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Research Article

Social and Cultural Dimensions of Postpartum Depression among Rural Yoruba Women in Oyo State, Nigeria: A Qualitative Inquiry

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ABSTRACT

Postpartum Depression (PPD) represents a significant public health challenge in sub-Saharan Africa, yet its cultural manifestations and contextual underpinnings remain inadequately understood. In rural Nigeria, emerging evidence suggests alarmingly high rates of maternal postpartum depression, yet the sociocultural factors shaping women's experiences remain largely unexplored. While epidemiological studies can quantify prevalence and identify risk factors, they cannot illuminate the lived experiences, cultural meanings, indigenous explanatory frameworks, or structural barriers that shape how postpartum distress is understood, expressed, and managed within specific cultural contexts. This qualitative study employed a descriptive phenomenological approach to explore how rural Yoruba women in Oyo State, conceptualize, experience, and respond to PPD within their sociocultural context. Fifty-two postpartum women participated through eight focus group discussions (n=32) and twenty in-depth interviews (n=20). Data collected using semi-structured guides exploring cultural beliefs, postpartum rituals, social support systems, emotional experiences, and help-seeking behaviors. Reflexive thematic analysis following Braun and Clarke's (2006) framework yielded four major themes: (1) Cultural imperatives of maternal stoicism and the enforced silence surrounding postpartum suffering; (2) The paradoxical nature of postpartum cultural practices as simultaneously protective and pathogenic; (3) Multilayered barriers to formal mental health care, including stigma, spiritual attributions, and adverse healthcare encounters; and (4) Indigenous explanatory models that frame distress through cultural lenses of "excessive thinking," spiritual affliction, physical depletion, or relational discord rather than biomedical psychiatric constructs.

These findings illuminate the cultural scaffolding that shapes the extraordinarily high PPD prevalence documented quantitatively. PPD among rural Yoruba women emerges from complex interactions between traditional gender expectations, postpartum ritual practices, spiritual belief systems, and structural deficiencies in psychosocial support. Culturally responsive interventions integrating traditional support systems with evidence-based mental health approaches, enhanced maternal mental health literacy, and provider cultural competency training are essential for reducing maternal morbidity in this population.

Keywords: Postpartum depression; Yoruba women; Cultural practices; Qualitative research; Nigeria; Maternal mental health; Social support

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INTRODUCTION

The feeling of happiness, wishes of congratulations, expression of joy from families and friends to welcome a new-born and the mother is great however, underneath the surface, many women are quietly engulfing with a mixed feeling of happiness, sadness, anxiety, overwhelming fatigue and lost of confidence otherwise known as postpartum depression. Postpartum Depression (PPD) constitutes one of the most prevalent complications of childbearing, affecting approximately 10-20% of women globally and representing a leading contributor to maternal morbidity and mortality [1,2]. The burden is disproportionately concentrated in Low-and Middle-Income Countries (LMICs), where prevalence estimates frequently exceed 20% and can reach 40% in specific populations [3,4]. This disparity reflects the confluence of multiple risk factors including poverty, gender-based violence, inadequate healthcare infrastructure, limited social support, and cultural practices that may compound vulnerability [5,6]. In sub-Saharan Africa, PPD prevalence demonstrates substantial regional variation. Studies document rates of 18.4% across the continent, with marked country-level differences: Uganda (43.0%), Cameroon (23.4%), Ethiopia (13.1%), and Ghana (3.8%) [7,8]. Within Nigeria, documented prevalence ranges from 10.7% to 44.5% depending on geographic location, screening instruments, and population characteristics [9,10]. Southern regions report rates between 10.7% and 30.0%, while Northern Nigeria shows prevalence of 21.8% [11].

A recent cross-sectional investigation conducted in Akinyele LGA, Oyo State, documented a PPD prevalence of 72.1%among the highest reported in Nigerian community settings [12]. This study of 398 nursing mothers additionally revealed that 72.1% possessed low knowledge of PPD, with only 16.8%aware that the condition is treatable. Regression analyses identified social support (β=0.403, $p<0.05$) and cultural practices (β=0.224, $p<0.05$) as significant predictors of PPD, with social support demonstrating stronger influence [12]. While these quantitative findings establish the magnitude of the problem and identify key risk factors, they cannot illuminate the lived experiences, cultural meanings, or contextual mechanisms that produce such extraordinary prevalence. While the medical aspects of postpartum depression are well documented, its social and cultural dimensions are equally significant, shaping how women experience, express and seek help for their symptoms. Understanding why postpartum depression is so pervasive, how cultural practices influence maternal mental health, and what barriers prevent help-seeking require methodological approaches that privilege women's voices and interpretive frameworks.

