



MISCONCEPTIONS ABOUT POSTPARTUM DEPRESSION AMONG FAMILY MEMBERS IN SAGAMU, NIGERIA: KNOWLEDGE, ATTITUDES, AND SOCIO-CULTURAL PREDICTORS.

Oluwabusolami E. Atekoja^{1*}, James A. Ojo¹, Olabisi M. Oluseye², Margaret M. Oladapo³, Elizabeth O. Oloruntola⁴, Adeola M. Awoniyi⁵, Temilade T. Ogundare¹, & Oluwaseyi E. Adeniyi¹

¹Department of Nursing Science, Olabisi Onabanjo University, Ago-Iwoye, Ogun State, Nigeria.

²Department of Community Health Nursing, University of Ibadan, Ibadan, Oyo State, Nigeria.

³Department of Community Health Nursing, University of Medical Sciences, Ondo, Ondo State, Nigeria.

⁴College of Nursing Sciences, Baptist Medical Centre, Saki, Oyo State, Nigeria.

⁵Clinical Nursing Department, University College Hospital, Ibadan, Oyo State, Nigeria.

(Corresponding Author: atekoja.busolami@oouagoiwoye.edu.ng, Mobile: +2348036592749)

ABSTRACT

Postpartum depression is a common yet underdiagnosed mental health issue that affects moms, babies, and families. In low- and middle-income countries, family members are crucial in identifying symptoms and facilitating care. This study assessed the knowledge, attitudes, and sociocultural factors influencing misconceptions about postpartum depression among family members in Sagamu Local Government Area, Ogun State, Nigeria. Data were collected among 392 adult family members of postpartum women using a multistage sampling technique. Data were collected using an interviewer-administered questionnaire and analysed using Chi-square tests and a logistic regression model. Most of the respondents (77.6%) demonstrated high knowledge of postpartum depression; however, 29.1% exhibited high levels of misconception. These findings indicate that knowledge and misconceptions co-existed, suggesting that although many respondents were aware of postpartum depression, a considerable proportion still held incorrect or culturally influenced beliefs about the condition. Chi-square analysis showed significant associations between misconceptions and educational level, monthly income, and cultural beliefs ($p < 0.05$). Also, there was a statistically significant association between cultural beliefs and societal norms and perception of postpartum depression ($\chi^2 = 5.632$, $df = 1$, $p = 0.001$). Despite high general knowledge of postpartum depression, misconceptions and culturally rooted beliefs remain widespread among family members and significantly shape perceptions of the condition. These findings highlight the need for family-centred mental health interventions to promote support for postpartum women.

Keywords: Cultural Beliefs, Family Perceptions, Maternal health, Mental Health disorder, Postpartum Depression

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INTRODUCTION

Postpartum depression (PPD) is defined as an episode of major depressive disorder or sometimes minor depression that occurs in the postpartum period (Qi et al., 2022). PPD is characterized by a low mood or loss of pleasure or interest in activities for long periods of time. It adversely affects mothers, infants, and families (Wang et al., 2021; Obioha et al., 2021). In countries with low and middle incomes like Nigeria, recognizing and managing PPD depends not only on clinical knowledge but also on family members' perceptions, attitudes, cultural beliefs, and societal norms about motherhood and mental health (Gowon et al., 2024; Poreddi et al., 2020). Family members usually serve as the primary observers, decision-makers, and support sources for postpartum women. Therefore, misconceptions, stigma, and cultural interpretations of PPD can delay help-seeking and access to appropriate care (Gowon et al., 2024; Obioha et al., 2021). These responses are also shaped by socio-demographic factors such as age, gender, education, occupation, and income (Adeyemo et al., 2020; Eke & Onyenirionwu, 2019). Understanding how these factors interact among family members is crucial for improving the

identification, prevention, and management of postpartum depression.

Beyond individual-level risk factors, postpartum depression represents a substantial global public health burden. Epidemiological evidence indicates that the prevalence of PPD is higher in developing countries (19.9%) than in developed settings (14.5%) (Wang et al., 2021). Among women without previous psychiatric illness who delivered healthy infants, the global prevalence remains approximately 17% (Adeyemo et al., 2020; Obioha et al., 2021). In Africa, the pooled prevalence of postpartum depression has been estimated at 16.84% (Obioha et al., 2021; Owolabi et al., 2023). These figures underscore the significant perceived severity of postpartum depression.

In Nigeria, postpartum depression is often overlooked. Research indicates that the prevalence is around 14.6% in the South-West and can reach up to 22.9% in the South-East (Obioha et al., 2021). Despite these statistics, postpartum depression is commonly normalized or misunderstood by families and communities, hindering early identification and prompt treatment.

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Postpartum depression is part of a range of postnatal mood disorders, which also includes postpartum blues and postpartum psychosis (Obioha et al., 2021; Owolabi et al., 2023). Postpartum blues usually start within a few days after childbirth and typically resolve within two weeks. In contrast, postpartum depression is marked by ongoing emotional and behavioral symptoms that disrupt a mother's ability to function (Mughal et al., 2022). The American Psychological Association (2022) notes that these symptoms encompass persistent sadness, anxiety, mood fluctuations, sleep issues, changes in appetite, low self-esteem, challenges in bonding with the baby, and intrusive or distressing thoughts.

