations brought by other factors such as geography, religion, and age.

3.6 Sample size

There is no consensus or clear criteria to guide researchers in determining the appropriate sample size in qualitative research (Mocănașu, 2020). In this study, the researcher intended to do 20 interviews from the beginning. However, sampling and data collection continued until the point of data saturation, which was achieved after interviewing 12 respondents. Data saturation implies that no new ideas, themes, or insights about the study's key issues emerge from additional data collection, indicating that the gathered information is sufficient to address the study's objectives comprehensively (Charmaz & Thornberg, 2021).

The richness and comprehensiveness of the collected data were evident, covering the key aspects of the lived experiences of women with postpartum depression in the Palestinian context. Participants provided detailed descriptions that thoroughly addressed the study's objectives. Although different researchers may opt to conduct additional interviews after reaching saturation to ensure completeness or verify consistency, the data collected in this study was deemed sufficient. The final interviews confirmed that the themes were consistent, and no new significant findings were identified. This decision reflects the confidence in the robustness and depth of the data, ensuring that the phenomenon was explored comprehensively within the scope of this research.

3.7 Inclusion criteria

All women aged from 18-45 years old were considered eligible if they had been clinically diagnosed according to the Diagnostic and Statistical Manual V (DSM-5) criteria with PPD and recovered 6 months ago and had a live-born baby.

3.8 Exclusion criteria

All the women who are known to have psychiatric backgrounds not related to childbirth were excluded from the study and all women born died babies were also excluded, women more than 45 years old or less than 18 years old

3.9 Instrument of the study (semi -Structured Interview)

The study used semi-structured interview guides that were developed according to the intensive literature review by referring for qualitative, quantitative and systematic review studies

The interview guide consisted of five questions followed by propping questions as presented in (table 3.1). The mothers were also asked about their sociodemographic characteristics and other related questions as age, residency, employment, educational level, income number of children type of hospital of the last delivery and mode of delivery in the last childbirth. (see the appendix A).

Table 3.1 Semi-structured interview Guide

Main Questions	Probe questions
Can you describe your experience of dealing with postpartum depression?	How did you feel during this period, and what challenges did you face? Describe these feelings please? What are the difficulties you faced at that period? How did you come to understand that you had postpartum depression, who helped you understand it? Tell me about your experience in the delivery room with the doctors and midwives the mode of delivery. How did this affect you?
How did you seek help and therapy to overcome postpartum feelings and what was the benefit?	What type of treatment did you receive? Explain more about your experience with the treatment. What about your ability to decide on the appropriate treatment? How did this treatment help you relieve symptoms of PPD? What about counseling? What are the obstacles that may prevent you from asking for help?
Describe your feelings towards the last child you gave birth to, after whose birth you began to feel feelings of depression?	How do you feel about your child? Tell me how the sex of the child affects you and your feelings after birth? How difficult is it to have a child when you are unable to take care of him/her?
How were you able to face the feelings that you described, and what were the methods of confrontation that were useful to alleviate the feelings of depression that you experienced?	Did you feel these strategies or activities were helpful for your mental health? When you started to feel better or to have some improvement?
Can you describe the reaction of people around you as closed family members, relatives or neighbors?	Tell me about the reaction and feelings of your husband, mother-in-law parents, and neighbors? How can you explain their feelings? Give me details about their reaction toward your condition and toward care of the baby? How were they able to provide you with support and assistance when needed?

3.10 Data Collection

Ethical approval for the study was obtained from Al-Quds University, ensuring full compliance with ethical guidelines and standards. Subsequently, permission letters were sent to the Ministry of Health (MOH), detailing the study's objectives, methodology, and ethical considerations to secure their endorsement. After receiving the necessary approvals, I arranged meetings with the heads of the participating clinics to introduce the study, including its title, purpose, and significance, and to request their permission to conduct the research within their facilities. During these meetings, I also sought their collaboration in identifying and recruiting women who met the inclusion criteria for postpartum depression (PPD). Once permissions were granted, I visited the designated MOH clinics and worked with healthcare professionals to access records and identify eligible participants. I specifically requested contact information for mothers who had previously recovered from PPD, ensuring that participant recruitment adhered to ethical standards, including confidentiality and informed consent.

Once I obtained the mothers' phone numbers, I reached out to them and scheduled appointments. The meetings were arranged based on the mothers' preferred locations, and face-to-face interviews were conducted using a semi-structured format that lasted between 60 and 80 minutes.

Each session began with a warm welcome, and I obtained informed consent from the participants. The interviews were recorded on a cell phone, allowing me to replay them multiple times to capture all necessary information. All data and recordings were saved in a single file, after which the audio files were transcribed into a table. Subsequently, the data were translated from Arabic to English, and thematic analysis was applied to initiate the analysis process. Additionally, a psychiatrist, Dr. Tawfik Salman (phone: 0599676031), was available to provide support if any participants experienced emotional distress during the interviews.

3.11 Data Analysis

We used the thematic analysis method to analyze the data. Thematic analysis is considered a straightforward, accessible method and effective for summarizing large datasets. It highlights key features of the data relevant to the research question. However, there are some limitations to this method including the risk for bias, and requires careful consideration to ensure themes are representative and not imposed (Braun & Clarke, 2006) In this approach, the researcher followed the following phases in thematic analysis:

- **Familiarization with the Data:** Reading and re-reading the data to become deeply acquainted with its content.

- **Generating Initial Codes:** Systematically coding interesting features of the data across the dataset.
- **Searching for Themes:** Grouping codes into broader themes that reflect significant patterns in the data.
- **Reviewing Themes:** Refining themes to ensure they accurately represent the data.
- **Defining and Naming Themes:** Clarifying the essence of each theme and developing concise, informative names.
- **Writing the Report:** Presenting the themes in a narrative that relates to the research question.

In this study, the recorded interviews were transcribed verbatim (word-for-word). The thematic method enabled an in-depth exploration of the meaning behind the participants' experiences, which is central to phenomenological research. The researcher read the transcripts multiple times to immerse themselves in the data. The interview texts were divided into meaning units, comprising words, sentences, or paragraphs. These meaning units were then condensed into shorter statements, abstracted, and assigned codes.

Collaborative and reflective discussions between the researcher and supervisor helped validate the accuracy of the interpretations. To enhance the study's credibility and trustworthiness, two strategies were employed: participant validation and peer debriefing. Participant validation involved sharing the interpretations and themes with the participants to confirm that the findings accurately reflected their lived experiences. This approach ensured that the analysis remained faithful to the participants' perspectives and minimized the risk of researcher bias.

Additionally, peer debriefing was conducted with a colleague familiar with qualitative research but not directly involved in the study. This provided an opportunity to discuss and refine the interpretations, challenging any assumptions and improving the rigor of the findings. Both strategies contributed to a comprehensive and reliable exploration of the lived experiences of women with postpartum depression in the Palestinian context. Through the analysis process, the researcher and supervisor frequently reviewed the transcriptions and coding scheme to ensure confirmability and trustworthiness. Agreement was reached on the interpretation process, and codes were organized into themes and subthemes. These themes and subthemes are presented in (**Table 4.2**).

3.12 Phenomenology and Lived Experience

Edmund Husserl, the founder of phenomenology, proposed a philosophical approach that seeks to explore and describe lived experiences as individuals, free from preconceived notions or external judgments that perceive them. Husserl emphasized the importance of returning "to the things themselves" ("zu den Sachen selbst"), advocating for the study of phenomena as they are experienced in their pure essence.

The live experiences approach aims to uncover the structures of consciousness and the meanings individuals ascribe to their experiences. Husserl's phenomenology is grounded in the concept of *epoché*—the suspension of preconceived beliefs—to allow researchers to explore phenomena through the subjective experiences of individuals. By focusing on how individuals interpret and give meaning to their experiences, phenomenology provides a deeper understanding of human existence and the essence of lived experiences.

In this study, Husserl's philosophical framework serves as the foundation for exploring the lived experiences of Palestinian women with postpartum depression. The descriptive phenomenological approach employed aligns with Husserl's emphasis on understanding phenomena from the perspective of those who experience them. The study seeks to capture the essence of postpartum depression as experienced by Palestinian women, considering their unique socio-cultural and political contexts.

Through the lens of phenomenology, the research highlights the subjective realities of these women, illustrating how their experiences are shaped by both internal psychological factors and external socio-political pressures. This aligns with Husserl's focus on the interplay between consciousness and the external world, demonstrating that postpartum depression is not only a medical condition but also a phenomenon deeply embedded in personal and collective lived realities.

By adopting Husserl's philosophical depth, this study transcends surface-level analysis, offering a nuanced understanding of postpartum depression. It sheds light on how Palestinian women make sense of their experiences, revealing the essence of their struggles and resilience. In doing so, the research not only contributes to the body of phenomenological studies but also provides a culturally and contextually grounded understanding of mental health challenges faced by women in Palestine.

3.13 Ethical consideration

Informed consent was obtained from the women who had PPD to participate in the study after the objectives were explained to them. It was made clear that the study would not have any harmful effects on them, their information would remain confidential, and they could withdraw from the study at any time. This proposal was also presented to the Ethics Committee of Al-Quds University.

3.14 Rigor of the study

The trustworthiness and validity of qualitative research depend on what the researcher saw and heard. (Elo et al., 2014) noted that credibility, transferability, dependability, and confirmability are important in establishing trustworthiness. One of the ways to ensure credibility and transferability is to ensure that those interviewed have the experience to discuss the phenomenon the researcher seeks to explore (deMarrais & Lapan, 2003).

3.14.1 Credibility

Since the purpose of qualitative research is to describe and understand the phenomenon, the participants are the only ones who can judge the credibility of the result which involves establishing whether the results of the qualitative research are credible or believable from the perspective of the participants in the research.

To ensure the credibility of the research, regular meetings with the academic supervisor during data collection and analysis were held, and the transcripts were reviewed to ensure the objectivity of the research analysis of data and to avoid any biases, three of the interviews were coded by the researcher and supervisor separately and then compared to enhance credibility, transparency, and dependability of this study.

Additionally, a review of codes was carried out with a supervisor in Al-Quds University to encourage consideration and exploration of additional perspectives. Checking and verifying codes by asking direct questions to the participants enabled the researcher to check these codes against the original meaning in the raw data. These two measures added more credibility to the data.

3.14.2 Confirmability

Qualitative research tends to assume that each researcher brings a unique perspective to the Study. According to (Anney, 2014), confirmability refers to the degree to which the results could be confirmed or corroborated by others. There are several strategies for enhancing confirmability. The researcher can document the procedures for checking and rechecking the data throughout the study. After the study, one can conduct a data audit that examines the data collection and analysis procedures to make judgments about the potential for bias or distortion (William, 2006). In this study, the researcher explained the reason for favoring interviews and the reason why she used them as a data collection method. The findings of the study were represented regularly to the supervisor for analysis and evaluation. In this study, the researcher interviewed the women.

3.14.3 Dependability

The researcher is responsible for describing and providing detailed descriptions of the data collection procedures, sampling decisions, analysis, and synthesis procedures were constantly reflected on and how the researcher reached the theoretical construct described; To obtain dependable findings, the researcher has to establish clear and repeatable procedures for the research and to reflect on the position she takes as she performs them (Gasson, 2003). The researcher was keen to explain the research design and its implementation, and it explained what was planned and what was executed on a strategic level; details of data collection have addressed clearly what was done in the field.

3.14.4 Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents it is the interpretive equivalent of generalizability (Bitsch, 2005; Tobin & Begley, 2004). According to Bitsch (2005), the “researcher facilitates the transferability judgment by a potential user through ‘Thick description’ and purposeful sampling”.

3.14.5 Methodological Rigor

To ensure the rigor of the study, several strategies were employed. Bracketing was utilized to manage and set aside the researcher’s preconceptions and biases, ensuring that the analysis remained focused solely on the participants’ lived experiences. The researcher documented their thoughts and reflections before data collection and analysis to maintain objectivity. Additionally, the thick description was applied by providing detailed and vivid accounts of the participants’ experiences, incorporating their emotions, contexts, and personal reflections, supported by direct quotes to capture the essence of their experiences authentically.

To maintain consistency, uniform data collection methods were employed throughout the study. All interviews were conducted using the same set of open-ended questions to minimize variations caused by methodological inconsistencies. Furthermore, was employed by integrating reflections, field notes, and discussions with the research supervisor to cross-validate the findings. This process ensured the credibility and trustworthiness of the results while affirming that the interpretations were faithful to the participants’ perspectives.

Chapter Four

Results

4.1 Introduction

This study used a qualitative design to explore the lived experiences of the women who had postpartum depression after the last childbirth, and who had recovered at least 6 months ago. This chapter presents the sociodemographic characteristics of the participating women and their experience with post-partum depression. SPSS version 26 was used to analyze the sociodemographic characteristics of the participants.

The women's narratives were analyzed by using thematic analysis which resulted in four major themes: Trapped in negative feelings, Insecurity in the surroundings, Trapped in sociocultural pressure, self-awareness, and recognition.

4.2 Socio-demographic Characteristics

The researcher interviewed 12 women who had a previous experience with postpartum depression. The ages of these women range from 18 to 35 years. The majority were aged between 18-25 years (45.45%), followed by 25-30 years (27.27%) and 30-35 years (27.27%). Geographically, 6 participants were from rural areas, 3 from camps, and 2 from urban areas across the West Bank. Regarding household income, 2 participants (16.67%) had an income between 2000-3500 ILS, while the remaining 10 (83.33%) earned more than 3500 ILS. Most participants (58.33%) had 3 children, with others having between 1 and 6 children. Most deliveries occurred in private hospitals (91.67%), with only one delivery in a governmental hospital (8.33%). In terms of education, one participant was a university student (9.09%), one had a diploma (9.09%), one was illiterate (9.09%), and the majority (72.7%) had primary education. Concerning the mode of delivery in the last childbirth, 5 participants (41.67%) had a caesarean section, 6 participants (50%) had a

normal vaginal delivery, and one participant (8.33%) had an instrumental delivery. These results are presented in the following (**table 4.1**).

The sample exhibited significant heterogeneity, encompassing women from various backgrounds, including Muslims and Christians, with varying levels of religiosity. Additionally, participants were drawn from urban areas, villages, and refugee camps, representing a wide range of socio-cultural contexts. This diversity allowed for a richer exploration of the lived experiences of postpartum depression.

Table 4.1 Distribution of the frequency and percentages of the participants' sociodemographic characteristics (12 women).