The Yoruba people of southwestern Nigeria possess rich cultural traditions surrounding childbirth and the postpartum period. Traditional practices include ọmọ ọrụn (postpartum seclusion), itọju abiyamọ (maternal care rituals), dietary prescriptions and proscriptions, infant care ceremonies, and structured social support from female relatives [13,14]. These practices reflect cultural values emphasizing community, intergenerational knowledge transmission, and spiritual protection. However, traditional postpartum systems also embed gender expectations that may intensify maternal stress. Yoruba patriarchal structures often prioritize male children, assign primary childcare and domestic responsibilities to women regardless of their recovery needs, and prescribe maternal stoicism as evidence of good character [15]. Women who express emotional difficulty may face social censure, spiritual suspicion, or dismissal of their concerns.

The dramatic PPD prevalence documented in Akinyele LGA demands deeper investigation into the cultural, social, and structural factors shaping maternal mental health in this population. Existing qualitative research on PPD in Nigeria remains limited, with most studies employing quantitative designs that cannot capture the complexity of women's experiences or the cultural contexts influencing symptom expression and help-seeking [16,17]. This study therefore aimed to: Explore how postpartum emotional distress is understood, labeled, and interpreted within the sociocultural context of rural Yoruba communities, Examine specific cultural practices and their perceived influence on maternal emotional wellbeing, Identify barriers to recognizing and seeking help for postpartum mental health problems and understand indigenous explanatory models for postpartum distress and their implications for care-seeking.

METHODS AND METHODOLOGY

Philosophical orientation and study design

This study employed a descriptive qualitative design grounded in interpretive phenomenological principles [18,19]. This methodological approach is particularly appropriate for exploring under-researched phenomena, understanding subjective meanings, and illuminating the relationship between individual experiences and sociocultural contexts [20]. Rather than imposing predetermined theoretical frameworks, the design allowed themes to emerge inductively from participants' narratives while maintaining sensitivity to cultural nuances.

Study setting and context

The research was conducted in Akinyele LGA, located in Oyo State, southwestern Nigeria. Akinyele is predominantly rural, with an estimated population of 239,745 [21]. The region is characterized by Yoruba ethnolinguistic homogeneity, agricultural livelihoods, limited healthcare infrastructure with few mental health services, strong adherence to traditional practices, and substantial reliance on spiritual and traditional healing systems. The area contains 37 government-operated health facilities providing maternal and child health services, though mental health care remains largely unavailable outside urban centers.

Participant selection and recruitment

Participants were purposively selected from the sampling frame of the preceding quantitative study [12], employing maximum variation sampling to capture diverse experiences across age, parity, socioeconomic status, and symptom severity. Inclusion criteria specified: (1) Postpartum status ≤ 12 months, (2) Residence in Akinyele LGA, (3) Edinburgh Postnatal

Depression Scale (EPDS) score ≥ 10 or self-reported significant emotional distress; (4) Willingness to participate; and (5) Cognitive capacity to provide informed consent. Initial contact occurred through community health workers who explained the study purpose and invited eligible women to participate. Recruitment continued iteratively until thematic saturation was achieved, the point at which no substantively new themes emerged from additional data collection [22]. The final sample comprised 52 participants distributed across eight Focus Group Discussions (FGDs) containing 6-8 women each (n=32) and twenty individual In-Depth Interviews (IDIs) (n=20). (Table 1) presents participant demographic characteristics.

Table 1: Sociodemographic characteristics of study participants (N=52)

Characteristic	Focus Groups (n=32)	In-Depth Interviews (n=20)	Total (N=52)
Age Range			
20-29 years	11 (34.4%)	7 (35.0%)	18 (34.6%)
30-39 years	18 (56.3%)	11 (55.0%)	29 (55.8%)
40-45 years	3 (9.4%)	2 (10.0%)	5 (9.6%)
Parity			
Primipara	14 (43.8%)	9 (45.0%)	23 (44.2%)
Multipara (2-3 children)	13 (40.6%)	8 (40.0%)	21 (40.4%)
Grand multipara (≥4)	5 (15.6%)	3 (15.0%)	8 (15.4%)
Education			
No formal education	17 (53.1%)	10 (50.0%)	27 (51.9%)
Primary education	9 (28.1%)	6 (30.0%)	15 (28.8%)
Secondary or higher	6 (18.8%)	4 (20.0%)	10 (19.2%)
Marital Status			
Married	28 (87.5%)	16 (80.0%)	44 (84.6%)
Single mother	4 (12.5%)	4 (20.0%)	8 (15.4%)
Religion			
Islam	18 (56.3%)	12 (60.0%)	30 (57.7%)
Christianity	13 (40.6%)	7 (35.0%)	20 (38.5%)
Traditional	1 (3.1%)	1 (5.0%)	2 (3.8%)
EPDS Score Range			
10-13 (Probable minor depression)	8 (25.0%)	4 (20.0%)	12 (23.1%)
≥ 14 (Probable major depression)	24 (75.0%)	16 (80.0%)	40 (76.9%)

Data collection procedures

Data collection occurred between February and May 2024, employing semi-structured interview guides developed collaboratively by the research team based on quantitative findings, literature review, and consultation with cultural experts. The guides were pilot-tested with three women not included in the final sample and refined accordingly. Key topic areas included: Cultural beliefs about pregnancy and postpartum period; traditional postpartum practices and their perceived effects; family and social support experiences; emotional and psychological experiences during postpartum period; understanding and labeling of emotional distress; help-

seeking behaviors and decision-making processes; Barriers to accessing care; and recommendations for improving maternal mental health support.