Failure to identify and treat postpartum depression has serious consequences. Untreated PPD negatively affects maternal quality of life, strains marital relationships, and contributes to family dysfunction (Eke & Onyenirionwu, 2019; Obioha et al., 2021). Moreover, maternal depression during the postpartum period has been linked to long-term adverse child outcomes (Eke & Onyenirionwu, 2019; Obioha et al., 2021). These consequences reinforce the importance of perceived severity within the Health Belief Model.

In this setting, family members are pivotal in influencing maternal mental health outcomes. In numerous Nigerian communities, childbirth and postpartum care are experiences centered around the family. Nonetheless, research indicates that family members often perceive depressive symptoms as typical aspects of motherhood, especially when these symptoms resemble postpartum blues (Mughal et al., 2022). Such misunderstandings serve as significant perceived obstacles to care, potentially hindering emotional support and delaying professional help (Gowon et al., 2024). Without sufficient knowledge, families may unintentionally worsen postpartum depression.

Despite the acknowledged significance of family involvement, research in Nigeria has predominantly concentrated on mothers' knowledge, prevalence, and risk factors associated with postpartum depression (Poreddi et al., 2020). Cultural beliefs and societal norms concerning motherhood significantly influence how families perceive postpartum depression (Gowon et al., 2024). In the Sagamu Local Government Area of Ogun State, where extended family involvement in maternal care remains prevalent, understanding

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family members' perspectives on postpartum depression is particularly crucial. However, empirical data on their knowledge, perceptions, and attitudes toward PPD within this context are limited.

Statement of the Problem
Ideally, postpartum depression (PPD) should be widely recognized as a common and treatable condition, with adequate knowledge among family members who serve as primary caregivers. In such a setting, family members would be able to correctly identify symptoms and facilitate timely help-seeking.

However, the current reality in many low- and middle-income countries, including Nigeria, deviates significantly from this ideal. PPD remains under-recognized and poorly managed despite its substantial burden (Wang et al., 2021). In Nigeria, mental health literacy regarding PPD is generally low, and misconceptions persist (Nwachukwu, 2022). This situation highlights a critical gap in the understanding of how knowledge, attitudes, and socio-cultural factors among family members contribute to misconceptions about PPD. Furthermore, socio-cultural dynamics such as stigma and spiritual attributions of illness remain underexplored (Afolabi & Adebawale, 2018). Evidence

suggests that the condition is often overlooked within maternal healthcare systems, including in Ogun State (Obioha et al., 2021). One of the major barriers to effective management of PPD is the limited knowledge of family members.

Therefore, this study aims to assess the knowledge, attitudes, and socio-cultural predictors of misconceptions about postpartum depression among family members in Sagamu, Ogun State, Nigeria.

Purpose of the study
The primary aim of this study is to assess misconceptions about postpartum depression among family members in Sagamu, Nigeria. The specific objectives are to:

1. assess the level of knowledge among family members on postpartum depression in Sagamu, Ogun State.
2. assess the perception of family members towards postpartum depression in Sagamu.
3. assess the attitudes of family members towards postpartum depression, including stigma and support.

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4. identify the perceived impact of cultural beliefs and societal norms on the management of postpartum depression within families in Sagamu.

Literature Review

Theoretical Framework

While the biopsychosocial model proposed by Engel (1977) offers a comprehensive framework for understanding postpartum depression, it was utilized in this study as a heuristic or guiding framework rather than being empirically tested in its entirety. Specifically, the study did not measure biological, psychological, and social domains as independent constructs using standardized scales. Instead, selected variables such as knowledge and attitudes (psychological domain) and cultural beliefs and societal norms (social domain) were employed as proxies to explore factors influencing misconceptions about postpartum depression. The biological component of the model was not directly assessed, as the study primarily focused on family members' perceptions rather than clinical or physiological determinants of postpartum depression. Consequently, the biopsychosocial model served to conceptually frame the study and interpret

findings, rather than to test causal pathways across its three domains.

Biological Dimension: The biological component of the model emphasizes physiological and genetic factors that contribute to the development of PPD, including hormonal fluctuations following childbirth, neurochemical imbalances, and genetic predisposition to depression (Stewart & Vigod, 2016). In the context of this study, knowledge of biological causes of PPD is a critical determinant of how family members interpret the condition.

Family members who possess accurate knowledge of the biological basis of PPD are more likely to recognize it as a legitimate medical condition and demonstrate supportive attitudes toward affected mothers. Conversely, poor knowledge or misinformation about biological factors may contribute to misconceptions, such as attributing PPD to personal weakness or intentional behaviour. This aligns with evidence suggesting that low mental health literacy is associated with stigma and delayed help-seeking (Jorm, 2012).

Psychological Dimension: The psychological domain focuses on individual-level factors such as beliefs,

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emotions, prior experiences, and coping mechanisms. In this study, attitudes toward PPD are conceptualized within this domain. Family members' personal beliefs about mental illness, prior exposure to psychological distress, and individual coping styles significantly influence how they perceive and respond to mothers experiencing PPD.

Individuals with prior knowledge or experience of mental health conditions may exhibit more empathetic and supportive attitudes, while those with negative or stigmatizing beliefs may trivialize symptoms or attribute them to non-medical causes. Such attitudes can reinforce misconceptions and hinder appropriate support for affected mothers (Odufuwa et al., 2022).