Variable	Category	Frequency	Percentage
Age	18-24 years	1	8.33%
	25-31 years	6	50.00%
	32-38 years	4	33.33%
	>38	2	16.67%
Place of Residency	Rural	5	41.67%
	Urban	5	41.67%
	Camp	1	8.33%
Employment Status	Employed full-time	4	33.33%
	Unemployed	8	66.67%
Educational Level	University Degree	6	50.00%
	High School	3	25.00%
	Middle School	2	16.67%
	College	1	8.33%
Household Income	2000-3500 ILS	9	75.00%
	More than 3500 ILS	3	25.00%
Table 4.1 Distribution of the frequency and percentages of the participants' sociodemographic characteristics (12 women).			
Number of Children	One	1	8.33%
	Two	0	0.00%
	Three	5	41.67%
	Four	2	16.67%
	Five	1	8.33%
	Six	3	25.00%
Place of Delivery	Private Hospital	10	83.33%
	Government Hospital	2	16.67%

4.3 Themes and subthemes of the women's experiences

The thematic analysis of the women's narratives resulted in **four major themes and twelve subthemes** that are presented in the following table:

Table 4. 2 Themes and subthemes of the women's experience with postpartum depression

Theme	Subtheme
Trapped in negative feelings	Trapped in negative feelings during pregnancy and childbirth
	Trapped in negative feelings toward Motherhood.
	Trapped in negative feelings toward the baby
	Trapped in negative feelings toward self
Insecurity with the surroundings	Insecurity within the family
	Insecurity with the health care
Trapped in the sociocultural pressure.	Facing Cultural obstacles
	Facing Gender-based discriminations
	Facing socio-economic burden
Table 4. 2 Themes and subthemes of the women's experience with postpartum depression	
Self-Awareness and recognition	Recognizing Postpartum Depression as an Illness and Treatment.
	Developing experience in Managing their signs and symptoms.
	Focusing on self needs.

4.3.1 Theme one: Trapped in negative feelings

This theme revealed that postpartum depression has negatively affected the daily lives of the participating women, and it was evident in their overall perception. The negative

feelings of these women are presented in the following subthemes: trapped in negative feelings toward pregnancy and childbirth, trapped in negative feelings toward motherhood, trapped in negative feelings toward the baby, and trapped in negative feelings toward self.

4.3.1.1 Trapped in negative feelings during pregnancy and childbirth

Most of the women with PPD in this study were trapped in negative feelings particularly when they have got the symptoms of PPD. They mainly conveyed symptoms such as guilt, loneliness, and fear. Some women reported their tendency towards suicidal thoughts and overwhelming domestic chores. Most women experienced somatic symptoms as a result of the PPD, such as weight loss, lack of energy, insomnia, and a sign of obsession with childbirth.

M4: “The last week of pregnancy was full of tears, and it continued. I couldn't sleep.” “While I was pregnant, I used to walk close to cars on the sidewalk, hoping they would run me over and I would die.”

M7:” I developed itching all over my body, and I wasn't eating. I was just drinking coffee. ”

Fears of the women who experienced PPD were mainly related to their thoughts about the delivery, being alone, and sometimes the absence of their husbands. They expressed their negative experience with the previous childbirth and how they felt anxious about the responsibility of childcare, fear of labor pain, or losing the baby. They also expressed guilt feelings toward the unplanned pregnancy.

M3: “I didn't realize what it meant to have a child. When the baby cried, I wouldn't look at her; what should I do to stop her crying? I was young when I got pregnant, and I did not want this pregnancy but I couldn't avoid it..... I thought 'Do I have to keep taking care of this child for the rest of my life?

M9:” When I started experiencing pregnancy symptoms, I felt like I didn't want it, even though the pregnancy was planned”.

Women were obsessed with childbirth; they talked about their intense pain and the bad treatment and negligence they faced during labor and childbirth. They talked about the prolonged hours of labour, and the severe pain they felt with induction which annoyed them and increased their fears. Some women experienced complications after the delivery as bleeding or fever, which intensified their fears and negative thoughts. These women conveyed that they did not receive the required support and reassurance from the healthcare providers, and they felt that their fears and thoughts were neglected. Further, they were not allowed to have companionship through childbirth which increases feelings of loneliness and neglect.

M3: “My Labor Pain was severe I was shouting but no one cares, people in the corridors of the hospital were looking at me, and this still bothers me until now.”

4.3.1.2..Trapped in negative feelings toward Motherhood.

Since the delivery of the baby, these Women experienced negative feelings towards motherhood. They expressed their sense of losing control and hating the idea of motherhood, whether their pregnancies were planned or not. They reported the difficulties they faced in caring for their newborn, including breastfeeding and performing simple tasks for the baby

M5” I was always under the covers in bed, and the baby cried, and I couldn't get up to breastfeed him.

”M7“.... For two months, I only changed my daughter's diapers, and I didn't feel any love for her.”

Women felt a sense of failure toward motherhood, and this gave them guilty feelings. They conveyed their rejection of the idea of becoming a mother and couldn't apply their role as a mother. This was mainly linked to the heavy responsibility that they were expected to face. Women struggled with managing the daily life activities and the household responsibilities in addition to caring for a new-born. The sad feelings that they felt after the delivery led to dissatisfaction with their situation and their new role as a mother.

M8:” When I saw the baby, I couldn't bond with him. I didn't breastfeed naturally, and I didn't know how to deal with him. I hated the idea of motherhood for the second time I didn't have any feelings towards the baby.”

M11:”I hated responsibility, and having a small child made me feel like I didn't want the responsibilities that came with having another child.

4.3.1.3 Trapped in negative feelings toward the baby

The feelings of the women toward the baby were unstable. Their feelings commuted between love and joy on the other hand they felt overwhelmed, confused, and guilty. Some women reported fear of harming their baby, whether unintentionally or due to intrusive thoughts. Some women have had the intent to harm their babies, but they were stopped. Two women in this study reported that they harmed their older children. Women were struggling with feelings of anger, irritation, or even regret towards their child, which can lead to emotional distress.

M4: “After giving birth, I remember that I had feeling that urged me to harm my son, I hide a large knife out of sight”but I regret and feel shame.

M6:” I felt the desire to harm my child, then I experienced rejection and acceptance. I then felt guilt and shame for even thinking such thoughts towards an innocent child”.

The narrative interviews showed that women with PPD often refused to see the child after giving birth and felt that the suffering they went through during childbirth was because of the child.

M1” I was in the hospital in an emergency..... I had difficult feelingsI refused to see the baby.”

Women were often afraid of visiting a doctor or receiving a diagnosis of postpartum depression. One reason for this fear is the concern that confirming the diagnosis might suggest they could harm their children one day. They are also worried about being alone and tend to avoid staying by themselves

M2: " I was afraid of receiving a diagnosis, especially when I heard about women who harmed their children due to postpartum depression. I didn't like being alone and always preferred to have someone with me”.

After delivery and by returning home these women felt guilty toward the other children in the house. They were struggling with the negative emotions and the increased responsibility and demands by having this baby. They were not able to provide enough care and their efforts to satisfy the needs of the family members were lacking. They expressed a lot of pain, fatigue, and depressed feelings toward the baby.

M3:"I couldn't bear it, neither my husband nor my children, nor my house. I couldn't even look at my child when he cried."

Some women reported extreme thoughts because of their depression. They experienced disturbing thoughts and fantasies about harming their baby. These thoughts were unwanted but at the same time were distressing and caused significant anxiety and fear. For instance, a women might have a fantasy about dropping her baby down the stairs or accidentally, despite having no intention or desire to act on these fantasies.

M1 “I cannot sleep.....I had thoughts of killing my baby. She cries all night, and once, I placed her in the bathtub, forgetting about her, when I returned, I found her turning blue.”.....but I felt guilt.

4.3.1.4 Trapped in negative feelings toward self

After birth women were immersed in a range of negative emotions towards themselves. These emotions seem to impact their self-perceived health. They were despaired and lost hope about their ability to recover. Further, they experienced confusion and uncertainty about themselves and reported harmful thoughts about themselves. They were overwhelmed with sad feelings and insecure. The following quotations will clarify some examples of their feeling toward self.

M12 "I felt like I wasn't part of this world at all"

M1: "Nothing helped me in my recovery, and I never felt happiness towards anything. I tried to distract myself from my thoughts through self-harm, starting to shake and feel tense."

The feelings of despair among these women were expressed by their talks about being lonely living with low self-esteem and losing hope. They believed that their lives were miserable and that they would never improve. They were isolated and conveyed that they lacked the Support.

M8 "At that time, I felt like I was living aimlessly, my existence seemed meaningless, and I experienced a lack of self-worth. I had problems with my husband without any reason.... I decided to leave the house and go to my family... I isolated myself from everyone and felt completely alone".

The harmful thoughts about their selves abandoned them from engaging in daily life activities or meeting the expectations of others. Despite their inside feelings of guilt, and blaming themselves for neglecting the baby and the family, they faced negative judgments from their family members as husbands, siblings, and others. When they improved and their symptoms were relieved, they tried to give care for their children.

M10 "I felt abandoned, unable to derive pleasure from anything or engage in any activity.I felt guilty towards my children and husband because I couldn't be with them.

M1 "I always tried to compensate by bringing joy to my children with whatever money I could get because I felt guilty."

4.3.2 Theme two Insecurity with the surroundings

Insecurity is often created within family relationships in the same home, throughout pregnancy, childbirth, and the subsequent experience of depression. Women in this study expressed feelings of insecurity within their families, highlighting the impact of experiences mixed with the feel of neglect and lack of acceptance and comfort.

4.3.2.1 Insecurity within the family

Women expressed feelings of insecurity within their families, highlighting the neglect of the psychological symptoms or lack of their acceptance that there is something wrong. Some women revealed experiencing physical violence from family members during pregnancy, which led to premature birth, bleeding, and psychological distress.

M1 "I experienced physical complications, bleeding from my mouth and nose due to being subjected to physical violence."

Women faced troubles with the family. They realized that the limited knowledge of the family about PPD often delays the diagnosis and complicates the treatment. When the symptoms appeared, the family tried to hide the problem. The women reported that they were afraid of the serious psychological symptoms, and they were worried about their relatives or other people in society. They reported fear of judgment from husbands and being stuck on social stigma, they try to hide their suffering instead of expressing it.

M1” The family started to lie about my symptoms and thoughts no one seems to care about me.”

The women reported that the family was not helpful in the diagnosis or management of the PPD. The family was not sure about the aroused conditions, they were not concerned about the symptoms of PPD, neglected these symptoms, and were not able to accept it as a disease. This aggravated the women's sense of isolation. However, they conveyed their essential need for support at the beginning of the symptoms and that the family neglected these symptoms because they were afraid of the sociocultural beliefs and stigma around the psychological symptoms.

M3”I felt that people around me were ignorant about the illness and influenced by societal views”.

Some women also talked about their husbands concealing their diagnosis of postpartum depression for many reasons, such as a short-sighted view of mental illnesses or fear for the woman’s reputation in the job market, as the husband helped and supported his wife without disclosing it or treating postpartum depression as a normal illness, but rather as a stigma that must be hidden.

M4” My husband was hesitant about disclosing my condition to others, but he provided support and assistance with the children and treatment.”

Through interviews, it becomes clear that the intense feelings of depression, fear, and anxiety are aggravated by a lack of understanding from those around them. They consistently describe a profound sense of being misunderstood compounds their emotional distress, such as

M12” My husband was affected by what happened to me and has been helping me a lot. He would tell me, "You can't keep living like this—this is just nonsense.”

M11” My dad would show us his tough side; he kept scolding and reprimanding me to snap out of it.”

While the fear of abandonment is a significant concern, this fear intensifies the feelings of isolation and can worsen symptoms, creating a cycle of anxiety and despair.

M9:” I also thought that everyone around me would leave, and I would be left alone, especially because my husband had work and had to leave”.

On the positive side of the women’s experience, and despite all the difficulties in dealing with the family members, some of them praised receiving appropriate support and the presence of supportive individuals in the family who have a background towards postpartum depression and dealt with the women in a way that contained feelings of sadness and pain and helped the women overcome difficult times, some husbands were very effective in helping women and gaining the women the appropriate support.

M9:” He was the only one who understood my condition. He wanted to help and delayed many things just to stay with me. He even asked about good doctors for me”.

4.3.2.2 Insecurity with the health care

Some women reported that they were lacking the support of healthcare providers. Those who delivered in Governmental hospitals reported less personalized care while those in private hospitals reported more attention care and support from the health care providers. Getting less attention and care from the health care providers might increase the signs of PPD as the mothers reported insecurity feelings

M3:” I gave birth in a private hospital in my previous deliveries but this time it was in a government hospital. The birth was quick, and the treatment was poor. I felt insecure.... I do not want to give birth there”.

Women suffered from limited treatment options with evading their participation in selecting the available options. The treatment options were limited to medication only. They reported a little benefit from the medications which increased their feelings of insecurity toward the provided care. They reported their needs for attention and advises. Insecurity with the given treatment forced them to hide their feelings and thoughts. Sometimes they increased the dose of the medication or even change it during a visit to the doctor.

M1:” I couldn't speak, and the doctor would prescribe medication without me being able to express myself”.

The women kept talking about their difficult experience with the delivery of the last baby. They experienced a lack of privacy, “harshness” and the lack of support received from midwives and other health care providers in the labor room.

M4:” I didn't like the medical staff at all, especially the midwives who treated me in a bad way during my delivery. They left me alone ----. There was another woman giving birth beside me, and there was no privacy at all.”

Women with PPD reported their need for social support and to be engaged with their environment to aid their recovery. However, they noted that doctors advised them to isolate themselves from their surroundings. This increased the women's feelings of insecurity; they felt that isolation would hinder their recovery. for example:

M1” I visited many doctors and sheikhs seeking treatment. The doctor advised me to distance myself from the environment around me.

The lack of awareness is not limited to the general public but extends to healthcare professionals as well. For instance, women reported that even their general doctors didn't recommend consulting a mental health specialist

M3:” There isn't enough awareness about postpartum depression. I wasn't aware of it, and even regular doctors didn't advise me to refer to a psychologist or psychiatrist.”

Access to healthcare facilities poses significant challenges for women with PPD. They reported the difficulties they faced when attending the governmental psychiatric clinics for investigation or treatment. These clinics lack personalized care or counselling due to the large number of patients who attend these clinics which are only available one day in the week, for a short period limiting the opportunity for the women to ask questions or to express their feelings. Some women who were referred to private clinics reported their satisfaction with the provided care, but they added that the private clinics are costly. They were not able to continue their treatments at these clinics due to the economic burden on the family.

M1: “The treatments at the government clinics were not helpful, and the doctors didn't provide me with options for treatment. I found relief only with one doctor who considered my troubles with the illness.”

M4: The medical treatment was cost, and our financial situation was also extremely challenging. I couldn't consistently afford the cost of the medication.”

Women experience worsened symptoms related to the side effects of the medications that they took. They reported some of these symptoms as excessive drowsiness, inability to manage household tasks, headaches, distraction, and difficulty concentrating. These apparent symptoms forced them to stop the medications without consulting a doctor.

M2:" I've started to lie about my symptoms and thoughts because no one cares for me, they only want me to take the drug, despite its adverse effect on my health.”

Some families believe in the traditional measures of treating psychiatric illness. They emphasized the importance of using these measures for women with PPD, despite the reported emotional and physical harm by the affected women. Women reported that these measures were not helpful, on the contrary, it intensified their anxiety and delayed their recovery.