Four trained female research assistants, all fluent Yoruba speakers with backgrounds in nursing, health education and public health, conducted interviews. All interviewers completed a three-day training program covering qualitative interviewing techniques, ethical considerations, cultural sensitivity, and trauma-informed approaches. Focus group discussions lasted 90-120 minutes and were held in community centers or health facilities in private spaces. In-depth interviews lasted 45-75 minutes and occurred in participants' homes or locations of their choosing to ensure comfort and confidentiality. All discussions were audio-recorded with participants' permission. Interviews were conducted in Yoruba to facilitate natural expression and cultural authenticity, then transcribed verbatim in Yoruba by trained transcriptionists. A bilingual research team member fluent in both Yoruba and English performed forward translation, which was then back-translated by an independent translator to ensure semantic equivalence and conceptual accuracy [23]. Discrepancies were resolved through team discussion. Field notes documenting non-verbal communication, contextual observations, group dynamics, and immediate impressions were recorded immediately following each session. A reflexive journal maintained by the principal investigator tracked evolving interpretations, methodological decisions, and researcher positionality throughout the study.

Data analysis

Data analysis followed Braun and Clarke's [24,25] six-phase reflexive thematic analysis approach, which emphasizes researcher interpretation and meaning-making rather than codebook adherence. The analytical process proceeded as follows:

Phase 1: Familiarization: The research team immersed themselves in the data through repeated reading of transcripts while listening to recordings, noting initial observations and patterns.

Phase 2: Generating initial codes: Two team members independently coded five transcripts line-by-line, identifying semantic and latent content relevant to research questions. Codes were compared, discussed, and a preliminary coding framework established. NVivo 12 software (QSR International) facilitated data management and coding organization.

Phase 3: Searching for themes: Codes were collated into potential themes reflecting patterned meanings across the dataset. Visual mapping and team discussions identified relationships between codes and emergent themes.

Phase 4: Reviewing themes: Themes were refined through iterative review at two levels: Examining coded extracts within each theme for coherence and assessing whether themes accurately reflected the entire dataset. Some themes were collapsed, others subdivided, and several reconceptualized.

Phase 5: Defining and naming themes: The essence and scope of each theme was clearly articulated, with careful attention to internal consistency and distinctiveness from other themes. Theme names were crafted to be concise yet evocative.

Phase 6: Producing the report: Compelling extracts illustrating each theme were selected, with analysis contextualizing findings within existing literature and study objectives.

Throughout analysis, the team engaged in reflexive practice, acknowledging how their own backgrounds, experiences, and assumptions might shape interpretations. Regular analytical meetings (weekly during active analysis) enabled triangulation of perspectives and enhanced rigor. Member checking was conducted with eight participants who reviewed preliminary findings and confirmed resonance with their experiences.

Methodological rigor

Trustworthiness was established through multiple strategies aligned with Lincoln and Guba's [26] criteria. Credibility was enhanced through prolonged engagement with the community, triangulation of FGD and IDI data, member checking, and peer debriefing. Transferability was supported by thick description of context, participants, and findings. Dependability was ensured through detailed audit trails documenting methodological decisions, an external auditor reviewing analytical processes, and systematic data management. Confirmability was strengthened through reflexive journaling, team consensus building, and grounding interpretations in participant quotes. Additionally, the research team included members from both insider (Yoruba) and outsider perspectives, balancing cultural understanding with analytical distance.

Ethical considerations

Ethical approval was obtained from the Oyo State Ministry of Health Research Ethics Committee (OSMHRE) (Reference No: AD 13/479/235). All participants provided written informed consent after receiving information about study purpose, procedures, voluntary participation, confidentiality protections, and right to withdraw without consequences. Given the sensitive nature of mental health discussions, interviews were conducted with emotional sensitivity. Women exhibiting significant distress during interviews were offered immediate support and referral to available healthcare services. Transportation reimbursement and light refreshments were provided for FGD participants. To protect confidentiality, all identifying information was removed from transcripts, and participants were assigned pseudonyms in reporting.

RESULTS

Four major themes emerged from the data, each comprising multiple subthemes that collectively illuminate the cultural dimensions of postpartum distress among rural Yoruba women. (Table 2) provides an overview of the thematic structure.