Social Dimension: The social component encompasses cultural beliefs, societal norms, family structures, and support systems that shape health perceptions and behaviors. In many Nigerian communities, socio-cultural factors play a dominant role in interpreting mental health conditions, including PPD. Cultural expectations that motherhood should be associated with joy and fulfillment may lead to the denial or minimization of depressive symptoms.

Furthermore, beliefs in supernatural causation, stigma associated with mental illness, and gendered expectations of maternal resilience may contribute to persistent misconceptions about PPD (Afolabi & Adebowale, 2018). Social support systems, including family networks, religious institutions, and community structures, can either facilitate or hinder appropriate responses to PPD.

Empirical Review

Empirical evidence on postpartum depression (PPD) has largely focused on prevalence and maternal outcomes, with limited attention to the role of family members despite their significant influence on maternal support and health-seeking behaviour. Existing studies indicate that knowledge, attitudes, and socio-cultural contexts are key determinants shaping perceptions and misconceptions about PPD, although findings remain inconsistent across settings.

Evidence on knowledge of PPD shows considerable variation. Among family members, moderate levels of knowledge have been reported, with higher knowledge associated with more favourable attitudes (Poreddi et al., 2020). Similarly, studies in Sagamu suggest relatively good awareness

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among mothers, although gaps in understanding persist (Leslie et al., 2024). In contrast, research from other low- and middle-income countries indicates substantial knowledge deficits; for instance, a large proportion of pregnant women were unaware of perinatal depression (Ransing et al., 2020), while many postpartum mothers demonstrated low knowledge levels (Mohammad et al., 2020). These disparities highlight persistent gaps in mental health literacy, which have been linked to misinterpretation of symptoms and delayed help-seeking.

Misconceptions about PPD are widespread and often rooted in misinformation and cultural interpretations. Common beliefs include viewing PPD as a temporary emotional state, a self-limiting condition, or a problem affecting only certain groups of women (Traci, 2023). Such misconceptions undermine recognition of PPD as a clinical condition requiring intervention. Notably, knowledge gaps are not limited to the general population; healthcare providers have also demonstrated limited understanding of PPD, potentially influencing the quality of care and information provided to families (Elshatarat et al., 2018).

Attitudes toward PPD reflect a complex interplay between empathy and stigma. While family members often express willingness to support affected mothers, negative perceptions such as viewing women with PPD as weak or incapable persist (Juntaruksa et al., 2017). Systematic reviews further indicate low mental health literacy, poor symptom recognition, and stigmatizing attitudes among both the public and perinatal women, which negatively affect help-seeking behaviour (Daehn et al., 2022). Cultural expectations surrounding motherhood also contribute to stigma by discouraging emotional expression and reinforcing the belief that motherhood should be inherently fulfilling (Insan et al., 2022).

Socio-cultural factors play a critical role in shaping perceptions of PPD. Studies have shown that cultural norms, family dynamics, and social support systems influence how symptoms are interpreted and managed. While supportive family environments may reduce the risk of PPD, negative interpersonal relationships and cultural expectations can exacerbate symptoms or delay recognition (Ekpenyong & Munshittha, 2023; Tembo & Burns, 2023). In some contexts, depressive symptoms are normalized as part of daily

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life, further limiting help-seeking (Babatunde & Moreno-Leguizamon, 2022).

Hypotheses

H₀1: There is no significant relationship between the sociodemographic characteristics and perception of family members on postpartum depression.

H₀2: There is no significant relationship between cultural beliefs and societal norms on the management of postpartum depression and perceptions about postpartum depression among family members

METHOD

Design

A descriptive cross-sectional research design was adopted because it allows for the collection of data at a single point in time, making it efficient for assessing the perceptions of family members towards postpartum depression among residents in Sagamu, Ogun State. The study was carried out in Sagamu, one of the twenty local government areas (LGAs) in Ogun State, Southwest Nigeria. It is a semi-urban LGA with a few rural settlements.

The choice of Sagamu was informed by empirical and contextual considerations. First, Ogun State has been identified as one of the regions in Nigeria with a notable burden of maternal mental health challenges, including postpartum depression, with community-based studies reporting varying levels of awareness and misconceptions (Adeyemo et al., 2020; Obioha et al., 2021). Sagamu, in particular,

hosts a diverse population with varying socio-economic, educational, and cultural backgrounds, which is essential for examining socio-cultural predictors of misconceptions. Additionally, the coexistence of traditional belief systems and modern healthcare practices in Sagamu makes it an appropriate setting to explore how cultural beliefs and societal norms influence perceptions of postpartum depression (Atekoja et al., 2025).