M1:” Those around me began to claim that I was possessed by demons and jinn, leading to sessions with religious leaders and scholars. I experienced physical violence during these treatment sessions. When I tried to escape, they grabbed me by my hair. My family even attempted to take me on a pilgrimage, but the situation worsened each time”.

4.3.3 Theme three: Trapped in the sociocultural pressure

4.3.3.1 Facing Cultural Obstacles

Women in this study found themselves trapped with the Socio-cultural burden. The sociocultural norms restricted their ability to think about their condition or to identify the situation and deal with the symptoms of the disease. They faced difficulties in seeking help due to the cultural and religious beliefs of the family.

Results revealed that women's own decision about the type of treatment is influenced by sociocultural norms. They were trapped in the negative cultural attitudes toward psychiatric illness and they faced the stereotypes and stigma toward their psychiatric illness. Women expressed their fears of stigmatization by society for example:

M11:” At first, I refused to go to the clinic because I was afraid of being transferred to a psychiatrist if they recognized that I have depression.”

Psychiatric illness is not well accepted in the Palestinian culture, particularly when it affects a woman. people often deny the disease and pretend another diagnosis rather than a psychiatric illness. The cultural myths about mental illness forced the family to treat the woman with PPD with sorcerers and Magic. They believe that using these treatment methods is better than medical management. They believe it will heal the symptoms quickly and will give quick benefits.

M11" In our culture, women who have just given birth usually stay indoors for 40 days, but I went with her and stayed at their place for a week. On the first day I went, I was sitting with my father, and it happened—I started shaking all over, trembling. My mother said, "It looks like someone put a curse on her (black magic).

However, most of the women in this study were didn't like use the traditional therapies but at the same time, they did not have the power to decide to change the treatment measures. They expressed the obstacles they faced in their decision about the treatment as being a

woman who is unable to decide in addition to the sociocultural beliefs about psychiatric illness.

4.3.3.2 Gender-based discrimination

The gender-based discrimination was presented in the women's experiences in this study. They expressed their fears about societal judgment particularly for being a woman with a psychiatric illness or psychiatric signs and symptoms. Gender-based discrimination is also reflected by the women's fear and anxiety of being judged by others for having a female baby. These fears intensified the women's condition and their symptoms of PPD were increased with the loss of security within the family for being a woman with mental illness and a lot of demands

M3:" they told me that if I became pregnant and gave birth to a boy, my life would change. It made a difference to me that I gave birth to a girl instead. Even though my eldest daughter helps me a lot, loves me always, and tries to calm me down, bringing a girl into this world felt like a heavy burden on my heart?"

Some women suffered from societal expectations of giving birth to a baby boy, and even from the reaction of the husband when giving birth to a baby girl instead of a boy. They insisted on their need to have a baby boy and emphasized that there was something wrong with the woman who was unable to give birth to a boy. They suggested that these women are having problems that must be 'fixed' or 'treated' for having a male child. This pressure only worsened the women's emotional state, leaving them more confused, feeling devalued, and burdened with guilt.

M1:" The family of my husband told me that I should help myself by giving birth to a male child then my depression would be relieved, but I wasn't convinced by this advice. My mother-in-law insisted that I try certain techniques to conceive a male child, but I didn't go through with it".

4.3.3.3 Facing Socioeconomic Burden

The rising costs of mental health treatment in Palestine have become a major barrier for many women, especially those suffering from postpartum depression. Access to mental health care, including therapy sessions and medications, is often costly. This financial burden leaves many women without treatment and support which worsens their conditions and increases their referrals to traditional and spiritual therapy because it is less expensive.

M1:" Due to financial constraints, I couldn't continue the treatment because it was expensive. Eventually, they took me to a sheikh who recited the Quran for me, claiming it was sorcery."

In some cases, despite the difficult economic situation, husbands encouraged their wives to seek psychological treatment from specialized doctors.

M5” My husband helped me go to the doctor despite our not-so-good financial situation”.

4.3.4 Theme four: Self-awareness and Recognition

Women in this study showed their intention to control their symptoms and to overcome negative emotions. They tried to change their lifestyle, both during their illness and after recovery. Some women emphasize the importance of thinking about self, and prioritizing self-care and well-being.

4.3.4.1 Recognizing Postpartum Depression as an Illness and Treatment.

Women in this study gained a deeper understanding of their illness. Their experience with the sociocultural attitudes toward PPD, as well as their struggle with the traditional treatments, were helpful. Women recognized that there is a serious problem that needs to be treated. Women also were seeking information about their illness; they read about it and they discussed some issues with the health care providers. This helped them to understand PPD and to get insights into the signs and symptoms.

M8“After the diagnosis and the beginning of treatment, I started reading about psychology and stopped self-blaming...”

Awareness about their illness encouraged them to talk more about it and to seek real help from a psychiatrist, despite the economic and sociocultural barriers. They decided to seek psychological treatment which helped them to retain their self-confidence. Women become able to advise other women with PPD whom they met at the clinics.

M9” I understood that PPD is a disease like any other disease that needs treatment and support, and I began to work on creating a positive atmosphere for myself “

M3” Now, I can talk to anyone suffering from symptoms and urging them to seek treatment.”

women’s experiences with doctors were beneficial in raising their awareness of the illness, helping them recognize and understand other aspects of postpartum depression and its risk factors·this contributes positively to their overall understanding.

M5” The psychiatrist helped me understand my condition well, and I developed a deep love for my children. They explained the concept of the happiness hormone and how to increase it. Despite having self-doubt and sensitivity before therapy, I now approach things with more patience and positivity.

4.3.4.2 Developing experience in Managing their signs and symptoms.

Women in this study mentioned that having PPD was challenging, and their awareness of the disease helped them to develop ways of coping as building a support network and setting **time management and social boundaries**.

M5:” I realized that it was worth it, and I needed to allocate time for myself to understand what was happening. I started allocating time for myself, engaging in sports and prayer to feel relaxed and at ease.”

Women discovered various aspects of themselves and were able to identify certain activities and actions that helped them to accept their illness and cope with the symptoms. Some women mentioned that spiritual practices like prayer were helpful, while others focused on personal hygiene, such as bathing, self-care, sports, and others. Some women joined social media platforms and clubs for reading books. Others were involved in charity associations.

M5” What helped me the most was creating a WhatsApp group. The idea was to exchange items among people in need, and I got involved in it. I felt like it took me out of the illness.

4.3.4.3 Focusing on self needs.

Women realized that no one cares about their own needs. This helped them to understand themselves and to focus on self-care needs. They tried to avoid self-blame and modify their lifestyle. They wanted to live peacefully and find a balance in their life avoiding the intrusion of others. They want to build up their own decision about themselves and about the treatment measures and follow-up care.

M11: "After recovering from depression, I started focusing on myself and taking better care of myself and my children. I got a driver's license, enrolled in a master's program, and worked on building my children's character, providing them with the best care.”

Women often live in societal conditions where they feel obligated to say "yes “during their illness and through their recovery. However, these women realized that the power of choice belongs to them first and then to others. They realized that it is crucial to make choices aligned with their own needs and not the needs of other family members.

M10:” I’ve become bold and strong; I don't care about upsetting people. The experience has positively influenced me, as saying "no" when I need to speak out has made me stronger”

Some women complained about being overly sensitive and highly affected by their surroundings. When they recovered from the symptoms, they focused on themselves and decided to protect their mental health and well-being. They described the experience with PPD as a turning point in their lives. They recognized their strengths and learned to make their own decision for themselves.

M12:” The experience has changed my personality a lot. I stopped being afraid and sensitive, the most important thing for me is to be well, and my children are doing well, Psychological therapy has been beneficial, and it's increasing my strength.”

Chapter Five

Ecological model

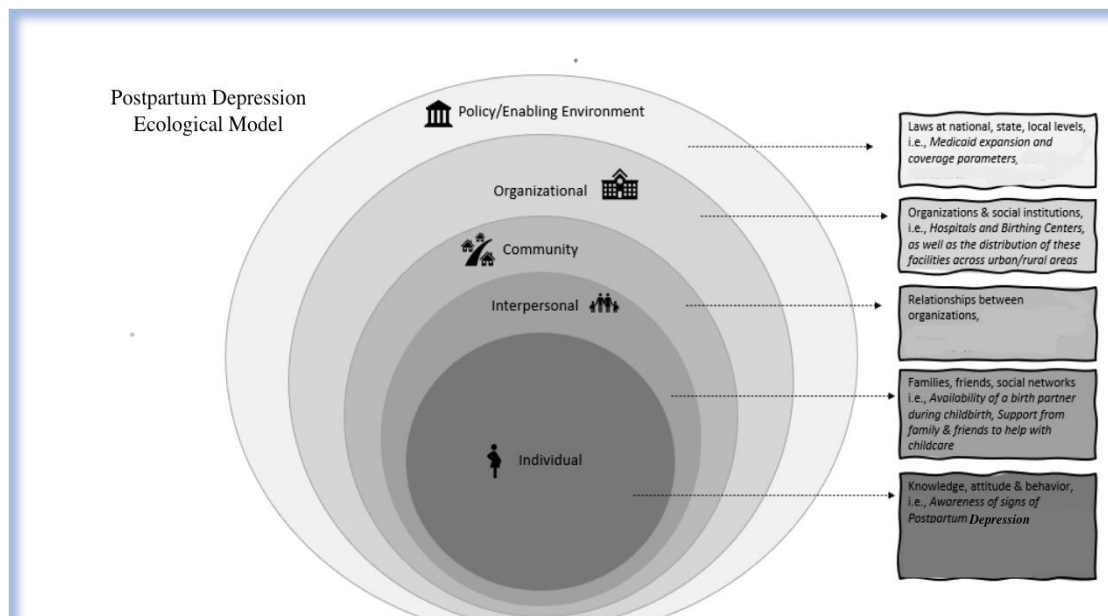
5.1 Introduction

The findings of this study have been mapped onto the socio-ecological model, with specific recommendations provided for healthcare providers to address PPD at the individual, interpersonal, organizational, community, and societal levels.

These recommendations aim to guide the development of appropriate support systems and interventions for women experiencing PPD. By leveraging this framework, healthcare providers and public health professionals can better identify and address the signs and symptoms of PPD, fostering increased help-seeking behaviors among affected women.

The recommendations emphasize a holistic approach to assessment and care, addressing the multifaceted needs of women with PPD and mitigating its potential adverse consequences. This approach is crucial to ensuring comprehensive support and promoting long-term well-being for these women. It is shown in the following figure (**Figure 5.1**).

Figure 5.1 Ecological Model adopted from Heise (1999)



5.2 Ecological Model Definition

The ecological model was selected in this study because it offered a concrete theoretical framework to account for the reciprocal interaction of behavior and environment (Newes-Adeyi et al., 2000). In this study, the researcher clarified how factors at one level influenced factors at another level to understand the experience of women with postpartum depression. With the dearth of information on women's experiences with postpartum depression in the Palestinian community, using such a model offers a framework for understanding the complex interplay of all factors affecting the experience of mothers with postpartum depression and provides a more comprehensive understanding of the emotional and social effects of the postpartum depression than that of what is known at present.

5.3 Factors Influencing Postpartum Depression

5.3.1 Individual-level

The findings of this study closely align with existing knowledge about postpartum depression (PPD), emphasizing how intrapersonal and interpersonal factors interact to shape the experiences of affected women. At the individual level, the study themes, such as Trapped in negative feelings toward self and Motherhood, demonstrate the profound emotional challenges faced by women. Participants in this study frequently reported a diminished sense of self-worth, highlighting the necessity of fostering self-awareness and providing tools for effective self-management.

Interpersonally, the themes of insecurity within the family and Insecurity within the healthcare system reflect the critical influence of relationships on PPD experiences. Women described strained or unsupportive relationships with husbands and family members, coupled with dissatisfaction in their interactions with healthcare providers. These findings align with existing literature emphasizing that a lack of emotional and practical support exacerbates isolation and emotional distress (Alvarez-Segura et al., 2014). The absence of a birth partner or family help with newborn care was particularly notable, aligning with the theme of Trapped in sociocultural pressures.

Moreover, the study's findings expand on the ecological model by demonstrating the interconnectedness of individual, relational, and societal influences. For instance, facing socioeconomic burdens and Gender-based discrimination exemplify how broader sociocultural pressures compound personal and relational challenges. This integrated perspective highlights the importance of addressing both individual self-efficacy and broader relational and societal dynamics to support women experiencing PPD. By focusing on these layers, this study enriches the understanding of PPD among Palestinian women and underscores the importance of tailored interventions that consider both individual resilience and systemic support structures.

5.3.2 Interpersonal relationship-level

The findings of this study align closely with the interpersonal dynamics described in the literature on postpartum depression (PPD). Women experiencing PPD often reported feelings of insecurity and inadequacy within their familial and healthcare relationships, which were reflected in themes such as Insecurity with the surroundings and being trapped in negative feelings. These themes highlight how strained or unsupportive relationships with husbands, family members, or healthcare providers can exacerbate emotional distress.

For example, many participants described a lack of emotional or practical support from their families, aligning with the observation that insufficient familial engagement can heighten isolation and depressive symptoms. Similarly, dissatisfaction with healthcare services or the absence of a compassionate birth partner was frequently noted as contributing to their feelings of insecurity. These findings underscore the importance of family structure, emotional support, and healthcare quality as protective factors against PPD.

Furthermore, the sociocultural pressure reflected in the study, including cultural obstacles and gender-based discrimination, intertwines with the interpersonal domain. It illustrates how societal norms and expectations amplify the challenges within personal relationships, further aggravating feelings of being trapped in negative emotions and isolation. This comprehensive connection between interpersonal dynamics and PPD emphasizes the critical need for fostering supportive relationships and addressing systemic barriers to improve postpartum mental health outcomes.

5.3.3 Socio-culture level

The sociocultural level plays a pivotal role in shaping women's experiences of postpartum depression, as evidenced by the findings of this study. Culture significantly influences how individuals perceive and respond to health-related challenges. It encompasses the "learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways" (Leininger, 2001, p. 47). In line with prior research, sociocultural factors contribute to increased depressive symptoms among postpartum women, particularly in societies where cultural and gender-based expectations impose additional burdens (Rathod, Graves, & Phiri, 2024).

Moreover, WHO data indicate that postpartum women with low social support have 4.63-fold higher odds of experiencing PPD than those with high social support.

In this study, themes such as Facing cultural obstacles, Gender-based discrimination, and Socio-economic burdens vividly illustrate how sociocultural pressures exacerbate feelings of isolation and helplessness. Participants frequently highlighted the weight of societal expectations, particularly about their roles as mothers and caregivers. The cultural stigma surrounding mental health further compounded their struggles, deterring many from seeking help or openly discussing their feelings.

The findings also align with the theme of Trapped in sociocultural pressure, wherein women described societal norms and family expectations that demanded unwavering strength and devotion to their maternal roles, often at the expense of their mental health. This highlights the urgent need for interventions that address the cultural stigma surrounding PPD and enhance community and familial support systems.