Table 2: Thematic structure of findings

Major Theme	Subthemes
Theme 1: Cultural imperatives of maternal stoicism and enforced silence	• Gender expectations and the "strong woman" ideal
	• Intergenerational transmission of stoic norms
	• Consequences of emotional expression
	• Isolation through silence
Theme 2: The paradox of postpartum cultural practices	• Protective dimensions of traditional support
	• Harmful aspects of restrictive practices
	• Gender preference and its emotional toll
	• The double-edged nature of ọmọ ọrụn (postpartum seclusion)
Theme 3: Multilayered barriers to formal mental healthcare	• Stigma and fear of "madness" labels
	• Spiritual explanatory frameworks
	• Family gatekeeping and alternative care pathways
	• Structural and financial obstacles
	• Negative healthcare encounters
Theme 4: Indigenous explanatory models of postpartum distress	• "Thinking too much": Cognitive overload framework
	• Spiritual attributions and supernatural causation
	• Physical depletion and bodily weakness
	• Relational discord and unmet expectations

Theme 1: Cultural imperatives of maternal stoicism and enforced silence

A dominant finding across participants' narratives was the powerful cultural expectation that women should endure postpartum challenges without complaint. This expectation functioned as a normative structure shaping women's responses to emotional distress and constraining their ability to acknowledge or seek help with mental health difficulties

Gender expectations and the "strong woman" ideal

Participants consistently described cultural standards equating maternal strength with silent endurance. Women explained that expressing emotional difficulty contradicted community ideals of motherhood and invited negative social evaluation.

A 32-year-old mother of two articulated this expectation: "In our culture, a strong woman does not cry after childbirth. You must show you can endure whatever comes. If you complain, people will say you are weak, that you don't have good character. They say, 'Other women have done this before you, why are you the one crying?'" (IDI-07)

This cultural script framed postpartum suffering as a normative expectation and test of feminine virtue rather than a potential health concern. Women who departed from this script risked social censure and damaged reputations.

A 28-year-old first-time mother described community responses to maternal distress: "When a woman is crying or showing she is not coping well, the older women will say, 'What is wrong with this one? Is she the first to born pikin [have a child]?' They make you feel like something is wrong with you, not that something is wrong with what you are experiencing." (FGD-3)

Intergenerational transmission of stoic norms

The imperative for silence was actively transmitted through intergenerational interactions, particularly from mothers-in-law and older female relatives who served as primary postpartum support figures. These senior women often explicitly discouraged emotional expression, framing it as character weakness or spiritual vulnerability.

A 35-year-old mother of three recalled her mother-in-law's admonitions: "When I was crying in the night because I felt so overwhelmed, my husband's mother told me, 'Stop this crying. Are you trying to wake -up the neighbours with your

unnecessary cry and invoke evil spirits up from their sleep? A mother must be strong. I suffered more than you and I didn't cry like this.' She made me feel ashamed." (IDI-12)

This transmission mechanism ensured that cultural expectations were reinforced at the precise moment when women might otherwise seek support, effectively closing off potential pathways to help.

Consequences of emotional expression

Women who violated silence norms faced tangible consequences including social ridicule, marital conflict, and spiritual suspicion. Several participants reported that family members attributed their emotional expressions to spiritual problems rather than legitimate distress.

A 26-year-old described her family's reaction: "My husband said maybe I went somewhere bad during pregnancy, that's why I'm having these problems. His family wanted to take me for deliverance [spiritual cleansing]. Nobody thought maybe I need to see doctor or that this is normal thing some women face." (IDI-15)

This spiritual reinterpretation transformed legitimate mental health concerns into moral or supernatural problems, further stigmatizing women and directing them away from appropriate care.

Isolation through silence

The combined effect of these cultural imperatives was profound emotional isolation. Women reported feeling utterly alone with their distress, unable to share their experiences even with close family members.

A 31-year-old mother described her isolation: "I felt like I was the only person in the world feeling this way. I couldn't tell my mother because she would say I'm ungrateful for my blessing. I couldn't tell my husband because he would say I'm being dramatic. I couldn't tell the health worker because she would write it in my file and people would know. So I just kept quiet and suffered alone." (FGD-5)

This isolation intensified symptoms and prevented women from recognizing that their experiences might be shared by others or amenable to intervention.

Theme 2: The paradox of postpartum cultural practices

Participants described diverse traditional postpartum practices that influenced their emotional wellbeing in complex and often contradictory ways. Some practices provided genuine support and facilitated recovery, while others intensified distress. Many practices contained both protective and harmful dimensions simultaneously.

Protective dimensions of traditional support

Several traditional practices were valued by participants as sources of practical help and emotional comfort. The practice of itọju-ọmọ (traditional postpartum care by senior women) was particularly appreciated when performed by supportive female relatives. Women described how grandmother figures provided infant bathing assistance, prepared special foods, performed therapeutic massage, and allowed mothers needed rest.

A 29-year-old explained: "My mother came to stay with me for three weeks. She would wake up in the night with the baby so I could sleep. She cooked all my food, she bathed the baby, she massaged my body with ori [shea butter]. I felt cared for. This really helped me to recover." (IDI-04)

Communal caregiving arrangements involving multiple female relatives created networks of support that distributed labor and provided mothers with companionship. Women contrasted this favorably with nuclear family isolation experienced by some urban women.