Participants

Eligible participants were consenting residents of the three wards in Sagamu Local Government Area, aged 18 years and above, with at least one postpartum mother in the family at the time of data collection. A postpartum mother was defined in this study as a woman who has given birth within the last six months prior to data collection. Accordingly, eligible

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respondents were family members who had at least one woman in their household or immediate family who delivered a baby within the past six months. Only permanent residents who had lived in the community for a minimum of six months and who could communicate in either English or Yoruba were included. Exclusion criteria were non-consenting individuals, residents younger than 18 years, and adults who were not permanent residents of the community. The sample size was calculated using the Kish-Leslie (1965) formula:

$$n = (Z^2 pq) / e^2$$

Using a 95% confidence level ($Z = 1.96$), an estimated prevalence of postpartum depression of 0.365 from a previous study in Lagos, Nigeria (Adeyemo et al., 2020). ($p = 0.365$), $q = 1 - p = 0.635$, and a margin of error of 0.05,

$$N = \frac{(1.96)^2 (0.365) (0.635)}{(0.05)^2}$$

$$N = \frac{(3.842) (0.2318)}{0.0025}$$

$$N = \frac{0.8906}{0.0025}$$

$$N = 356.23$$

=356 respondents

Attrition Rate: $\frac{\text{Previous sample size}}{\text{standard attrition rate}}$

Standard Attrition Rate

- 1

$$\text{Attrition Rate: } 356 * 10 / 10 - 1 = 396$$

The required sample size was 392.

A multi-stage sampling technique (a composite sampling technique involving two or more sampling techniques) was employed. Sagamu Local Government Area was purposively selected for the study.

Stage 1: Selection of wards: There are fifteen wards in Sagamu Local Government Area. Three wards; Aiyegbami/Ijokun (Ward 3), Sabo I (Ward 4), and Sabo II (Ward 5) were selected using a purposive sampling technique. The selection was based on their high population density, residential characteristics, and likelihood of identifying households with postpartum mothers, which are central to the study objectives. These wards are predominantly residential and represent a mix of socio-economic and cultural backgrounds typical of the Sagamu population. The use of purposive sampling at this stage was considered appropriate because the target population family members of postpartum mothers is not evenly distributed across all wards.

Stage 2: Selection of streets: There are about 20 to 35 streets per ward; for the three

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(3) wards, there is a minimum of 60 streets. 10 streets were selected for each of the 3 wards by a simple random sampling technique, making it a total of 30 streets.

Stage 3: Selection of houses: A systematic random sampling technique was used in selecting houses for the study. There are an average of 20 houses per street (60 streets × 20 houses = 1,200 houses). A systematic sampling technique was used to select households within the selected streets. The sampling interval (k) was determined using the formula:

$$k = \frac{N}{n}$$

Where:

N = total number of houses in the selected streets (1,200)

n = required number of houses to be sampled (600)

Thus,

$$k = \frac{1200}{600} = 2$$

This implies that every second house was selected for inclusion in the study after a random starting point was determined.

Stage 4: Selection of participants (family): In an average Nigerian suburban community, more than one family resides in a house. Simple random sampling was used to select at least one family member

within the selected houses in each ward until the calculated sample size was achieved.

Instrument

A total of 392 copies of the questionnaire were administered for data collection in this study using an interviewer-administered questionnaire. The items in the questionnaire were adopted from the literature (Obioha et al., 2021) in line with the research objectives. Five sections were included in the questionnaire. The questionnaire was prepared in English and translated into Yoruba, the main local language. Back translation was equally done to ensure that the content of the instrument is intact. Section A obtained data on the sociodemographic characteristics of the respondents, such as age, gender, tribe, religion, and occupation. It consisted of six (6) questions aimed at describing the key features of the target population for the study. Section B obtained data on the Level of knowledge among family members on postpartum depression in Sagamu, Ogun State, with 19 items that can be completed within 5 minutes, ranging from Yes or No options. Correct response scored 1 point, while an incorrect response scored 0 points. The maximum point a respondent can have is

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19, while the minimum point is 0. Perception was categorized into High and Low. Scores for each category are: 0 – 10 = Low, and 11 - 19.0 = High.

Section C obtained data on the perceptions of family members on PPD, and this consists of 7 items with a Yes or No response (correct response represents 1 point and incorrect response represents 0 points.)

Section D elicited information on the attitudes of family members towards postpartum depression, including stigma, support, and willingness to seek help, and this consisted of 9 items having options using a 4-point Likert scale: Strongly agree (1), Agree (2), Disagree (3), and Strongly disagree (4).

To ensure consistent interpretation, items were coded such that higher scores reflected more positive attitudes toward postpartum depression. Consequently, negatively worded items (e.g., statements reflecting stigma or misconceptions) were reverse-coded prior to analysis. After coding, individual item scores were summed to obtain a composite attitude score, with higher scores indicating more favorable and supportive attitudes, and lower scores indicating negative or stigmatizing attitudes.

Section E comprised items eliciting information on cultural beliefs and societal norms on the management of postpartum depression within families in Sagamu, and this had 12 items, ranging from Yes or No options. Yes score = 1 point, No score = 0 points.

The study instrument was originally developed in English and subsequently adapted to ensure cultural and linguistic appropriateness for respondents in Sagamu, Ogun State, where Yoruba is widely spoken. The translation and adaptation process followed standard cross-cultural research guidelines, including forward translation, back-translation, expert review, and pretesting.