5.3.4 Community-level reactions

Community-level reactions refer to the broader social and institutional contexts in which support systems, healthcare facilities, and community services operate. In this study, the community level was explored to evaluate the quality of care, accessibility of services, and the availability of psychosocial support for women experiencing postpartum depression. Results indicated that inadequate knowledge among healthcare providers often leads to underdiagnosis or misdiagnosis of PPD. Additionally, systemic issues such as budget constraints and limited financial resources hinder women from seeking timely and effective help, exacerbating mental health challenges.

The ecological model offered a comprehensive framework to examine how various community systems interact with and impact women's experiences of PPD. Specifically, it provided insights into the gaps in healthcare delivery, the inadequacy of psychosocial resources, and societal barriers such as stigma and cultural misconceptions about mental health. This aligns with findings from the study, where women reported feeling trapped in

sociocultural pressures and insecurity with the healthcare system. These themes reflect the disconnect between available resources and the needs of postpartum women.

Community interventions are vital to addressing these gaps. They include raising awareness among healthcare professionals about PPD, ensuring financial support for mental health services, and fostering a supportive community environment. By addressing these systemic issues, the well-being of postpartum women can be significantly improved, reducing the prevalence and impact of depressive symptoms.

5.4 Using an ecological Model to Empower Women during PPD experience.

Studying the phenomenon of postpartum depression (PPD) offers a critical opportunity to support and empower women by addressing the challenges they face at multiple levels of their lives. The ecological model provides a comprehensive framework to guide these efforts, ensuring that interventions are tailored to the specific needs of individuals, families, communities, and society at large.

At the individual level, we can raise awareness about PPD by developing workshops and informational campaigns to educate women about its symptoms, risk factors, and management strategies because the lack of knowledge among women during their experience was widely ranging. By equipping women with knowledge, they can better recognize the early signs of PPD and seek timely intervention, early detection protects the whole society, the women and family. In addition, providing tools such as stress management techniques and counseling sessions after delivery, can improve their self-esteem and self-efficacy, enabling them to navigate the postpartum period with confidence.

Interpersonal relationships also play a pivotal role in addressing PPD. study highlights the importance of family and partner support, emphasizing the need for strong, healthy relationships. This can be achieved through awareness campaigns that inform family members about their roles in supporting postpartum women. Partner counseling and the creation of peer support groups can further provide women with a sense of belonging and encouragement, helping to mitigate feelings of isolation.

At the community level, the study underscores the importance of healthcare services and community resources. Enhancing the mental health training of healthcare providers, such as midwives and nurses, can improve their ability to identify and address PPD effectively. Collaborating with hospitals and clinics to integrate mental health services into maternal care is also crucial. Moreover, establishing accessible resources such as hotlines and online counseling platforms can ensure that women receive the help they need, even in remote areas.

Cultural and societal factors significantly influence the experiences of postpartum women. Through public awareness campaigns, raising awareness can challenge the stigma

associated with mental health issues, fostering an environment where women feel comfortable seeking help. It can also initiate conversations about cultural norms and unrealistic expectations placed on mothers, advocating for a more supportive and understanding societal framework.

Lastly, the focus on postpartum depression (PPD), helped in recognizing the significant impact of PPD on the affected women. The findings of this study can be beneficial for policymakers, to advocate maternal mental health services. The health care Providers in the Palestinian context need to understand the importance of screening women during the postnatal Period for the early signs of PPD to ensure early detection and support for affected women. Collaboration with non-governmental organizations and community leaders is also a priority, as their involvement can amplify the reach and effectiveness of these initiatives. These combined efforts are expected to promote the health and well-being of the women experiencing PPD.

Chapter Six

Discussion

6.1 Introduction

The purpose of this study was to explore the experiences of Palestinian women with postpartum depression, shedding light on their emotional struggles, and the sociocultural obstacles they face, and providing them with a platform to voice their concerns. The discussion of the research findings is grounded in the women's understanding and interpretations of their circumstances and experiences.

The findings highlight a complex interplay between internal emotional conflicts, external pressures, and self-awareness. This chapter aims to link these findings to the previous studies, offering a comprehensive understanding of the multifaceted challenges faced by women experiencing postpartum depression. The discussion will start by Worthing this Quranic verse:

"And we have enjoined upon man to his parents' good treatment. His mother carried him with hardship and gave birth to him with hardship." (Surah Al-Ahqaf, 46:15).

This verse highlights the difficulties of motherhood, illustrating how a woman endures significant hardships during pregnancy, childbirth, and the postpartum period. The phrase "His mother carried him with hardship" emphasizes the physical and emotional toll that pregnancy takes on a woman, while "gave birth to him with hardship" speaks to the pain and challenges associated with labor.

Pregnancy and childbirth are a major physical, psychological, and social event in every woman's life. Instead of being a joyful experience, pregnancy may become a worrisome and fearful event in a few patients, feelings of anxiety and fear accompany some participants during the last weeks of pregnancy, whether due to previous experiences or without clear reason.

6.2 Theme one: Mother trapped in negative feelings.

6.2.1 Trapped in negative feelings toward pregnancy and childbirth.

Women experience an unwelcome beginning to motherhood. They were trapped in negative feelings toward pregnancy, particularly during the third trimester which is considered a critical period. Anticipating labor and thinking about motherhood responsibilities showed significant psychological changes, and women often experience increased anxiety and stress at this period (Răchită et al., 2022).

Women in this study reported that their depressive symptoms started during the third trimester of pregnancy. This finding aligns with existing research indicating that antenatal depression can be a strong predictor of postpartum depression. According to a study done by Yu et al., (2023) approximately 50% of women who suffer from antenatal depression are likely to develop postpartum depression.

Participants shared their experiences with the physical symptoms they encountered during the last weeks of pregnancy. They reported suffering from insomnia, weight loss, anhedonia, headaches, and an inability to carry out daily tasks, including household chores (Williamson et al., 2015). Additionally, a few participants experienced unexplained itching with no apparent physical cause, a kind of somatic experience they are going through. This highlights the diverse physical manifestations of depression, suggesting that the condition can have wide-ranging effects on the body, some of which are not fully understood (Schaffir et al., 2018).

A concerning finding in this study is that some participants experienced suicidal thoughts during their pregnancy, Suicidal thoughts during pregnancy are considered a serious symptom and associated with both maternal and fetal risks (Gelabert et al., 2024), When considering all maternal deaths occurring within the first year postpartum, suicide ranks as one of the leading causes of maternal mortality (Gelabert et al., 2024).

One of the paradoxes revealed by the study, planned pregnancies didn't provide immunity against postpartum depression knowing that according to a previous study About 39% of pregnancies in Palestinian women are unplanned (Shalabi-Abbas, 2017). Previous experiences, financial conditions, emotional preparedness, and the presence of psychological support all played a crucial role in determining the mental health outcomes of mothers during the postpartum period.

Some women in this study shared their concerns and fears about childbirth, sometimes for justified reasons such as the fear of the birthing process itself, the responsibilities that come with having a new member in the family, or feelings of loneliness due to their husbands' absence. Palestinian women tended to seek help first from their husbands, making their absence a significant obstacle. However, absence was not the only issue; some women complained about their husbands' lack of understanding regarding the nature

of the illness and its mechanisms, as well as their limited ability to provide adequate support. This was largely due to the challenges in raising awareness about mental health. In many cases, husbands were unavailable because of work commitments, as many in the Palestinian community work in construction or other informal jobs that are not tied to specific institutions. Due to financial necessity, husbands are often unable to take time off work to stay with their wives, which became one of the causes of fear. Women expressed anxiety about enduring labour without their husbands present, as they viewed their husbands as a critical source of psychological support.

On the other hand, we observed some cases where women became obsessed with the details of childbirth. Some would call their doctors late at night to inquire about the birthing process, displaying heightened anxiety and preoccupation. The sense of danger and fear intensified for women in emergencies that required urgent medical interventions such as premature labor pain and bleeding.

Regarding sleep deprivation and lack of sleep expressed by women during the final stages of pregnancy, studies have indicated that sleep deprivation has consequences on both the physical and mental health of the mother. Research shows that 40% of pregnant women suffer from sleep disturbances during the last weeks of pregnancy (Peters et al., 2023), while Chang et al.,(2010) noted that sleep deprivation is a potential risk factor associated with postpartum depression, and while this connection seems clear, it has not received significant attention.

6.2.2 Trapped in negative feeling toward Motherhood

The concept of "motherhood" encompasses a broad range of experiences, acknowledging that women in this study face numerous challenges in various aspects during this transformative period. The way a woman navigates her motherhood significantly impacts her child's development and overall life journey. This period is both sensitive and crucial, as it shapes not only the mother's well-being but also influences the emotional and psychological growth of the child. Understanding these challenges is essential for providing adequate support to mothers. Maushart (1999), describes these challenges by reporting that "Once a woman becomes a mother, her life will never again be quite her own, or in quite the same way." Mothering is considered a critical component of functioning, yet there is no specific job description for motherhood. Expectations of mothering are generally defined by a woman's culture.

Moreover, the absence of mothering is negatively associated with language development, socio-emotional and behavioural development. Emotional deprivation or neglect can have detrimental effects on children's mental health, delaying their cognitive and emotional growth (Strathearn et al., 2020). On the other hand, emotional attention from the mother fosters self-confidence and equips the child to deal with future challenges. In contrast, a

lack of support may lead to psychological issues and delays in cognitive and social development (Sridhar et al., 2024).

The mothers in this study reported experiencing a profound conflict between the mother they felt they were to be, and the real mothering they experienced. This sentiment aligns with findings from a study conducted by Coates et al.,(2014), which highlighted the overwhelming emotions mothers face during the transition to motherhood. Both studies underscore the difficulties in adjusting to new roles, feelings of guilt, being overwhelmed, trapped, and emptiness.

In a study on immigrant women in Canada conducted by Mamisachvili et al.,(2013), it reported that some women expressed feelings of guilt about their roles as mothers, with one mother mentioning that she hired a nanny to allow her to sleep at night. This decision left her feeling shame and guilt, as employing a nanny or domestic help is often associated with certain social classes. The mothers felt pressured to justify the presence of additional help for their babies. Overall, the mothers' emotions toward motherhood were complex, sharing a common struggle with feelings of shame, guilt, and concerns over societal expectations. These women often felt they were falling short of their ideals for motherhood, reinforcing an ongoing sense of inadequacy in their roles.

6.2.3 Trapped in negative feelings toward the baby

One prominent memory of the shared experience of women in this study was being trapped in feelings toward their children. Considerable variation has been shown in how women responded, some performed caregiving tasks without any emotional involvement and treated it as a duty and feeling of empty, while others didn't do the tasks already and expressed the inability to leave the bed. In some cases, women spoke freely about urges to end their children's lives, describing intense inner conflicts as they resisted these thoughts. Women described their experiences during depression as "strange," stating, "It felt like we weren't ourselves."

Women reported feeling a burden from their baby, which was quickly followed by anxiety over their new responsibilities, and subsequently sadness and guilt. Moreover, some mothers directly associated their painful childbirth experiences or difficult pregnancies with their babies, often blaming their children for their struggles. Many women reported feeling a lack of empathy toward their babies, occasionally contemplating the idea of getting rid of the baby. This complex emotional landscape revealed intense contradictions, as women express linked their existence to that of their babies. For example, some mothers intentionally hid objects that could be used to harm the baby, keeping them completely out of their sight. Many women already have a real experience of harming their babies.

Returning to the part that most women talked about, which is try harming the baby, the urge to commit infanticide or attempts to harm their child, only to stop at the last moment,

was a significant harsh experience for many Palestinian women. Infanticide is defined as the act of child murder within the first year of life (Spinelli, 2001). These experiences raised numerous ethical dilemmas related to postpartum depression. For instance, one woman expressed a desire to protect her child from potential harm by others, while another reported being deeply disturbed by her baby's crying. A common thread among these women was a diagnosis of postpartum depression while disclosing such thoughts to avoid societal judgment was prevalent.

Research indicates that mothers without psychotic symptoms are less likely to act on thoughts of harming their children (Wisner et al., 2003). Some mothers described their actions as impulsive and retaliatory. These incidents often occurred during periods of intense infant crying, the mother's physical pain, or while she was sleep-deprived. In some cases, women who expressed these thoughts to their husbands later denied them, fearing separation from their babies. Some mothers admitted to hiding their emotions even during therapy sessions to protect their babies from the therapist's intervention.

Mothers reported a complete absence of protective instincts toward their babies, at times wishing for the baby's life to end without their direct involvement. These feelings were often accompanied by physical symptoms such as dizziness and vomiting as well as difficulties to breast feeding. Consistent with previous research on breastfeeding which reported that breastfeeding rates among mothers with postpartum depression are notably more likely to decline or cease (Feldens et al., 2012; Nishioka et al., 2011; Stuebe et al., 2013). Women in this study distanced themselves from their babies and described themselves as not being "conscious" of the baby's development. One mother articulated that caring for her child felt like merely completing a task, such as feeding or changing the diaper while losing the emotional sense toward the baby.

6.2.4 Trapped in negative feelings toward self.

Research on PPD highlights a complex array of negative emotions that women experience toward themselves, women feel overwhelmed, isolated, and trapped by societal expectations. In this study, some mothers described feeling lost, and trapped, as if they were from another world or place, these findings align with the study conducted in Canada (Shalabi-Abbas, 2017).

They took time to explain their sense of disconnection from both society and themselves, often experiencing emotional isolation that even led to self-pity. These mothers reported feeling anger, dissatisfaction, and guilt towards themselves, as well as shame, which stemmed from their perception of failing to meet the idealized expectations of joyful, self-sacrificing motherhood. According to Dr. Abrams & Curran, (2009), the core psychosocial process of postpartum depression was explained as a "loss of control" over their emotions, thoughts, and actions.

6.3 Theme two: Insecurity with the surroundings

6.3.1 Insecurity within the family

Building emotional security within a family provides a solid foundation for healthy relationships and fosters personal growth, especially crucial for postpartum women. According to the biopsychosocial model of postpartum depression showed that social support plays a vital role in protecting against depressive symptoms (Yim et al., 2015). In the study of Milgrom et al., (2019), a supportive family environment, which includes emotional validation and practical assistance was considered as a preventive factor, easing the challenges of the postpartum period and fostering a healthier recovery. Given that Palestinian society is family-oriented, other family members—such as aunts, mothers, sisters-in-law, or mothers-in-law—also played a role in raising awareness within the family. Despite this positive presence, the support provided in this study often fell short of addressing the depth of the women’s struggles.

In a study examining postpartum women, those who found themselves in unsupportive social environments were at a significantly higher risk of emotional disturbances after childbirth. Participants frequently reported lacking social support, fearing stigma if they disclosed depressive feelings, and noting limited understanding of postpartum depression among family members (Zhang & Jin, 2016; McLeish & Redshaw, 2017). This lack of support or awareness often intensified their sense of isolation, leaving them hesitant to seek help (Huang et al., 2023).

Women in this study suffered from a lack of understanding regarding the nature of postpartum depression, which led to varying reactions from their families. Some described experiencing “anger” or even “disapproval” from family members toward their condition and the treatment, including medication.