A 33-year-old observed: "Our tradition is good because you are not alone. Your mother, your aunt, your neighbors, they all come to help. You have people to talk to, to learn from. It's not like some women in the city who are alone with the baby all day." (FGD-2)

Postpartum bonding rituals including naming ceremonies, ritual bathing, and spiritual protection ceremonies were valued for their communal affirmation and sense of transition into motherhood.

Harmful aspects of restrictive practices

However, participants also described how certain traditional practices intensified rather than alleviated distress. Prolonged postpartum seclusion, while intended as protective rest, often became isolating confinement. Women described weeks confined to small spaces with limited social interaction. A 27-year-old first-time mother explained: "They said I should not go outside for six weeks, should not see visitors, should stay only in my room. At first it was okay, but after some time I felt like a prisoner. I was just me and the baby in that room. I started feeling very dark thoughts." (IDI-09)

Dietary restrictions represented another source of distress. Traditional food taboos prohibited consumption of numerous foods believed harmful during postpartum period, sometimes leaving women undernourished or anxious about inadvertent violations.

A 30-year-old described: "There is long list of food you cannot eat, some fish, some vegetables. They say if you eat these things, the baby will have problems. But I was so hungry and weak. Sometimes I would eat small thing they said not to eat, then I would worry the whole day that something bad will happen to my baby because of what I ate." (FGD-6)

Physical exhaustion from rigid requirements to resume full domestic duties quickly after childbirth, regardless of physical recovery status, was frequently mentioned.

A 34-year-old mother of four lamented: "By two weeks, they expect you to be doing all the housework again like cooking, cleaning, fetching water. Your body is still recovering, you're not

sleeping at night, but tradition says a woman must take care of her home. If you complain, they say you are lazy." (IDI-14)

Gender preference and its emotional toll

The cultural preference for male children emerged as a particularly distressing practice. Women who delivered girls, especially as first children, described intense emotional pressure, disappointment from family members, and personal feelings of failure. The anguish in participants' voices when discussing this issue was palpable.

A 25-year-old mother shared through tears: "When my baby was a girl, my husband's family was so disappointed. They didn't even want to do proper naming ceremony. They said I should hurry and get pregnant again to try for a boy. His mother said maybe something is wrong with me. I cried every night because I felt like I had failed. Even though I loved my daughter, I felt like everybody saw me as useless." (IDI-18)

This gender-based devaluation created profound conflict for women between maternal love for their daughters and internalized cultural messages about their inadequacy.

A 36-year-old mother of three girls described: "After my third girl, my husband started staying out at night. People in the community would say, 'Sorry' to me, like someone had died. I started hating myself. Why can't my body produce a boy? What is wrong with me? This thinking made me feel so depressed." (FGD-7)

The pressure for male children intersected with other vulnerabilities to intensify PPD risk, particularly when combined with financial stress or marital conflict.

The double-edged nature of employee

The practice of postpartum seclusion illustrated the complex duality of cultural traditions. While intended to provide protected recovery time, its implementation sometimes created conditions that research literature identifies as PPD risk factors: Social isolation, restricted mobility, and severed social connections.

A 32-year-old reflected on this contradiction: "The tradition is meant to protect you, but sometimes it makes things worse. You are supposed to be resting, but you are also cut off from everyone. You're alone with your thoughts. For someone who is already feeling down, this isolation can make it much worse." (IDI-11)

Several women suggested that modified versions of traditional practices retaining supportive elements while reducing restrictive ones would better serve maternal mental health.

Theme 3: Multilayered barriers to formal mental healthcare

Despite experiencing significant distress, very few participants had sought formal healthcare for emotional problems. Multiple barriers at individual, family, community, and health system levels prevented help-seeking.

Stigma and fear of "madness" labels

Mental health stigma emerged as the most potent barrier. Participants feared that acknowledging emotional problems would result in being labeled "mad" (wèrè) or mentally unstable, carrying severe social consequences.

A 29-year-old explained: "If people know you went to see doctor for your mind, they will call you craze [crazy]. They will say you are wèrè. Your children will suffer, people will not want to marry from your family. This thing can follow you for life." (IDI-06)

The distinction between physical and mental complaints shaped help-seeking patterns. Women felt comfortable seeking care for physical complaints like body pain or fever but viewed mental health concerns as shameful secrets.

A 33-year-old articulated this division: "If my body is paining me, I can go to clinic freely. But if my heart [mind] is troubled, I cannot talk about it. People will not understand. They will think something is fundamentally wrong with you as a person." (FGD-4)

This stigma was particularly acute for mothers, as mental health problems were seen as incompatible with maternal identity and potentially endangering children.

Spiritual explanatory frameworks

Many participants and their families attributed postpartum distress to spiritual rather than psychological causes. Common spiritual explanations included witchcraft attacks, spiritual husband interference, ancestral curses, or demonic oppression. These attributions directed help-seeking toward spiritual rather than medical solutions.