Initially, the questionnaire was translated from English into Yoruba by a bilingual expert proficient in both languages and knowledgeable in public health terminology. The focus was on achieving conceptual equivalence rather than a literal translation, especially for culturally sensitive constructs such as postpartum depression and related emotional states. Subsequently, an independent bilingual translator, who was unaware of the original version, performed a back-translation of the Yoruba version into English. The original and back-translated versions were

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compared to identify discrepancies, ambiguities, and potential misinterpretations, and necessary revisions were made to ensure accuracy and consistency. Finally, the instrument underwent expert review by professionals in nursing, public health, and mental health to evaluate content validity, cultural relevance, and clarity of items, with particular attention given to terms lacking direct cultural equivalents. For example, the term “*baby blues*” was adapted to a culturally meaningful expression; “*ìyípadà imòlára lẹ̀yìn ìbíṃọ̀ (tí kì í pé)*” (temporary emotional changes after childbirth) to enhance comprehension and contextual relevance.

Finally, the adapted questionnaire was pretested among a small sample of respondents from a similar population outside the study area. Feedback from the pretest informed minor modifications in wording, sequencing, and clarity to improve understanding and reduce ambiguity.

This rigorous translation and cultural adaptation process ensured that the instrument was valid, reliable, and culturally appropriate, thereby enhancing the accuracy of responses and the overall quality of the data collected.

The validity of the instrument was established by ensuring that the items under each section of the questionnaire measure the intended constructs. This was determined through the face and content validity criteria. Face validity was established by ensuring the questions measured what they were supposed to measure, and content validity was established with information from the literature. A pretest was conducted using Cronbach's alpha to assess the internal consistency of the instrument using 10% of the sample size. The instrument was pretested in the Aiyeye community using 39 copies of the questionnaire, and the subscale measuring knowledge of postpartum depression had a Cronbach's Alpha of 0.82, signifying good reliability, while the subscale on cultural beliefs and societal norms also demonstrated good reliability with an alpha value of 0.80. The subscales assessing perceptions about postpartum depression ($\alpha = 0.75$) and attitudes towards postpartum depression ($\alpha = 0.78$) fell within the acceptable range. These findings suggest that the questionnaire items are internally consistent and reliable for assessing perceptions of postpartum depression among family members in Sagamu Local Government Area.

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Procedure

Data were collected with the help of five trained research assistants, and participants were informed about the benefits of the study and that participation was voluntary. The process of data collection was conducted from 4th to 19th October 2024 for three weeks on both weekdays and weekends. Most respondents understood English, and only a few used the Yoruba translated version.

Informed consent was obtained from the participants. The questionnaire formulated for this study was administered using an interviewer-administered approach. Additionally, Ethical approval (OOUTHNHREC/903/2024AP) was obtained from the Health Research and Ethics Committee of Olabisi Onabanjo University (OOUHREC). Participants were provided with an informed consent form outlining the purpose of the study and requesting respondents' approval to participate. The study's guiding ethical principles, informed consent, respect for individuals, beneficence, non-maleficence, and justice was followed by the researchers. All of these actions were taken to guarantee that respondents understood confidentiality and anonymity and that participation was voluntary. Participants who endorsed

sensitive items related to self-harm were debriefed and provided with information on available mental health support and referral services.

Method of Statistics Analysis

Data were checked for completeness, coded, and analyzed using SPSS version 26. Descriptive statistics, including frequencies and percentages, were used to summarize respondents' socio-demographic characteristics and key study variables such as knowledge, perceptions, attitudes, and cultural beliefs regarding postpartum depression (PPD). Composite scores were computed and categorized to enhance clarity and facilitate analysis. Inferential statistics were conducted using the Chi-square (χ^2) test to examine associations between socio-demographic variables and levels of misconception about PPD, as well as the relationship between cultural beliefs and societal norms and perception of PPD. The Chi-square test was chosen because the variables analyzed were categorical, making it appropriate for determining whether there is a statistically significant association between independent variables (e.g., socio-demographic characteristics, cultural beliefs) and the dependent variable (perception/misconception of PPD).

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Statistical significance was set at $p < 0.05$, and results were presented in tables and charts.

RESULTS

Socio-Demographic Characteristics of Respondents

The response rate was 100%. As shown in Table 1, all 392 respondents were included in the analysis. Most participants were aged 18–25 years (32.1%), followed by those aged 36–45 years (28.1%), 26–35 years (20.9%), and 46 years and above (18.9%). Females constituted the majority of respondents (64.3%). Nearly half were other family members of the mother

(48.0%), while the remainder were siblings (21.7%), parents (21.2%), and spouses (9.2%). Regarding education, 42.1% had a tertiary education, 30.1% had secondary education, 17.3% had primary education, and 10.5% had no formal education. More than half were self-employed (58.9%), whereas 22.2% were unemployed. Monthly income ranged from less than ₦30,000 (25.0%) to above ₦91,000 (27.8%).