There was a sense of impatience or frustration toward these women’s struggles, This, in turn, reinforced feelings of insecurity among the women. Some women also reported their experience of violence from their husbands. Three out of twelve women stated they faced physical violence during pregnancy which Intensifies the feeling of insecurity within the family, A study conducted in Hebron at West Bank by Mattar et al., (2024) investigated the prevalence and risk factors associated with postpartum depression among Palestinian women in the northern region of Hebron. It found that one of the most significant factors linked to postpartum depression was domestic violence, either before or during pregnancy.

Additionally, mentation who they are suppressing their emotions and refraining from sharing them on two separate occasions. In one instance, they felt that no one cared, while in another, they feared being misunderstood or mismanaged as postpartum depression cases. In both cases, this reflects a gap in emotional security and a lack of safety that women feel toward family members. Most participants in the study indicated that they

primarily relied on their husbands for support, which contrasts with other societies where mothers were often the main source of emotional and practical support in the postpartum period (Negron et al., 2013).

In Arab communities, support for women with postpartum depression often takes the form of practical assistance, such as helping with household chores and caring for the baby. In contrast, support in Western societies tends to be more emotional, focusing on providing understanding and empathy for the mother's emotional needs, encouraging women to express their emotions openly, without fear of judgment, and providing emotional guidance (Heron et al., 2012).

Through the interviews conducted, it was found that the support provided to women was insufficient. The forms of support often consisted of advice and moral teachings, which the women felt were not needed during that critical postpartum period. This finding parallels the results of a qualitative study conducted in Canada by Wardrop & Popadiuk, (2013), which summarized that Western women also receive inadequate emotional support and unhelpful advice during the postpartum period. This highlights the necessity for providing appropriate psychological support from family members, allowing women with PPD to feel secure during this sensitive time.

6.3.2 Insecurity with the health care

Women with PPD in this study reported their feelings of insecurity from the healthcare providers. However, the American College of Obstetricians and Gynaecologists (ACOG) suggests that healthcare providers should initiate contact with mothers within three weeks after delivery to facilitate early screening and intervention for depression (Moore Simas et al., 2023). Despite these recommendations ACOG and the U.S. Preventive Services Task Force (USPSTF) for discerning perinatal depression regularly, these screenings occur only about 40% of the time. In contrast, screenings for gestational diabetes reach a 96% completion rate (Aktaş & Aydın, 2019).

women have encountered challenges within the healthcare system during their postpartum care, they reported a lack of knowledge among healthcare staff in understanding and managing the PPD, which led to incorrect advice, which pushed women to seek alternative methods, such as spiritual healing, or suppress their emotions entirely rather than expressing them and sometimes women stopped their treatment alone, the action undertaken due to insufficient support from the health care provider.

Women recounted multiple experiences with healthcare providers across different periods. Those who gave birth in governmental hospitals mentioned a lack of privacy and inadequate birth facilities. Since childbirth is a critical experience, its impact remains with women for a long time. They remember the details of the labour experience and the incidents that took place, which often hold deep emotional significance when discussed, A systematic review done by (Basu et al., 2012) examining public sector services in

healthcare has shown that these services frequently encounter limited availability of essential resources, including equipment, medications, and adequately trained healthcare staff.

Women also shared their experiences with psychiatric treatment, noting that some struggled to open to their doctors about their thoughts and feelings. They often felt that the psychiatrist seemed not interested and focused only on prescribing medication, which caused side effects like headaches, without involving the patients in their treatment decisions or even asking for their input. This approach made them feel marginalized and isolated, as the psychiatrist is responsible for diagnosing and treating them, yet there is a lack of effective communication. This gap between the psychiatrist and the patients contributes to delays in treatment and the worsening of their condition.

The limited understanding of some healthcare providers can be attributed to insufficient training and preparation to address various mental health challenges. Many institutions, such as the Harvard School of Public Health, recommend incorporating training programs to support healthcare providers and enhance their skills in effectively managing mental health issues (Alderwick et al., 2021).

A study conducted by Townsend, Brassel, Baafi, & Grenyer, (2020), reported postnatal psychological implications indicate that women's satisfaction with childbirth is significantly influenced by the quality of care they receive, especially from midwives and overall, from the healthcare provider. A qualitative study obtained to study the experience of mothers who delivered by a midwife conducted by Aktaş & Aydın, (2019), showed that the negative experience of women came from many reasons one of them is the low quality of the relationship between the midwife and the women and lack of privacy.

Some doctors have also provided misguided advice to women with postpartum depression and showed significant disappointment and dissatisfaction which Consistent with previous studies (Hanach et al., 2024; Sanchez-Birkhead et al., 2011) Women reported that doctors advised them to isolate themselves from their surrounding environment or downplayed the need to consult a psychiatrist. Such guidance was given not only by general practitioners but also by some treating psychiatrists, which further complicated the women's experiences in seeking appropriate mental health support.

6.4 Theme three: Trapped in the sociocultural pressure.

6.4.1 Facing Cultural obstacles

According to the ecological model designed for postpartum depression, societal norms play a crucial role in shaping women's postpartum experiences. Social expectations and cultural views on mental health conditions can hinder women from seeking help. For some women, social and cultural factors make it challenging to seek support from family members, as these norms often carry "sociocultural burdens" defined as rules or

expectations of behavior and thoughts based on shared beliefs within a specific cultural or social group (Basu et al., 2012).

At the individual level, societal norms significantly influenced women's reluctance to seek help. Many women chose not to ask for support due to the stigma associated with mental health conditions, shaped by their perceptions of psychiatric illnesses and community expectations. Feelings of shame and fear about discussing their mental health and seeking assistance were common across most women, with no notable differences in their demographic backgrounds. This suggests that societal stigma around mental health impacts women widely, regardless of their sociodemographic characteristics.

At the Interpersonal Level, the influence of family and individuals on women with postpartum depression (PPD) was significant. Many families attributed the women's symptoms to supernatural causes, such as black magic. Some families even encouraged women to stop taking their medication, while others blamed them for their condition. This reflects the collective understanding within Palestinian society, where mental health issues are often viewed negatively. Mental illnesses are commonly treated as spiritual problems, leading families to suggest religious or spiritual healing through traditional healers rather than consulting psychiatric professionals, or even to recommend having another child as a remedy.

Although there were widespread misconceptions within families regarding women with postpartum depression (PPD), these societal views often caused significant fear and distress among the affected women. In many cultures, including the Palestinians, the preference for male children created additional pressures. Despite the absence of religious justifications for such biases, families often linked the birth of a son to lineage and status. Some even saw subsequent pregnancies aimed at having a male child as a remedy for women's struggles, intensifying their burden.

6.4.2 Facing Gender-based discriminations

This societal preference sometimes motivated women to strive for a male child, while others, already burdened, drew support from their young daughters. Such pressures reflect the societal and familial dynamics that influence women's mental health during the sensitive periods of pregnancy and childbirth.

According to the ecological model the societal level, the preference for male children in certain cultures has created additional pressure on women. Studies conducted in Pakistan and Indonesia (Dosani et al., 2022; Jackson et al., 2014) have found that rates of postpartum depression (PPD) were higher among women who gave birth to female infants compared to those who gave birth to male infants.

Two studies conducted in Egypt and Turkey found that one of the causes of postpartum depression among women was their preference for giving birth to a male child. This preference was attributed to cultural and, at times, misinterpreted religious beliefs (Danaci et al., 2002; Elrassas et al., 2022).

6.4.3 Facing socio-economic burden

Moving to socioeconomic burden, according to recent reports, Palestine's poverty levels are expected to reach 74.3% in 2024, affecting around 4.1 million individuals. This increase in poverty is linked to various economic factors, including high unemployment rates, inflation, and ongoing genocide at Gaza strip UNDP (2024, November 14).

The high cost of treatment in private psychiatric clinics has been a major barrier for many women seeking help for postpartum depression (PPD), especially after the economic consequences of the recent Israeli attacks on Gaza and widespread job losses in the West Bank. Furthermore, the financial strain caused by the COVID-19 pandemic has worsened the situation, making it even harder for many to afford private care.

Women have reported not being able to complete their treatment in private clinics due to these financial challenges. Additionally, mental health services provided by the Palestinian Ministry of Health (MOH) are limited, and many women have expressed dissatisfaction with the care, particularly the lack of individual attention from healthcare providers. This disparity between the private and public sectors has left women feeling neglected, especially in the public sector where the medical staff's attention to individual cases is minimal.

In addition to the financial difficulties, women also mentioned the high cost of medications and the need for ongoing follow-up with mental health specialists. Because of these financial barriers, many women have chosen not to seek treatment or have discontinued their care, which has only worsened their mental health struggles.

Mental health services in Palestine face a shortage of specialized professionals and resources. Government clinics, which offer more affordable services, may lack the specialized staff and resources needed for complex conditions like PPD. This gap in service provision can make it challenging to receive effective care.

The financial situation of women in communities has been a significant risk factor for postpartum depression. High costs associated with seeking professional mental health care have also contributed to the worsening of women's conditions. Financial barriers have made it difficult for many women to access proper treatment, exacerbating their mental health struggles and prolonging their recovery, A Systematic Literature Review done at Arab region has found the most prominent socio-demographic factor that was associated with PPD was low income which was reported to be significantly higher in depressed mothers (Ayoub et al., 2020).

6.5 Theme four: Self-Awareness and Recognition

6.5.1 Recognizing Postpartum Depression as an Illness and Treatment.

Several triggers exacerbate emotions in postpartum depression. Many women attempted to transform their experience into a more positive journey by learning about depression as an illness, comparable to any other physical condition. They recognized the importance of seeking proper treatment and receiving help from qualified professionals. This strategy

became a key method for helping themselves and gaining expertise in managing their emotions, ultimately finding the right path to recovery.

Women realized that knowledge about the illness, its symptoms, and treatment played a fundamental role in addressing postpartum depression. They acknowledged that a lack of awareness and understanding hindered their ability to seek help and initiate recovery. Additionally, overcoming cultural sensitivities was identified as crucial in facilitating their healing journey.

6.5.2 Developing experience in Managing their signs and symptoms.

Women employed various strategies to help themselves overcome feelings of postpartum depression. These included relaxation techniques and focusing on their spiritual well-being. For instance, one Muslim woman spoke about returning to prayer and listening to the Quran. Various studies have reported spirituality and religious practices as a major coping strategy (Healey et al., 2013; Rahnama et al., 2015). Activities like bathing and creating a personal environment that fostered comfort were also common strategies used to alleviate negative emotions.

Additionally, women leveraged modern tools such as social media to engage in charitable activities, exchanging acts of kindness and support within their communities. These approaches proved to be both positive and impactful for overcoming depressive feelings. The effectiveness of these methods in fostering emotional resilience and community engagement among women with PPD was also highlighted in the previous studies (Atuhaire et al., 2021; Hanach et al., 2024).

6.5.3 Focusing on self needs.

The experience of depression helped women better understand themselves. Despite the emotional challenges they faced, most viewed the journey as beneficial. It liberated them from self-imposed or societal constraints, allowing them to focus on their desires and unmet needs. These sentiments were echoed by women across various cultures worldwide. For Palestinian women, the experience of depression and subsequent recovery provided deep self-awareness. Many expressed gratitude for the transformation, recognizing their inner strength and the profound changes the journey brought to their personalities, knowing that according to the ecological model Personal traits influenced the mothers' behavior and their approach to dealing with depression and the type of personality affect how the mother will deal with feelings.

6.6 Strength of the Study

Adopting a qualitative research approach was deemed suitable for the nature of this study, as it strengthened the investigation by:

1. Face-to-face interviews enabled participants to elaborate on their experiences and explain their feelings. The qualitative method was used to study a marginalized phenomenon, namely the lived experiences of postpartum depression among Palestinian women, allowing for an in-depth understanding of this issue.
2. The study tackled widespread misconceptions about mental illness and the emotions associated with it. Selecting this topic was challenging due to the prevalent denial and stigma surrounding mental disorders within the community.
3. The data was rooted in the participants' categories of meaning, providing rich descriptions of their individual experiences with postpartum depression. By incorporating the exact words and expressions used by the women, the study enabled participants to reflect on their experiences, including their evolving perspectives after treatment or psychological support. It highlighted how women realized they were suffering from postpartum depression and expressed the emotions they had previously been unable to articulate, offering a clearer picture of the often-unspoken suffering these women endured.
4. The researcher identified the social and cultural context of Palestinian society, particularly norms related to mental illness and the factors associated with postpartum depression. These findings were inductively linked to the ecological model as a conceptual framework, providing a broader understanding of the issue.
5. The study underscored a significant gap in awareness and statistical data concerning postpartum depression. Many cases of suicide or filicide in Palestine appeared to be linked to undiagnosed women who progressed from postpartum depression to postpartum psychosis. This highlighted the urgent need for developing special protocols, and policy recommendations, and increasing mental health awareness. Moreover, the study addressed a critical dilemma found in similar cultural contexts: the stigmatizing view of mental illness and the lack of adequate understanding of mental health conditions. This approach not only sheds light on the individual experiences of women but also emphasizes the societal and systemic barriers that need to be addressed to improve mental health outcomes.

6.7 Limitations of the study

1. The study involved a relatively small sample due to its qualitative nature, limiting the generalizability of the findings to the broader population.
2. The participants were primarily from specific geographic or cultural settings, which may not fully represent the diversity of experiences among women in different regions or socioeconomic backgrounds.

3. The study relied on self-reported data collected during interviews. This approach might have been influenced by social desirability bias or participants' difficulty recalling specific events or feelings accurately.
4. The sensitive nature of the topic could have led some participants to withhold certain details or experiences, potentially impacting the comprehensiveness of the data.
5. Cultural stigma surrounding mental health in Palestinian society may have discouraged some women from participating, skewing the sample toward those more willing to share their experiences.
6. While the ecological framework provided valuable insights, it may have constrained the analysis by focusing on predetermined categories, potentially overlooking other relevant factors or perspectives.
7. There was a lack of national and regional studies focusing on the lived experiences of postpartum depression among Palestinian women. This limitation required the researcher to rely heavily on comparisons with universal studies, which may not fully capture the unique cultural and societal dynamics of the Palestinian context.
8. The research relied on a small and purposive sample, which, while appropriate for qualitative research, limits the generalizability of the findings to a broader population.
9. The entire process of recruiting participants and collecting data was time-consuming and challenging due to the sensitive nature of the research topic, particularly within the context of Palestinian society, where mental health remains a stigmatized subject.

6.8 Conclusion

This study explored the multifaceted experiences of Palestinian women with postpartum depression (PPD), addressing the interplay of sociocultural, economic, and psychological factors. Through qualitative methods, the research provided insights into the challenges these women face, including negative emotions toward motherhood, insecurity in familial and healthcare settings, and the sociocultural pressures exacerbating their condition. The findings emphasize the urgent need for culturally tailored interventions, improved healthcare services, and comprehensive awareness campaigns to address these challenges. The study's contributions are significant, as it highlights a neglected yet critical aspect of women's health in Palestine, bridging a gap in existing research. While the findings are context-specific, they have implications for broader discussions on maternal mental health in similar socio-economic and cultural settings.