A 27-year-old described her family's interpretation: "My mother-in-law said my problem is spiritual attack. She said someone is using juju [witchcraft] against me because they are jealous. She took me to bàbáláwo [traditional diviner] who gave me some things to drink and to bathe with. She didn't believe this is something doctor can treat." (IDI-17)

Religious leaders reinforced these frameworks. Several women reported that when they approached pastors or imams for help, they were told to pray more, fast, or undergo spiritual deliverance rather than seek medical care.

A 31-year-old recounted: "I went to my pastor and told him I'm feeling very bad, crying all the time. He said it's spiritual warfare, that I need to pray and fast for three days. He gave me anointing oil to use. He didn't say I should see doctor." (IDI-10)

These spiritual interpretations were not necessarily incorrect within women's cultural frameworks but often precluded consideration of biomedical interventions that might provide relief.

Family gatekeeping and alternative care pathways

Family members, particularly husbands and mothers-in-law, frequently served as gatekeepers controlling women's access to healthcare. Several participants described wanting to seek help but being prevented or discouraged by family members.

A 26-year-old explained: "I told my husband I want to go to hospital, that I'm not feeling well in my mind. He said, 'What will they do there? This kind of problem is not for hospital. Let's go to church instead.' He wouldn't allow me to go." (IDI-19)

Economic dependency intensified this gatekeeping, as women often lacked independent resources for healthcare and required permission or financial support from husbands to access services. Traditional and religious healers were viewed as more appropriate, accessible, and culturally congruent sources of help.

A 35-year-old described her treatment pathway: "First I went to ìyà-álàgbo [herbs-provider woman]. She gave me some herbs to drink and told me things to do. When it didn't get better, we went to see àlùfáà [Islamic healer]. He gave me prayer water. Nobody suggested hospital until it was very serious." (FGD-8)

Structural and financial obstacles

Even when women desired formal healthcare, structural barriers prevented access. Geographic distance to facilities, lack of transportation, and opportunity costs of travel represented significant obstacles in rural areas.

A 28-year-old described: "The nearest hospital where they might have someone who knows about this thing is very far. To go there costs transport money we don't have, and it would take the whole day. Who will watch my other children? Who will do the farm work? It's not possible." (IDI-08)

Direct and indirect healthcare costs deterred care-seeking among economically vulnerable families. Women explained that families prioritized spending limited resources on physical illness perceived as more serious or life-threatening.

A 37-year-old noted: "If you tell your husband you need money to see doctor for feeling sad, he will say, 'We don't have money for such things. You are not dying.' But if you have malaria, he will find the money because he can see it's serious." (FGD-1)

The absence of mental health services in primary care facilities meant that even women who accessed antenatal or postnatal care received no screening, psychoeducation, or support for emotional difficulties.

Negative healthcare encounters

Previous negative experiences with healthcare providers significantly influenced help-seeking decisions. Women described encounters characterized by dismissiveness, judgmental attitudes, lack of privacy, and failure to take their concerns seriously.

A 30-year-old recounted: "When I tried to tell the nurse at the clinic that I was feeling very anxious and crying a lot, she just laughed and said, 'Every new mother feels like that. You will be fine. Stop being dramatic.' She made me feel stupid for even bringing it up." (IDI-13)

Several women reported that providers seemed too busy to listen to emotional concerns or quickly redirected conversations to infant health, communicating that maternal mental health was not a legitimate healthcare priority.

A 29-year-old explained: "When you go to clinic for baby immunization, they ask about the baby, is your baby eating, is baby sleeping. Nobody asks about the mother. If you try to say something about how you are feeling, they say, 'Okay, okay,' and move on to the next person. You feel like your problems don't matter." (FGD-6)

Concerns about confidentiality also deterred disclosure. Women feared that information shared with healthcare providers would be documented in records, discussed with colleagues, or inadvertently revealed to community members. These experiences and fears created substantial disincentives for engaging formal healthcare for mental health concerns.

Theme 4: Indigenous explanatory models of postpartum distress

Women rarely employed biomedical terminology such as "depression" or "postpartum depression" when describing their experiences. Instead, they utilized culturally grounded explanatory frameworks that shaped how they understood their distress, communicated about it, and determined appropriate responses. These indigenous models reflected Yoruba cultural concepts of personhood, illness causation, and the relationships between physical, social, spiritual, and emotional dimensions of health.

"Thinking too much": Cognitive overload framework

The most common indigenous explanation for postpartum distress was the concept of "thinking too much" (rírònu-púpò). Women attributed their symptoms to excessive worry about multiple stressors including financial difficulties, marital problems, childcare responsibilities, and family relationships. This framework located distress in external circumstances rather than internal pathology.