Table 1: Socio-Demographic Characteristics of Respondents

Variables	Characteristics	Frequency N=392	Percentage (100 %)
Age as of the last birthday	18-25	126	32.1
	26-35	82	20.9
	36-45	110	28.1
	46 and above	74	18.9
Sex	Male	140	35.7
	Female	252	64.3
	Spouse	36	9.2
Relationship to the mother	Parent	83	21.2
	Sibling	85	21.7
	Other family member	188	48.0
	Primary education	68	17.3
Highest level of Education	Secondary education	118	30.1
	Tertiary education	165	42.1
	None	41	10.5
	Unemployed	87	22.2
Occupation	Self-employed	231	58.9
	Private organization	47	12.0
	Public organization	27	6.9
	< ₦30,000	98	25.0
Monthly income (Naira)	₦31,000 - ₦60,000	83	21.2
	₦61,000- ₦90,000	102	26.0
	> ₦91,000	109	27.8

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Knowledge of Postpartum Depression

Table 2 presents findings on the perception of family members regarding postpartum depression (PPD). All participants (100%) were aware of postpartum depression. Over half of the participants 226(57.7%) stated they knew someone who had experienced PPD. Only 134(34.2%) of participants believed that postpartum depression affects

only the mother. Most 361 (92.1%) knew that postpartum depression can be treated early, and 331(84.4%) agreed that it can be prevented. The most frequently identified symptoms included persistent sadness 383(97.7%), difficulty concentrating 367(93.6%), and thoughts of self-harm or harm to the baby 354(90.3%). The overall perception of PPD among the participants was high 304(77.6%).

Table 2: Knowledge of family members on postpartum depression

Statement	Yes F(%)	No F (%)
Had heard of postpartum depression before this survey	392 (100.0%)	-
Knew someone who had experienced postpartum depression	226 (57.7%)	166 (42.3%)
Postpartum depression affects only the mother	134 (34.2%)	258 (65.8%)
Postpartum depression can affect the baby and other family members	309 (78.8%)	83 (21.2%)
Postpartum depression can be treated early	361 (92.1%)	31 (7.9%)
Postpartum depression can be prevented	331 (84.4%)	61 (15.6%)
The risk factors for postpartum depression:		
Age	298 (76.0%)	94 (24.0%)
Family history	316 (80.6%)	76 (19.4%)
Maternal use of alcohol	306 (78.1%)	86 (21.9%)
Lack of sleep	338 (86.2%)	54 (13.8%)
Unemployment	318 (81.1%)	74 (18.9%)
Poor marital relationships	361 (92.1%)	31 (7.9%)
Symptoms of postpartum depression:		
Persistent sadness	383 (97.7%)	9 (2.3%)
Isolation	355 (90.6%)	37 (9.4%)
Withdrawal	346 (88.3%)	46 (11.7%)
Poor sleep/oversleeping	350 (89.3%)	42 (10.7%)
Crying more often	348 (88.8%)	44 (11.2%)
Difficulty concentrating	367 (93.6%)	25 (6.4%)
Thoughts of harming oneself or the baby	354 (90.3%)	38 (9.7%)
Level of Knowledge		
Low (0-10)	88	22.4
High (11 - 19.0)	304	77.6

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Perceptions and Misconceptions about Postpartum Depression

Perceptions of postpartum depression among respondents are shown in Table 3. Nearly half of the respondents equated postpartum depression with “baby blues,” while a notable proportion perceived PPD as a rare condition or doubted its legitimacy

as a medical disorder. Overall, 114 respondents (29.1%) demonstrated high levels of misconception, whereas 278 (70.9%) had low levels of misconception regarding postpartum depression. In addition, 104 participants believed that PPD is not a genuine medical condition, while 78 assumed it only affects women with a prior history of mental illness

Table 3: Perceptions of family members about PPD

Statement	Yes F (%)	No F (%)
Postpartum depression is the same as “baby blues”	190 (48.5%)	202 (51.5%)
Postpartum depression is a rare condition	176 (44.9%)	216 (55.1%)
Postpartum depression is not a real medical condition	104 (26.5%)	288 (73.5%)
Only women who have a history of mental illness can develop PPD	78 (19.9%)	314 (80.1%)
Postpartum depression will go away on its own without treatment	134 (34.2%)	258 (65.8%)
Postpartum depression affects only first-time mothers	65 (16.6%)	327 (83.4%)
Postpartum depression is caused by a lack of love for the baby	90 (23.0%)	302 (77.0%)
Overall Perception	Frequency (392)	Percent (%)
Low misconception (0 – 3.5)	278	70.9
High misconception (3.6-7.0)	114	29.1

Attitudes toward Postpartum Depression

The attitudes of family members toward postpartum depression are presented in Table 4. While a majority of respondents acknowledged that all postnatal mothers could be at risk and 276 (70.5%) indicated

willingness to recommend professional care, negative perceptions persisted, with 122 (31.2%) describing women with PPD as unpredictable and 97 (24.8%) considering them difficult to live with.

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Table 4: Attitudes Towards Postpartum Depression

Statement	Strongly agreed	Agreed	Disagreed	Strongly disagreed
	F (%)	F (%)	F(%)	F(%)
Postpartum depression is not a serious condition	48 (12.2%)	66 (16.8%)	159 (40.6%)	119 (30.4%)
All postnatal mothers are at risk of developing PPD	108 (27.6%)	162 (41.3%)	101 (25.8%)	21 (5.4%)
PPD can be caused by possession by an evil spirit	40 (10.2%)	48 (12.2%)	151 (38.5%)	153 (39.0%)
Depressed mothers are unpredictable	115 (29.3%)	223 (56.9%)	44 (11.2%)	10 (2.6%)
Depressed mothers are dangerous to live with	52 (13.3%)	128 (32.7%)	168 (42.9%)	44 (11.2%)
Avoid a mother who has PPD	25 (6.4%)	43 (11.0%)	187 (47.7%)	137 (34.9%)
PPD is contagious, and might get depressed in a few moments	14 (3.6%)	47 (12.0%)	148 (37.8%)	183 (46.7%)
Advise a mother with PPD to see a doctor	42 (10.7%)	174 (44.4%)	110 (28.1%)	66 (16.8%)