Despite its contributions, the study faced limitations, such as a limited geographical scope and reliance on qualitative interviews, which may not fully capture the diversity of

experiences. Future research could expand on these findings by incorporating longitudinal studies and exploring the perspectives of healthcare providers. By addressing postpartum depression, this research calls for a collective effort to empower women during one of the most vulnerable periods of their lives. Prioritizing maternal mental health is not only a moral obligation but also a key to ensuring the well-being of families and communities.

6.9 Recommendation

Raise Awareness and Reduce Stigma Implement nationwide campaigns to normalize conversations about postpartum depression (PPD) and combat stigma associated with mental health issues, in all areas, and engage religious and community leaders to foster supportive attitudes toward seeking psychological help.

- **Enhance Maternal Mental Health Services** Integrate mental health evaluations into routine postnatal care in both public and private healthcare facilities.
- **Train healthcare providers, especially midwives, and nurses, on early detection and management of PPD.**
- **Establish accessible mental health support centers specifically designed for postpartum women, with a focus on underserved areas.**

Provide Family-Centered Support:

- **Develop educational programs targeting family members, especially spouses, to recognize the symptoms of PPD and provide emotional and practical support.**
- **Facilitate family counselling sessions to address communication gaps and enhance the overall support system for new mothers.**

Address Socioeconomic Barriers:

- **Advocate for financial assistance programs to support low-income families in accessing necessary psychological and medical care.**
- **Lobby for policies ensuring maternity leave and workplace accommodations that consider the psychological challenges postpartum women may face.**

Culturally Sensitive Interventions:

- **Design programs that respect the sociocultural norms of Palestinian society while addressing gender-based discrimination and the pressures women face during and after pregnancy.**

- Incorporate community-based peer support groups to offer women a platform to share their experiences and strategies for coping.

Policy and Research Development:

- Encourage policymakers to adopt a comprehensive maternal mental health strategy, integrating it into national healthcare priorities.
- Conduct further research focusing on the intersection of mental health, socio-cultural dynamics, and economic constraints to refine interventions for postpartum women.

Promote Self-Care and Empowerment:

- Create workshops to empower women with skills for self-care, stress management, and emotional regulation.
- Provide accessible materials (e.g., pamphlets, apps) offering guidance on postpartum mental health, coping strategies, and available resources.

Reference

- Abrams, L., & Curran, L. (2009). “And You're Telling Me Not to Stress?” a Grounded Theory Study of Postpartum Depression Symptoms among Low-Income Mothers. *Psychology of Women Quarterly*, 33, 351-362. <https://doi.org/10.1111/j.1471-6402.2009.01506.x>
- Agrawal, I., Mehendale, A. M., & Malhotra, R. (2022). Risk factors of postpartum depression. *Cureus*, 14(10).
- Aktaş, S., & Aydın, R. (2019). The analysis of negative birth experiences of mothers: a qualitative study. *Journal of reproductive and infant psychology*, 37(2), 176-192. <https://doi.org/10.1080/02646838.2018.1540863>
- Alderwick, H., Hutchings, A., Briggs, A., & Mays, N. (2021). The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews. *BMC public health*, 21(1), 753. <https://doi.org/10.1186/s12889-021-10630-1>
- Alharbi, A. A., & Abdulghani, H. M. (2014). Risk factors associated with postpartum depression in the Saudi population. *Neuropsychiatric Disease and Treatment*, 10, 311–316. <https://doi.org/10.2147/NDT.S57556>
- Alonazi, H. G., & Jahan, S. (2022). Prevalence of Postpartum Depression among Women in Childbearing Age Attending Primary Health Care Centres, Qassim Region. *Health Psychology Research*, 10(2).
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)*. <https://doi.org/10.1176/appi.books.9780890425787>
- Atuhaire, C., Rukundo, G. Z., Brennaman, L., Cumber, S. N., & Nambozi, G. (2021). Lived experiences of Ugandan women who had recovered from a clinical diagnosis of postpartum depression: a phenomenological study. *BMC Pregnancy and Childbirth*, 21(1), 826. <https://doi.org/10.1186/s12884-021-04287-2>
- Austin, M. P., Kildea, S., & Sullivan, E. (2007). Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. *Medical Journal of Australia*, 186(7), 364-367.
- Ayoub, K., Shaheen, A., & Hajat, S. (2017). Prevalence and associated factors of post-partum depression in Palestinian mothers: a cross-sectional study. *The Lancet*, 390, S31.
- Ayoub, K., Shaheen, A., & Hajat, S. (2020). Postpartum depression in the Arab region: A systematic literature review. *Clinical practice and epidemiology in mental health: CP & EMH*, 16(Suppl-1), 142.
- Azami, M., Badfar, G., Soleymani, A., & Rahmati, S. (2019). The association between gestational diabetes and postpartum depression: A systematic review and meta-analysis. *diabetes research and clinical practice*, 149, 147-155.

- Baattaiah, B. A., Alharbi, M. D., Babteen, N. M., Al-Maqbool, H. M., Babgi, F. A., & Albatati, A. A. (2023). The relationship between fatigue, sleep quality, resilience, and the risk of postpartum depression: an emphasis on maternal mental health. *BMC psychology*, 11(1), 10.
- Basu, S., Andrews, J., Kishore, S., Panjabi, R., & Stuckler, D. (2012). Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review. *PLOS Medicine*, 9(6), e1001244. <https://doi.org/10.1371/journal.pmed.1001244>
- Beck, C. T. (2003). Recognizing and screening for postpartum depression in mothers of NICU infants. *Advances in neonatal care*, 3(1), 37-46.
- Blankers, S. A., Go, K. A., Surtees, D. C., Splinter, T. F., & Galea, L. A. (2024). Cognition and Neuroplasticity During Pregnancy and Postpartum. In *Neuroendocrine Regulation of Mammalian Pregnancy and Lactation* (pp. 253-281). Cham: Springer International Publishing.
- Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Saraiva Coneglian, F., Diniz, A. L., Tunçalp, Ö., Javadi, D., Oladapo, O. T., Khosla, R., Hindin, M. J., & Gülmezoglu, A. M. (2015). The Mistreatment of Women during Childbirth in Health
- Borrero, L., Dietsch, A., Santurri, L. E., & Ewen, H. H. (2024). New Mothers With Postpartum Depression: A Qualitative Exploration of Healthcare Decision-Making. *Qualitative Health Research*, 34(3), 217-226. *Facilities Globally: A Mixed-Methods Systematic Review. PLoS medicine*, 12(6), e1001847. <https://doi.org/10.1371/journal.pmed.1001847>¹
- Bradshaw, H., Riddle, J. N., Salimgaraev, R., Zhaunova, L., & Payne, J. L. (2022). Risk factors associated with postpartum depressive symptoms: A multinational study. *Journal of Affective Disorders*, 301, 345-351.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101 .
- Chang, J. J., Pien, G. W., Duntley, S. P., & Macones, G. A. (2010). Sleep deprivation during pregnancy and maternal and fetal outcomes: is there a relationship? *Sleep Med Rev*, 14(2), 107-114. <https://doi.org/10.1016/j.smrv.2009.05.001>
- Chin, K., Wendt, A., Bennett, I. M., & Bhat, A. (2022). Suicide and maternal mortality. *Current psychiatry reports*, 24(4), 239-275.
- Coates, R., Ayers, S., & de Visser, R. (2014). Women's experiences of postnatal distress: a qualitative study. *BMC Pregnancy and Childbirth*, 14(1), 359. <https://doi.org/10.1186/1471-2393-14-359>

- Danaci, A. E., Dinç, G., Deveci, A., Sen, F. S., & İçelli, I. (2002). Postnatal depression in turkey: epidemiological and cultural aspects. *Soc Psychiatry Psychiatr Epidemiol*, 37(3), 125-129. <https://doi.org/10.1007/s001270200004>
- De Avila Quevedo, L., Scholl, C.C., de Matos, M.B. et al. Suicide Risk and Mood Disorders in Women in the Postpartum Period: a Longitudinal Study. *Psychiatr Q* 92, 513–522 (2021). <https://doi.org/10.1007/s11126-020-09823-5>
- Deakin University. (2024). Descriptive phenomenology. *Deakin University Library Guides*. Retrieved from <https://deakin.libguides.com/qualitative-study-designs/phenomenology>
- Dennis, C. L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth*, 33(4), 323-
- Dennis, C.-L. (2003). The effect of peer support on postpartum depression: a pilot randomized controlled trial. *The Canadian Journal of Psychiatry*, 48(2), 115-124.
- Dhaher, E., Mikolajczyk, R. T., Maxwell, A. E., & Krämer, A. (2008). Factors associated with lack of postnatal care among Palestinian women: A cross-sectional study of three clinics in the West Bank. *BMC Pregnancy and Childbirth*, 8(1), 26. <https://doi.org/10.1186/1471-2393-8-26>
- Diaz-Ogallar, M. A., Hernandez-Martinez, A., Linares-Abad, M., & Martinez-Galiano, J. M. (2024). Mother-child bond and its relationship with maternal postpartum depression. *Journal of Reproductive and Infant Psychology*, 1-24.
- Di Mascio, V., Kent, A., Fiander, M., & Lawrence, J. (2008). Recovery from postnatal depression: a consumer's perspective. *Archives of Women's Mental Health*, 11(4), 253-257. <https://doi.org/10.1007/s00737-008-0024-7>
- Diana, S., Wahyuni, C. U., & Prasetyo, B. (2020). Maternal complications and risk factors for mortality. *J Public Health Res*, 9(2), 1842. <https://doi.org/10.4081/jphr.2020.1842>
- Donna L. Hoyert, P. D., Division of Vital Statistics. (2020). *Maternal Mortality Rates in the United States*. National Center for Health Statistics, CSC.
- Dosani, A., Yim, I. S., Shaikh, K., Lalani, S., Alcantara, J., Letourneau, N., & Premji, S. S. (2022). Psychometric analysis of the edinburgh postnatal depression scale and pregnancy related anxiety questionnaire in Pakistani pregnant women. *Asian journal of psychiatry*, 72, 103066.
- Elflein, J. (2019). *Maternal mortality rates worldwide in 2019, by country*. <https://www.statista.com/aboutus/our-research-commitment/1013/john-elflein>
- Elrassas, H., Taha, G. R., Soliman, A. E.-D. M., Madbole, S. A. E. K., & Mahmoud, D. A. M. (2022). Prevalence and related factors of perinatal depression in Egyptian mothers. *Middle East Current Psychiatry*, 29(1), 35. <https://doi.org/10.1186/s43045-022-00203-2>

- Feldens, C. A., Vitolo, M. R., Rauber, F., Cruz, L. N., & Hilgert, J. B. (2012). Risk factors for discontinuing breastfeeding in southern Brazil: a survival analysis. *Matern Child Health J*, 16(6), 1257-1265. <https://doi.org/10.1007/s10995-011-0885-7>
- Fischer, S., & Morales-Suárez-Varela, M. (2023, January). The bidirectional relationship between gestational diabetes and depression in pregnant women: a systematic search and review. In *Healthcare* (Vol. 11, No. 3, p. 404). MDPI.
- Frokjaer, V. G. (2020). Pharmacological sex hormone manipulation as a risk model for depression. *Journal of Neuroscience Research*, 98(7), 1283-1292
- Gelabert, E., Plaza, A., Roca-Lecumberri, A., Bramante, A., Brenna, V., Garcia-Esteve, L., Lega, I., Subirà, S., Toscano, C., & Torres-Giménez, A. (2024). Suicide Attempts during Pregnancy and Postpartum: A Systematic Review and Meta-Analysis. *Matern Child Health J*, 28(9), 1443-1453. <https://doi.org/10.1007/s10995-024-03956-w>
- Hanach, N., Radwan, H., Bani Issa, W., Saqan, R., & de Vries, N. (2024). The perceived mental health experiences and needs of postpartum mothers living in the United Arab Emirates : A focus group study. *Midwifery*, 132, 103977. <https://doi.org/https://doi.org/10.1016/j.midw.2024.103977>
- Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior therapy*, 35(4), 639-665
- Healey, C., Morriss, R., Henshaw, C., Wadoo, O., Sajjad, A., Scholefield, H., & Kinderman, P. (2013). Self-harm in postpartum depression and referrals to a perinatal mental health team: an audit study. *Arch Womens Ment Health*, 16(3), 237-245. <https://doi.org/10.1007/s00737-013-0335-1>
- Heron, J., Gilbert, N., Dolman, C., Shah, S., Beare, I., Dearden, S., Muckelroy, N., Jones, I., & Ives, J. (2012). Information and support needs during recovery from postpartum psychosis. *Arch Womens Ment Health*, 15(3), 155-165.
- Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A., & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *Lancet*, 384(9956), 1775-1788. [https://doi.org/10.1016/s0140-6736\(14\)61276-9](https://doi.org/10.1016/s0140-6736(14)61276-9)
- Huang, W., Li, G., Wang, D., Qu, H., Tian, M., & Wang, Y. (2023). Postpartum depression literacy in Chinese perinatal women: a cross-sectional study. *Frontiers in Psychiatry*, 14, 1117332
- Jackson, J. B., Miller, R. B., Oka, M., & Henry, R. G. (2014). Gender differences in marital satisfaction: A meta-analysis. *Journal of marriage and family*, 76(1), 105-129.
- Jennings, G. R. (2005). Business, Social Science Methods Used in. In K. Kempf-Leonard (Ed.), *Encyclopedia of Social Measurement* (pp. 219-230). Elsevier. <https://doi.org/https://doi.org/10.1016/B0-12-369398-5/00270-X>

- Khatib, S., Sharif, N., Rabadi, H. (2023). The effectiveness of integrated mental health and psychological support interventions in reducing postpartum depression of mothers in palestine: a randomized control trial. *Population Medicine*, 5(Supplement), A1264. <https://doi.org/10.18332/popmed/163815>
- Kaluzeviciute, G., & Lloyd, C. E. (2021). A qualitative exploration of CBT and psychodynamic therapists' views, experiences and perceptions of integrating different therapeutic modalities into their private practice with adult clients: Study protocol. *Journal of Concurrent Disorders*.
- Klier, C. M., Muzik, M., Rosenblum, K. L., & Lenz, G. (2001). Interpersonal psychotherapy adapted for the group setting in the treatment of postpartum depression. *The Journal of psychotherapy practice and research*, 10(2), 124.
- knoema. (2022). *atlas Palestine*. <https://knoema.com/atlas/Palestine/Birth-rate>
- Lawrence, P. J., Craske, M. G., Kempton, C., Stewart, A., & Stein, A. (2017). Intrusive thoughts and images of intentional harm to infants in the context of maternal postnatal depression, anxiety, and OCD. *The British journal of general practice : the journal of the Royal College of General Practitioners*, 67(661), 376–377. <https://doi.org/10.3399/bjgp17X692105>
- Lubotzky-Gete, S., Ornoy, A., Grotto, I., & Calderon-Margalit, R. (2021). Postpartum depression and infant development up to 24 months: A nationwide population-based study. *Journal of affective disorders*, 285, 136-143.
- Mamisachvili, L., Ardiles, P., Mancewicz, G., Thompson, S., Rabin, K., & Ross, L. E. (2013). Culture and postpartum mood problems: similarities and differences in the experiences of first- and second-generation Canadian women. *J Transcult Nurs*, 24(2), 162-170. <https://doi.org/10.1177/1043659612472197>
- Mandelli, L., Souery, D., Bartova, L., Kasper, S., Montgomery, S., Zohar, J., ... & Serretti, A. (2016). Bipolar II disorder as a risk factor for postpartum depression. *Journal of affective disorders*, 204, 54-58.
- Mattar, B., Abu-Rmeileh, N. M., & Wahdan, Y. (2024). Postpartum depression symptoms: prevalence, risk factors, and childbirth experiences in Palestine. *BMC public health*, 24(1), 1357.
- Maushart, S. (1999). The mask of motherhood: How becoming a mother changes everything and why we pretend it doesn't. (*No Title*).
- McKinney, J., Keyser, L., Clinton, S., & Pagliano, C. (2018). ACOG Committee Opinion No. 736: optimizing postpartum care. *Obstetrics & Gynecology*, 132(3), 784-785.
- McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional wellbeing of organised peer support in pregnancy and early parenthood: a qualitative study. *BMC pregnancy and childbirth*, 17, 1-14.
- Mehta, S., & Mehta, N. (2014). An overview of risk factors associated to postpartum depression in Asia. *Mental illness*, 6(1), 14-17.