A 28-year-old articulated this model: "I'm not sick in my body or my mind. The problem is I'm thinking too much. I think about how we will feed the children, how I will buy things for the baby, about my husband who is not working. All this thinking is making me not to sleep, making me to cry. If the problems were solved, I would be fine." (IDI-05)

This explanatory model implied that relief would come from resolving external problems rather than treating internal mental states. It also carried less stigma than psychiatric labels, as "thinking too much" was viewed as a reasonable response to difficult circumstances rather than evidence of mental weakness or instability.

Several women distinguished between "normal worrying" expected of responsible mothers and pathological "too much thinking" that interfered with functioning.

A 32-year-old explained: "Every mother worries about her children, this is normal. But when the worrying becomes so much that you cannot eat, cannot sleep, cannot take care of the baby properly, then it has become too much. It has passed the normal boundary." (FGD-2)

Spiritual attributions and supernatural causation

Many participants interpreted their distress through spiritual lenses, attributing symptoms to supernatural forces including witchcraft, evil spirits, spiritual husband interference, or ancestral displeasure. These explanations were particularly common when symptoms seemed inexplicable or disproportionate to circumstances.

A 34-year-old described her family's interpretation: "My husband's people said someone in the family is using witchcraft against me. They said that's why I'm not happy even though I have a healthy baby. They said jealous people don't want me to enjoy my blessing. They took me to babalawo who confirmed it and gave me protection." (IDI-16)

The concept of "spiritual husband" (ọkọ òrun), a spiritual entity believed to interfere with women's earthly marriages and motherhood emerged in several narratives. Women described symptoms including nightmares, inexplicable sadness, lack of affection for their husbands, or difficulty bonding with infants as evidence of spiritual husband interference.

A 29-year-old explained: "The pastor said I have spiritual husband that is troubling me. He said that's why I'm feeling this way, why I don't want my husband to touch me, why I feel far away from my baby sometimes. He did deliverance prayer for me to break the covenant." (IDI-20)

Spiritual explanations provided culturally coherent frameworks that made sense of distressing experiences while absolving women of personal blame. However, they also directed help-seeking away from evidence-based mental health interventions.

Physical depletion and bodily weakness

Women frequently attributed emotional symptoms to physical exhaustion and bodily depletion caused by pregnancy, childbirth, and lactation. This somatic explanatory model emphasized the body's material needs and limitations.

A 31-year-old articulated this understanding: "My body is weak because pregnancy and childbirth took so much from me. I'm breastfeeding which is draining me more. My blood is low. This is why I cannot cope well, why I feel tired and sad. If I could rest properly and eat good food to build my blood, I would be better." (IDI-03)

The concept of "low blood" (ẹ̀jẹ̀ kéré) was frequently invoked, reflecting beliefs about blood loss during childbirth depleting vital bodily resources and requiring replenishment through rest and specific foods.

A 26-year-old explained: "After delivery, your blood is low. This affects everything your strength, your mood, you're thinking. Until the blood is built up again through proper nutrition and rest, you will feel weak and down. This is common knowledge among our mothers." (FGD-5)

This physical depletion framework implied that interventions should focus on nutritional supplementation, rest, and physical strengthening rather than psychological treatment. Several women described seeking herbs, tonics, or foods believed to "build blood" as primary responses to their distress.

Relational discord and unmet expectations

Women also understood their distress through relational frameworks, attributing symptoms to disappointed expectations, lack of support, or discord in key relationships. Marital dissatisfaction, mother-in-law conflict, and unmet expectations of postpartum support figured prominently in these explanations.

A 30-year-old described: "I thought when the baby came, my husband would be more responsible, would help me, would show more care. Instead, he is the same as before going out with friends, not bringing money home, not helping with anything. This disappointment is what is making my heart heavy. It's not that something is wrong with me; it's that my situation is not what I expected." (IDI-12)

For women experiencing gender preference disappointment, delivering girls when sons were expected, relational explanations centered on family rejection and social devaluation.

A 27-year-old explained: "How can I be happy when nobody in my husband's family is happy with me? When they look at me with disappointment? When they talk like my baby is a burden? This treatment is what is making me sad, not some sickness in my head." (FGD-7)

These relational explanatory models implied that symptom relief required changes in social relationships and family dynamics rather than individual psychological intervention. Women emphasized that their distress was rational and proportionate to genuinely difficult circumstances rather than disordered thinking requiring correction.

Integration of multiple explanatory models

Many women employed multiple explanatory frameworks simultaneously, drawing on different models to explain different symptoms or to make sense of their experiences to different audiences.

A 33-year-old illustrated this integration: "Sometimes I think it's because I'm weak from childbirth and not getting enough rest. Sometimes I think maybe there is spiritual attack because it came so suddenly. Sometimes I think it's because of the stress with my husband's family. Maybe it's all of these things together." (IDI-14)

This explanatory flexibility reflects the pragmatic pluralism common in African healing contexts, where multiple causative frameworks coexist and inform treatment choices [27]. However, notably absent from most women's explanatory repertoires were biomedical psychiatric frameworks. (Table 3) summarizes the indigenous explanatory models and their treatment implications.