Cultural Beliefs and Societal Norms

As shown in Table 5, cultural beliefs and societal norms strongly influenced respondents' views on postpartum depression. Nearly half 185 (47.2%) respondents perceived PPD as a sign of maternal weakness, while 183 (46.7%) attributed it to spiritual forces or afflictions. Community and family support were also acknowledged, with 255 (65.1%) reporting community support and 302 (77.0%) affirming family support. In addition, 135

(34.4%) believed that PPD was more common among women who were not properly married, and 208 (53.1%) noted that mothers with PPD are often stigmatized. A total of 260 (66.3%) indicated that it is culturally acceptable to discuss PPD openly, while 306 (78.1%) stated that seeking professional help is encouraged. With respect to the overall influence of cultural beliefs and societal norms, 37 (9.4%) reported a low perceived impact, whereas 355 (90.6%) reported a high perceived impact.

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Table 5: Cultural Beliefs and Societal Norms

Statement	Yes F(%)	No F (%)
In my culture, PPD is a sign of weakness in the mother	185(47.2%)	207(52.8%)
PPD is caused by spiritual forces/affliction	183(46.7%)	209(53.3%)
Community members support mothers with PPD	255(65.1%)	137(34.9%)
PPD is common among women who are not properly married	135(34.4%)	257(65.6%)
Mothers with PPD are often stigmatized	208(53.1%)	184(46.9%)
It is acceptable in my culture to talk openly about PPD	260(66.3%)	132(33.7%)
Mental health issues like PPD are not taken seriously	214(54.6%)	178(45.4%)
Family members are supportive of mothers experiencing PPD	302(77.0%)	90(23.0%)
Seeking professional help for PPD is encouraged	306(78.1%)	86(21.9%)
It is believed that PPD will go away on its own without treatment	192(49.0%)	200(51.0%)
Mothers are expected to be strong and not show signs of PPD	255(65.1%)	137(34.9%)
PPD is mostly seen among women who are witches	59(15.1%)	333(84.9%)
Overall Score	Frequency	Percent (%)
Low Impact (0-6.0)	37	9.4
High impact (6.1-12.0)	355	90.6
Total	392	100.0

Bivariate Analysis of Factors Associated with Perception of Postpartum Depression

The Chi-square analysis detailed in Table 6 evaluated the relationship between selected socio-demographic variables, namely age, gender, educational level, and monthly income and respondents' perceptions (misconception levels) of postpartum depression. These variables were chosen based on their theoretical significance and empirical evidence linking them to mental health literacy and perception in previous research. Variables such as occupation and relationship to the mother were excluded from the inferential analysis due to a lack of

theoretical consistency in prior literature as strong predictors of mental health perception.

Age group was not significantly associated with perception of postpartum depression ($\chi^2 = 6.214$, $df = 3$, $p = 0.102$). Similarly, no statistically significant association was observed between gender and perception of postpartum depression ($\chi^2 = 1.842$, $df = 1$, $p = 0.175$). Educational level showed a statistically significant association with perception of postpartum depression ($\chi^2 = 18.963$, $df = 3$, $p < 0.001$). Monthly income was also significantly associated with perception of postpartum depression ($\chi^2 =$

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9.487, $df = 3$, $p = 0.023$). In addition, a statistically significant association was found between cultural beliefs and societal norms and perception of postpartum depression ($\chi^2 = 5.632$, $df = 1$, $p = 0.001$).

The null hypothesis (H_{01}) is partially rejected, as some socio-demographic variables (education and income) were significantly associated with perception, while others were not.

Table 6: Chi-Square Analysis of Socio-Demographic Factors Associated with Perception of Postpartum Depression (PPD)

Variable	Low Misconception n (%)	High Misconception n (%)	χ^2	df	p-value
Age group			6.214	3	0.102
18–25 years	92 (73.0)	34 (27.0)			
26–35 years	63 (76.8)	19 (23.2)			
36–45 years	73 (66.4)	37 (33.6)			
≥46 years	50 (67.6)	24 (32.4)			
Gender			1.842	1	0.175
Male	94 (67.1)	46 (32.9)			
Female	184 (73.0)	68 (27.0)			
Educational level			18.963	3	<0.001
No formal education	18 (43.9)	23 (56.1)			
Primary education	38 (55.9)	30 (44.1)			
Secondary education	86 (72.9)	32 (27.1)			
Tertiary education	136 (82.4)	29 (17.6)			
Monthly income			9.487	3	0.023
< ₦30,000	60 (61.2)	38 (38.8)			
₦31,000–₦60,000	55 (66.3)	28 (33.7)			
₦61,000–₦90,000	78 (76.5)	24 (23.5)			
> ₦91,000	85 (78.0)	24 (22.0)			

The result in Table 7 shows the relationship between cultural beliefs and societal norms and the perception of postpartum depression among family members. Among respondents with low misconceptions, more than half, 21 (56.8%), had low cultural beliefs and societal norms scores, while 16 (43.2%) had high scores. Conversely, among respondents with high

misconceptions, the majority, 262 (73.8%), had high cultural beliefs and societal norms scores, whereas 93 (26.2%) had low scores. Overall, 114 (29.1%) respondents had low cultural beliefs and societal norms scores, while 278 (70.9%) had high scores. In terms of perception, 37 (9.4%) respondents had low misconceptions, while the majority, 355 (90.6%), had high

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misconceptions. There was a statistically significant association between cultural beliefs and societal norms and perception of postpartum depression ($\chi^2 = 5.632$, $df = 1$, $p = 0.001$). The null hypothesis (H_{02}) is

rejected, as there is a statistically significant relationship between cultural beliefs/societal norms and perception of postpartum depression.