- Milgrom, J., Hirshler, Y., Reece, J., Holt, C., & Gemmill, A. W. (2019). Social Support—A Protective Factor for Depressed Perinatal Women? *International Journal of Environmental Research and Public Health*, 16(8), 1426. <https://www.mdpi.com/1660-4601/16/8/1426>
- Miller, M. L., & O'Hara, M. W. (2020). Obsessive-compulsive symptoms, intrusive thoughts and depressive symptoms: a longitudinal study examining relation to maternal responsiveness. *Journal of reproductive and infant psychology*, 38(3), 226-242.
- Moore Simas, T. A., Whelan, A., & Byatt, N. (2023). Postpartum Depression—New Screening Recommendations and Treatments. *JAMA*, 330(23), 2295-2296. <https://doi.org/10.1001/jama.2023.21311>
- Negron, R., Martin, A., Almog, M., Balbierz, A., & Howell, E. A. (2013). Social support during the postpartum period: mothers' views on needs, expectations, and mobilization of support. *Matern Child Health J*, 17(4), 616-623. <https://doi.org/10.1007/s10995-012-1037-4>
- NEW UN REPORT: THE IMPACTS OF WAR HAVE SET BACK DEVELOPMENT IN GAZA BY MUCH AS 69 YEARS. United Nations Development Programme. <https://www.undp.org/press-releases/new-un-report-impacts-war-have-set-back-development-gaza-much-69-years>
- Newes-Adeyi, G., Helitzer, D. L., Caulfield, L. E., & Bronner, Y. (2000). Theory and practice: applying the ecological model to formative research for a WIC training program in New York State. *Health Education Research*, 15(3), 283-291. <https://doi.org/10.1093/her/15.3.283>
- Nishioka, E., Haruna, M., Ota, E., Matsuzaki, M., Murayama, R., Yoshimura, K., & Murashima, S. (2011). A prospective study of the relationship between breastfeeding and postpartum depressive symptoms appearing at 1-5 months after delivery. *J Affect Disord*, 133(3), 553-559. <https://doi.org/10.1016/j.jad.2011.04.027>
- O'Hara, M. W., & Wisner, K. L. (2014). Perinatal mental illness: definition, description and aetiology. *Best Pract Res Clin Obstet Gynaecol*, 28(1), 3-12. <https://doi.org/10.1016/j.bpobgyn.2013.09.002>
- O'Hara, M. W., Schlechte, J. A., Lewis, D. A., & Wright, E. J. (1991). Prospective study of postpartum blues: biologic and psychosocial factors. *Archives of general psychiatry*, 48(9), 801-806.
- O'hara, M. W., Stuart, S., Gorman, L. L., & Wenzel, A. (2000). Efficacy of interpersonal psychotherapy for postpartum depression. *Archives of general psychiatry*, 57(11), 1039-1045.
- Parsell, C., Kuskoff, E., & Constantine, S. (2024). What is the scope and contribution of lived experience in social work? A scoping review. *The British Journal of Social Work*, 54(8), 3429-3448
- *Pediatrics*, 146(4).Negron, R., Martin, A., Almog, M. et al. Social Support During the Postpartum Period: Mothers' Views on Needs, Expectations, and Mobilization of

Support. *Matern Child Health J* 17, 616–623 (2013). <https://doi.org/10.1007/s10995-012-1037-4>

- Peters, A. E. J., Verspeek, L., Nieuwenhuijze, M., Harskamp-van Ginkel, M., & Meertens, R. (2023). The relation between sleep quality during pregnancy and health-related quality of life—A systematic review. *The Journal of Maternal-Fetal & Neonatal Medicine*, 36(1), 2212829.
- Qandil, S., Jabr, S., Wagler, S., & Collin, S. M. (2016). Postpartum depression in the Occupied Palestinian Territory: a longitudinal study in Bethlehem. *BMC Pregnancy and Childbirth*, 16(1), 1-10.
- Răchită, A., Strete, G. E., Suci, L. M., Ghiga, D. V., Sălcudean, A., & Mărginean, C. (2022). Psychological Stress Perceived by Pregnant Women in the Last Trimester of Pregnancy. *International Journal of Environmental Research and Public Health*, 19(14), 8315. <https://www.mdpi.com/1660-4601/19/14/8315>
- Rahnama, P., Javidan, A. N., Saberi, H., Montazeri, A., Tavakkoli, S., Pakpour, A. H., & Hajiaghababaei, M. (2015). 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*, 53(12), 870-874. <https://doi.org/10.1038/sc.2015.10>
- Ricci, S. (2024). *Essentials of maternity, newborn, and women's health nursing*. Lippincott Williams & Wilkins.
- Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: a synthesis of recent literature. *General hospital psychiatry*, 26(4), 289-295.
- Ross, L. E., Evans, S., Sellers, E., & Romach, M. (2003). Measurement issues in postpartum depression part 1: anxiety as a feature of postpartum depression. *Archives of Women's Mental Health*, 6(1), 51-57.
- Rusu, & Mocanasi, D. (2020). Determining the sample size in qualitative research. *International Multidisciplinary Scientific Conference on the Dialogue between Sciences & Arts, Religion & Education*, 4(1), 181–187. <https://doi.org/10.26520/mcdsare.2020.4.181-187>
- Salmon, J., Hesketh, K. D., Arundell, L., Downing, K. L., & Biddle, S. J. H. (2020). Changing Behavior Using Ecological Models. In K. Hamilton, L. D. Cameron, M. S. Hagger, N. Hankonen, & T. Lintunen (Eds.), *The Handbook of Behavior Change* (pp. 237-250). Cambridge University Press. <https://doi.org/DOI:10.1017/9781108677318.017>
- Sanchez-Birkhead, A. C., Kennedy, H. P., Callister, L. C., & Miyamoto, T. P. (2011). Navigating a new health culture: experiences of immigrant Hispanic women. *J Immigr Minor Health*, 13(6), 1168-1174. <https://doi.org/10.1007/s10903-010-9369-x>
- Saraswat, N., Wal, P., Pal, R. S., Wal, A., Pal, Y., & Roohi, T. F. (2021). A detailed biological approach on hormonal imbalance causing depression in critical periods (postpartum, postmenopausal and perimenopausal depression) in adult women. *The Open Biology Journal*, 9(1).

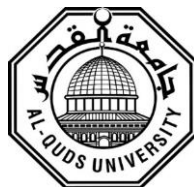
- Schaffir, J., Kunkler, A., Lynch, C. D., Benedict, J., Soma, L., & Doering, A. (2018). Association between postpartum physical symptoms and mood. *Journal of psychosomatic research*, 107, 33-37.
- Seyfried, L. S., & Marcus, S. M. (2003). Postpartum mood disorders. *Int Rev Psychiatry*, 15(3), 231-242. <https://doi.org/10.1080/0954026031000136857>
- Shalabi-Abbas, E. (2017). Unintended pregnancy in Palestinian women living in Ramallah District, occupied Palestinian territory: a qualitative study. *The Lancet*, 390, S22. [https://doi.org/10.1016/S0140-6736\(17\)32023-8](https://doi.org/10.1016/S0140-6736(17)32023-8)
- Shuffrey, L. C., Lucchini, M., Morales, S., Sania, A., Hockett, C., Barrett, E., ... & program collaborators for Environmental influences on Child Health Outcomes. (2022). Gestational diabetes mellitus, prenatal maternal depression, and risk for postpartum depression: an Environmental influence on Child Health Outcomes (ECHO) Study. *BMC Pregnancy and Childbirth*, 22(1), 758.
- Silverman, M. E., Reichenberg, A., Savitz, D. A., Cnattingius, S., Lichtenstein, P., Hultman, C. M., Larsson, H., & Sandin, S. (2017). The risk factors for postpartum depression: A population-based study. *Depression and anxiety*, 34(2), 178-187
- Smith-Nielsen, J., Tharner, A., Krogh, M. T., & Vaever, M. S. (2016). Effects of maternal postpartum depression in a well-resourced sample: Early concurrent and long-term effects on infant cognitive, language, and motor development. *Scandinavian journal of psychology*, 57(6), 571-583.
- Spinelli, M. G. (2001). A Systematic Investigation of 16 Cases of Neonaticide. *American Journal of Psychiatry*, 158(5), 811-813. <https://doi.org/10.1176/appi.ajp.158.5.81>
- Sridhar, H., Kishore, M. T., & Chandra, P. S. (2024). Child developmental outcomes associated with postpartum depression and anxiety in low and middle-income countries: a systematic review. *Archives of Women's Mental Health*.
- Stewart, D. E., & Vigod, S. N. (2019). Postpartum depression: pathophysiology, treatment, and emerging therapeutics. *Annual review of medicine*, 70, 183-196.
- Stroud, J. T., Bush, M. R., Ladd, M. C., Nowicki, R. J., Shantz, A. A., & Sweatman, J. (2015). Is a community still a community? Reviewing definitions of key terms in community ecology. *Ecology and evolution*, 5(21), 4757-4765.
- Stuebe, A. M., Grewen, K., & Meltzer-Brody, S. (2013). Association between maternal mood and oxytocin response to breastfeeding. *J Womens Health (Larchmt)*, 22(4), 352-361. <https://doi.org/10.1089/jwh.2012.3768>
- Strathearn, L., Giannotti, M., Mills, R., Kisely, S., Najman, J., & Abajobir, A. (2020). Long-term cognitive, psychological, and health outcomes associated with child abuse and neglect
- Tan, J., Xiong, Y., Wang, X., Wei, S., Luo, C., Huang, S., ... & Wu, F. (2024). Influencing factors for postpartum depression in women with gestational diabetes mellitus. *Frontiers in Endocrinology*, 15, 1423127.

- Tunçalp, Ö., Were, W. M., MacLennan, C., Oladapo, O. T., Gülmezoglu, A. M., Bahl, R., Daelmans, B., Mathai, M., Say, L., Kristensen, F., Temmerman, M., & Bustreo, F. (2015). Quality of care for pregnant women and newborns-the WHO vision. *Bjog*, 122(8), 1045-1049. <https://doi.org/10.1111/1471-0528.13451>
- Vahid-Ansari, F., & Albert, P. R. (2021). Rewiring of the serotonin system in major depression. *Frontiers in psychiatry*, 12, 802581
- Van Lieshout, R. J., Layton, H., Savoy, C. D., Haber, E., Feller, A., Biscaro, A., ... & Ferro, M. A. (2022). Public health nurse-delivered group cognitive behavioural therapy for postpartum depression: A randomized controlled trial. *The Canadian Journal of Psychiatry*, 67(6), 432-440.
- Wildali, D., Nazzal, S., Hamshari, S., & Belkebir, S. (2024). Prevalence and risk factors of postpartum depression among women attending primary healthcare centers in northern of West Bank/Palestine: a cross-sectional study, 2022. *BMC women's health*, 24(1),
- Wisner, K. L., Gracious, B. L., Piontek, C. M., Peindl, K., & Perel, J. M. (2003). Postpartum disorders: Phenomenology, treatment approaches, and relationship to infanticide. In *Infanticide: Psychosocial and Legal Perspectives on Mothers Who Kill*. American Psychiatric Publishing, Inc.
- Wardrop, A. A., & Popadiuk, N. E. (2013). Women's Experiences with Postpartum Anxiety: Expectations, Relationships, and Sociocultural Influences. *Qualitative Report*, 18, 6.
- WHO. (2021). *New global targets to prevent maternal deaths*. <https://www.who.int/news/item/05-10-2021-new-global-targets-to-prevent-maternal-deaths>
- Williamson, J. A., O'Hara, M. W., Stuart, S., Hart, K. J., & Watson, D. (2015). Assessment of postpartum depressive symptoms: The importance of somatic symptoms and irritability. *Assessment*, 22(3), 309–318. <https://doi.org/10.1177/1073191114544357>
- Ye, Z., Wang, L., Yang, T., Chen, L. Z., Wang, T., Chen, L., ... Qin, J. (2020). Gender of infant and risk of postpartum depression: a meta-analysis based on cohort and case-control studies. *The Journal of Maternal-Fetal & Neonatal Medicine*, 35(13), 2581–2590. <https://doi.org/10.1080/14767058.2020.1786809>.
- Yim, I. S., Tanner Stapleton, L. R., Guardino, C. M., Hahn-Holbrook, J., & Dunkel Schetter, C. (2015). Biological and psychosocial predictors of postpartum depression: systematic review and call for integration. *Annu Rev Clin Psychol*, 11, 99-137. <https://doi.org/10.1146/annurev-clinpsy-101414-020426>
- Yu, J., Zhang, Z., Deng, Y., Zhang, L., He, C., Wu, Y., Xu, X., & Yang, J. (2023). Risk factors for the development of postpartum depression in individuals who screened positive for antenatal depression. *BMC Psychiatry*, 23(1), 557. <https://doi.org/10.1186/s12888-023-05030-1>

- Zhang, Y., & Jin, S. (2016). The impact of social support on postpartum depression: The mediator role of self-efficacy. *Journal of health psychology, 21*(5), 720-726.