Table 7: Relationship between the cultural beliefs and societal norms on the management of postpartum depression and perception about postpartum depression among family members

		Cultural Beliefs and Societal Norms Level		Total	d.f	X^2 - value	p- value
		Low	High				
Level of Perception s	Low	21 (56.8%)	16 (43.2%)	37 (9.4%)	1	5.632	0.001
	High	93 (26.2%)	262 (73.8%)	355 (90.6%)			
	Total	114 (29.1%)	278 (70.9%)	392 (100.0%)			

DISCUSSION

This study examined family members' knowledge, attitudes, and socio-cultural influences shaping misconceptions about postpartum depression (PPD) in Sagamu Local Government Area, Ogun State, Nigeria. While awareness of postpartum depression was generally high among family members, misconceptions persisted. This supports evidence that awareness alone does not guarantee correct understanding or appropriate responses to maternal mental health issues (Olorunfemi et al., 2021; Wang et al., 2021). The elevated level of awareness aligns with global trends showing increasing recognition of postpartum depression,

especially in low- and middle-income countries (Adeyemo et al., 2020; Stewart et al., 2022; Wang et al., 2021). Worldwide, postpartum depression affects many women, underscoring its importance as a public health concern (World Health Organization [WHO], 2015). In Nigeria, community-based research reports moderate to high awareness levels, likely due to improved maternal health education and antenatal care (Adeyemo et al., 2020; Ajibade et al., 2022; Obioha et al., 2021). However, as this study indicates, increased awareness alone does not necessarily lead to accurate perceptions or supportive actions.

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The persistence of misconceptions among family members reflects patterns reported in previous studies, where postpartum depression is often normalised, minimised, or attributed to non-medical causes within families and communities (Corrigan et al., 2010; Hanlon et al., 2010; Shorey et al., 2021; Yildiz et al., 2021). In many contexts, particularly within sub-Saharan Africa, depressive symptoms following childbirth are interpreted through cultural and social lenses, including spiritual explanations or expectations of maternal resilience, which can obscure recognition of the condition as a health problem (Gowon et al., 2024).

Furthermore, cultural beliefs and societal norms significantly influence the perception of postpartum depression among family members. Evidence indicates that beliefs regarding motherhood, the stigma associated with mental illness, and culturally ingrained expectations affect whether symptoms are acknowledged or dismissed. Studies have demonstrated that in many communities, emotional distress following childbirth is often perceived as a normal experience or a reflection of personal weakness rather than a clinical condition necessitating care (Insan et al., 2022; Olorunfemi et al., 2021). Similarly, qualitative research among African

populations has shown that cultural norms may lead to the normalization of depressive symptoms, thereby limiting recognition and support for affected mothers (Babatunde & Moreno-Leguizamon, 2022).

The findings underscore the significant impact of socio-cultural contexts on maternal mental health, wherein family members' perceptions are influenced not only by individual knowledge but also by collective beliefs and social expectations. Such contexts may perpetuate misconceptions and contribute to delays in seeking appropriate care or providing adequate support to mothers experiencing postpartum depression. Overall, the study's findings highlight that although awareness of postpartum depression may be on the rise, misconceptions remain deeply entrenched within family and community structures. Addressing these misconceptions necessitates approaches that extend beyond mere information dissemination to include culturally informed strategies that actively engage families and communities in redefining beliefs and attitudes toward maternal mental health.

The findings underscore the need for culturally appropriate, family-centered mental health education to address

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misconceptions about postpartum depression. Integrating maternal mental health into routine primary healthcare services, with active involvement of families and community stakeholders, is essential to improve recognition, reduce stigma, and strengthen support for affected mothers.

The cross-sectional design limits causal inference. Data were self-reported and may be affected by recall and social desirability bias. Additionally, the study was conducted in a single community, which may limit generalizability.

Conclusion and Recommendation

There is a need to implement targeted, culturally sensitive mental health education programmes for family members to address misconceptions about postpartum depression (PPD). Healthcare providers should integrate family-centered education

into routine antenatal and postnatal services to enhance early recognition and support. Community-based interventions involving religious leaders, community stakeholders, and local media should be strengthened to reduce stigma and improve mental health literacy. Additionally, policymakers should prioritize the integration of maternal mental health services into primary healthcare, with emphasis on community engagement. Further studies are recommended to evaluate the effectiveness of interventions aimed at improving knowledge, attitudes, and socio-cultural perceptions of PPD. Likewise, quasi-experimental studies should evaluate the effectiveness of family-centred, culturally adapted psychoeducation programmes on reducing misconceptions about PPD.”

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