Appendix :

1. The Questioner



نموذج الموافقة على المشاركة بالدراسة عنوان الدراسة : التجارب المعيشية للنساء الفلسطينيات المصابات باكتئاب ما بعد الولادة

اسم الباحثة: مرح محمد موسى سباتين
اسم المشرفة: د مها نحال
التخصص: ماجستير في صحة الأم والطفل
العنوان: جامعة القدس – أبو ديس المبنى الرئيسي
رقم الهاتف: 0568653725

البريد الإلكتروني: Marahsabatee98@gmail.com

تتمحور هذه الدراسة حول تجربة النساء الفلسطينيات مع مرض اكتئاب ما بعد الولادة وتأثيره على النواحي (الجسدية، والنفسية والاجتماعية والعائلية) للنساء اللواتي عايشن تجربة اكتئاب ما بعد الولادة. وتهدف هذه الدراسة إلى: التعرف بعمق على تجربة النساء الفلسطينيات مع اكتئاب ما بعد الولادة واطهار العوامل التي قد تؤثر على تجربة النساء الفلسطينيات مع اكتئاب ما بعد الولادة.

نشكرك على موافقتك لإجراء هذه المقابلة والتي ستستغرق من ٦٠-٨٠ دقيقة. سوف يتم تسجيل المقابلة لإعادة تحليلها ودراستها والمعلومات المأخوذة ستستخدم فقط لأغراض بحثية. إن المشاركة في هذا الدراسة اختيارية. إذ يمكنك أن ترفضي المشاركة، أو أن تتراجعي عن المشاركة في الدراسة في أي وقت. كذلك يمكنك أن ترفضي الإجابة على أي سؤال لا ترغبين في الإجابة عليه. لن تصل اجاباتك الى أي شخص اخر غير الباحث الرئيسي والمشرف على الدراسة وخبير التقييم بعد ما تكون كل الأسماء قد حذفت. إذا كان لديك أي أسئلة أو استفسارات إضافية، أستطيع أنا أن ساعدك فيها وأستطيع أن أسأل فريق البحث عنها.

موافقة المشاركة

تعرفت على الهدف من الدراسة وفهمته بوضوح، وتمت الإجابة على كل أسئلتني. أوافق طوعياً على أن أشارك في الدراسة وأعلم أنه في حال كانت لدي أسئلة تتعلق بالدراسة، بإمكانني الاتصال بالباحثة مرح سباتين على الرقم (0568653725) كما أوضحت الباحثة ان بإمكانني الاتصال مع الطبيب النفسي د. توفيق سلمان في حالة احتياجي لاي مشورة تتعلق بالحالة النفسية التي كنت اعاني منها في السابق. رقم الطبي(0599676031) والبريد الإلكتروني tawfiq.salman@gmail.com. أدرك بذلك أن لدي كامل الحرية للتراجع عن هذه الموافقة وأوقف المشاركة في هذه الدراسة، في أي وقت، حتى بعد توقيع هذا البيان.

التاريخ _____
التوقيع _____
توقيع الباحثة _____

الاستبيان :

الجزء الأول: معلومات عامة عن النساء المشاركات

1- العمر

- 18-24 سنة
 25-31 سنة
 32-38 سنة
 أكثر من 38 سنة

2 - مكان الإقامة

- مدينة
 قرية
 مخيم

3- الوضع الوظيفي الحالي

- اعمل بدوام كامل
 اعمل بدوام جزئي
 عاطلة عن العمل

4- المستوى التعليمي

- مدرسة ابتدائية
 مدرسة أساسية
 المدرسة الثانوية
 كلية
 الجامعة

5- دخل الأسرة:

- أقل من 1900 شيكل
 بين 2000-3500 شيكل
 أكثر من 3500 شيكل

6- عدد الأطفال

7- مكان الولادة الاخيرة

- مستشفى خاص
 مستشفى حكومي

8- طريقة الولادة الاخيرة

- الولادة الطبيعية
 ولادة باستخدام الشفط او الأدوات المساعدة
 عملية قيصرية

الجزء الثاني: التجارب المعيشية للنساء الفلسطينيات المصابات باكتئاب ما بعد الولادة

السؤال الأول: يرجى وصف مشاعرك بعد ولادة آخر طفل

1. كيف بدأت هذه المشاعر؟ منذ متى بدأت تشعرين تعيشين أعراض اضطراب اكتئاب ما بعد الولادة؟
2. ما الذي شعرت به بالضبط هل يمكنك وصف هذه المشاعر من فضلك؟ ما هي الصعوبات والتحديات التي واجهتك خلال تلك المدة؟
3. كيف فهمتي أنك تعاني اكتئاب ما بعد الولادة، ومن الذي ساعدك على فهمه. كيف أثرت هذه التجربة على شخصيتك

أخبريني عن تجربتك في غرفة الولادة مع الأطباء والقابلات وطريقة الولادة كيف أثر هذا عليك؟

السؤال الثاني: كيف طلبتي المساعدة والعلاج للتغلب على المشاعر التي راودتك بعد الولادة وكيف كانت الفائدة ما نوع العلاج الذي تلقيته؟ اشرحي لي من فضلك تجربتك مع العلاج؟

1. ما نوع العلاج الذي تفضليه وتشعرين بتحسناً باتباعه؟ ماذا عن قدرتك على اتخاذ القرار بالنسبة للعلاج المناسب كيف ساعدك هذا العلاج على تخفيف أعراض اكتئاب ما بعد الولادة؟
2. ماذا عن الاستشارة؟ من الذي قدم لك الاستشارة ومن استطاع التحدث معك؟
3. ما هي العوائق التي منعتك أو قد تمنعك من طلب المساعدة؟

السؤال الثالث: صفي مشاعرك تجاه آخر طفل أنجبته والذي بعد ولادته بداتي تشعرين بمشاعر الكناية

1. ما هو شعورك تجاه طفلك؟
 2. قولي لي كيف يؤثر جنس الطفل عليك وعلى مشاعرك بعد الولادة؟
 3. ما مدى صعوبة إنجاب طفل وأنت غير قادره على الاعتناء به / بها؟
- السؤال الرابع: كيف استطعت مواجهة المشاعر التي وصفتها وما هي طرق المواجهة التي كانت مفيدة للتخفيف من مشاعر الكناية التي عايشتها

1. ما هي الطرق التي أدت الى تحسين مشاعرك؟ وساعدت في تحسن صحتك النفسية؟
2. هل شعرت بأن هذه الطرق أو الأنشطة جيدة بالنسبة لك؟
3. متى بدأت تشعرين بالتحسن أو ببعض التحسن؟

السؤال الخامس: هل يمكنك وصف رد فعل الناس من حولك كعائلة أفراد العائلة المقربين، الأقارب، الجيران؟ أخبريني عن ردة فعل زوجك والديك وحمامتك والجيران

1. كيف يمكنك تفسير مشاعرهم؟
2. أعطيني تفاصيل أكثر حول رد فعلهم تجاه حالتك وتجاه رعاية الطفل؟
3. كيف استطاعوا أن يقدموا لك الدعم والمساعدة عند الحاجة؟

A- permission letter

State of Palestine
Ministry of Health
Education in Health and Scientific
Research Unit



دولة فلسطين
وزارة الصحة
وحدة التعليم الصحي
والبحث العلمي

Ref.:
Date:.....

الرقم: ٤٤٤٤٤٤٤٤
التاريخ: ٢٠٢٠/١٠/١٠

عطفة الوكيل المساعد لشؤون الصحة العامة وصحة الاسرة المحترم،،،
تعبية واحترام،،،

الموضوع: تسهيل مهمة بحث

يرجى تسهيل مهمة الطالبة: مرح محمد موسى سباتين- برنامج ماجستير صحة امومة

وطفولة/ جامعة القدس، في عمل بحث بعنوان:

" التجارب المعيشية للنساء الفلسطينيات العصابات باكتئاب ما بعد الولادة "

من خلال السماح للطالبة بالحصول على معلومات من خلال مقابلة النساء عينة الدراسة في

عيادات الصحة النفسية(بعد اخذ موافقتين) وموافقة الطبيب المسؤول عن الحالة، واشراف

اكاديمي: د. مها نحال، وذلك في:

- مراكز الصحة النفسية في مديريات الصحة في : نابلس- بيت لحم - الخليل (شمال-

وسط- جنوب)

على ان يتم الالتزام باساليب واخلاقيات البحث العلمي.

على ان يتم تزويد الوزارة بنسخة PDF من نتائج البحث.
مع الاحترام،،،

د. عبد الله القواسمي

رئيس وحدة التعليم الصحي والبحث العلمي



نسخة: منسقة برامج الدراسات العليا- كلية التمريض المحترمة/ جامعة القدس

c- Ethical approval letter

Al-Quds University
Faculty of Health Professions
Nursing Department
Jerusalem-Abu Dies



جامعة القدس
كلية المهن الصحية
حائرة التمريض
القدس-أبو ديس

Date: 24\3\2021

Recommendation letter

To whom it may concern

It is my pleasure to highly recommend **Miss. Marah Sabateen** for joining the higher education program at your university to obtain master degree in Midwifery. Miss. Marah joined our Midwifery program, College of Health Professions- Al-Quds University in September 2016 and graduated in October 2020.

I have known Miss. Marah as a distinguished student. She is bright, energetic, and proved to be a good student in midwifery with high performance. Marah has excellent theoretical background, worked and is still working very hard to gain clinical experience in the field of Midwifery. We are in need of such an enthusiastic and knowledgeable person to continue education in the field of Midwifery as the Master's degree specialists in Midwifery are lacking in Palestine. I believe that Miss. Marah is an excellent candidate for the Master's degree and I recommend her to be accepted in your program. Miss. Marah is a committed, cooperative and hardworking, so I hope that she will find acceptance on application for continuing her education.

If you have further inquiries, please don't hesitate to correspond with me on my e-mail: mnahal@staff.alquds.edu

Sincerely yours

DR Maha Nahal

PhD in Health care sciences

Pediatric Nurse

College of Health Professions

Al Quds University

Dr. Maha Nahal
Midwifery Department

التجارب المعيشة للنساء المصابات بالاكتئاب ما بعد الولادة في الضفة الغربية فلسطين: دراسة وصفية ظاهرته

الباحثة: مرص محمد موسى سباتين

إشراف: د. مها صدقي صالح نبال

الملخص

المقدمة: يُعد الاكتئاب ما بعد الولادة (PPD) مشكلة كبيرة تؤثر على النساء في سن الإنجاب، وهو يشكل تحديًا حاسمًا لصحة الأم على المستوى العالمي. معالجة الاكتئاب ما بعد الولادة تتماشى مع الاستراتيجيات العالمية لتحسين صحة الأمهات وتقليل الأمراض والوفيات القابلة للوقاية. نظرًا للانتشار المرتفع للاكتئاب ما بعد الولادة، الذي يؤثر على 10-15% من الأمهات سنويًا، تتطلب هذه المشكلة جهودًا كبيرة، مع التركيز على التقييمات النفسية والاجتماعية خلال فترة ما بعد الولادة. في السياق الفلسطيني، هناك فجوة ملحوظة في البحث الذي يستكشف تجارب واحتياجات ومشاعر النساء خلال هذه الفترة الحرجة.

الهدف: استكشاف التجارب المعيشة للنساء المصابات بالاكتئاب ما بعد الولادة في الضفة الغربية بفلسطين .

المنهجية: تم استخدام تصميم نوعي وصفي ظاهراتي لاستكشاف تجارب النساء اللواتي تم تشخيصهن مسبقًا بالاكتئاب ما بعد الولادة بعد الإنجاب. تم تجنيد 12 امرأة من عيادات الصحة النفسية التابعة لوزارة الصحة الفلسطينية. جُمعت البيانات باستخدام مقابلات شبه منظمة بعد الحصول على موافقتهم الشفوية. تم تحليل البيانات باستخدام طريقة تحليل المحتوى، بينما تم تحليل الخصائص الاجتماعية والديموغرافية للمشاركات باستخدام برنامج التحليل الإحصائي (SPSS). (26) أجريت الدراسة على مدار 14 شهرًا، من يونيو 2023 إلى ديسمبر 2024 .

النتائج : كانت تجارب النساء المصابات بالاكتئاب بعد الولادة شديدة الصعوبة ويمكن فهمها من خلال أربعة موضوعات رئيسية و12 فرعية. يتمثل الموضوع الأول في "الحبوس في المشاعر السلبية"، والتي تصور الاضطراب العاطفي الذي واجهته النساء، بما في ذلك الشعور بالحبس في

مشاعر سلبية خلال فترة الحمل والولادة، تجاه الأمومة، والمولود، ونفسيتهن الشخصية. هذه السلبية المتزايدة شكلت إدراكهن لتجاربهن وعلاقتهن بالآخرين.

أما الموضوع الثاني، "الضعف مع المحيطين"، فيسلط الضوء على شعور عميق بالضعف وانعدام الثقة. وكان هذا الضعف يظهر داخل الأسرة وتمدد إلى تفاعلاتهن مع النظام الصحي، حيث كان الدعم غالباً يُنظر إليه على أنه غير كافٍ.

أما الموضوع الثالث، "الحبوس في الضغوط الثقافية والاجتماعية"، يعكس التحديات الاجتماعية والثقافية التي واجهتها النساء. فقد واجهن عقبات ثقافية، تمييزاً جنسياً، وأعباءً اقتصادية، مما زاد من معاناتهن وأكد مشاعر العزلة واليأس.

أما الموضوع الأخير، "الوعي الذاتي والتعرف"، فيكشف عن رحلة تدريجية نحو فهم وإدارة حالتهم. بدأت النساء في إدراك الاكتئاب بعد الولادة كمرض يتطلب العلاج، وتطوير استراتيجيات للتعامل مع الأعراض، وتحولت تركيزهن إلى الاهتمام بأنفسهن واحتياجاتهن الشخصية. تقدم هذه الموضوعات صورة شاملة للتعقيدات العاطفية والاجتماعية والثقافية للاكتئاب بعد الولادة، مقدمة رؤى قيمة حول تجارب النساء المتأثرات بالاكتئاب.

المخلص: قدمت هذه الدراسة رؤى قيمة حول التجارب المعيشة للنساء المصابات بالاكتئاب ما بعد الولادة، وأبرزت التحديات العاطفية والنفسية والاجتماعية والثقافية التي وجهنها. كما استكشفت الطبيعة المتعددة الأوجه للاكتئاب ما بعد الولادة في السياق الفلسطيني وتأثيره على معاناة النساء من المشاعر السلبية وانعدام الأمان والضغوط المجتمعية. تؤكد هذه النتائج على الحاجة الملحة لتقييم العلامات والأعراض المبكرة للاكتئاب ما بعد الولادة من قبل مقدمي الرعاية الصحية المؤهلين، مع الأخذ بالاعتبار التدخلات الحساسة ثقافياً وزيادة الوعي بالصحة النفسية وتعزيز أنظمة الدعم لتلبية الاحتياجات الفريدة للنساء خلال فترة ما بعد الولادة. تسهم هذه الدراسة في سد الفجوة البحثية في هذا المجال وتدعو إلى مزيد من الاستكشاف لهذه الظاهرة لتحسين نتائج الصحة النفسية للأمهات .

الكلمات المفتاحية: الاكتئاب ما بعد الولادة، التجارب المعيشة ، الظواهر الوصفية.