Table 3: Indigenous explanatory models of postpartum distress and their implications

Explanatory model	Core attribution	Typical explained	Symptoms implied treatment	Cultural function
"Thinking too much" (ríròmu púpọ)	Excessive worry about external stressors	Insomnia, worry, crying, difficulty concentrating	Problem-solving, practical assistance, reducing stressors	Normalizes distress as reasonable response; reduces stigma
Spiritual causation	Witchcraft, evil spirits, spiritual husband, ancestral displeasure	Nightmares, inexplicable sadness, lack of bonding, marital difficulties	Prayer, deliverance, traditional divination, spiritual protection	Provides meaning; absolves personal blame; culturally coherent
Physical depletion	Blood loss, bodily exhaustion, nutritional deficiency	Fatigue, weakness, low mood, poor concentration	Rest, nutritional supplementation, herbal tonics, "blood building"	Provides meaning; absolves personal blame; culturally coherent
Relational discord	Unmet expectations, lack of support, family conflict	Sadness related to relationships, disappointment, sense of isolation	Family counseling, relationship repair, increased support	Contextualizes distress in social relationships; implies systemic rather than individual problem

DISCUSSION

This qualitative investigation provides essential contextual understanding of the extraordinarily high 72.1% PPD prevalence documented in the preceding quantitative study [12]. The findings reveal that postpartum depression among rural Yoruba women emerges from complex interactions between cultural gender expectations, traditional postpartum practices, spiritual belief systems, and profound deficiencies in mental health support infrastructure. Rather than representing primarily biological or individual psychological dysfunction, the high prevalence reflects social suffering embedded in cultural structures, economic hardships, and healthcare system failures.

The cultural imperative for maternal stoicism identified in this study resonates with research from other African and Asian contexts demonstrating how cultural norms constrain women's ability to acknowledge or express postpartum difficulties [28,29]. Similarly found that Indian women's postpartum depression was often silenced by cultural expectations that motherhood should be joyful and uncomplaining [30]. This enforced silence has multiple detrimental effects: It prevents early recognition of symptoms, intensifies isolation and shame, blocks access to support, and reinforces stigma by maintaining invisibility of common experiences [31]. The paradoxical nature of traditional postpartum practices simultaneously supportive and restrictive aligns with cross-cultural research on postpartum rituals [32,33]. Studies from China [34], Malaysia [35], and Turkey [36] document similar tensions between beneficial aspects of traditional support systems and harmful dimensions of restrictive practices. The practice of postpartum seclusion, intended as protective rest, can create precisely the conditions of social isolation, restricted mobility, severed support networks that research identifies as PPD risk factors [37,38].

Gender preference for male children emerged as a particularly potent source of distress in this study, corroborating findings from other patriarchal contexts. Patel, Rodrigues, and DeSouza (2002) documented similar patterns in India where women delivering girls experienced elevated PPD risk due to family disappointment and social devaluation [39]. Research from Kenya [40] and Turkey [36] has likewise identified gender preference as a significant cultural predictor of maternal mental health problems. This finding highlights how deeply embedded patriarchal values translate into individual psychological suffering, demonstrating that PPD cannot be understood apart from gender inequities and power dynamics [30]. The multilayered barriers to formal mental healthcare documented in this study help explain the disconnect between high symptom prevalence and low treatment utilization. Mental health stigma has been extensively documented as a primary barrier to care-seeking across African contexts [17,41,42]. In Nigeria specifically, Gureje and colleagues (2005) found widespread misconceptions equating mental health problems with "madness" and supernatural causation, precisely the patterns observed in this study [17].

The prominence of spiritual explanatory frameworks and reliance on religious or traditional healing aligns with established patterns of mental healthcare-seeking in sub-Saharan Africa [43,27]. Kleinman's (1980) seminal work on explanatory models demonstrates that how illness is understood fundamentally shapes treatment decisions [44]. When depression is attributed to spiritual forces, logical help-seeking involves spiritual solutions like prayer, deliverance, and divination rather than biomedical intervention. These pathways are not inherently problematic; indeed, faith-based and traditional healing systems provide important support and meaning-making functions [42]. However, exclusive reliance on these pathways without integration of evidence-based mental health interventions leaves many women without adequate treatment.

Family gatekeeping represents an under-recognized but critical barrier in collectivist cultural contexts where healthcare decisions are made communally rather than individually [45]. Women's subordinate position within household hierarchies, economic dependency on male partners, and lack of autonomous decision-making authority constrain their ability to access care even when they recognize the need [9]. This finding

underscores that interventions targeting only individual women will be insufficient; Family members, particularly husbands and mothers-in-law, must be engaged as partners in maternal mental health promotion.

Negative healthcare encounters reported by participants reflect broader patterns of disrespect and dismissiveness in maternal healthcare documented across low-resource settings [46,47]. When healthcare providers lack training in mental health, hold stigmatizing attitudes, or work in systems without time or resources for psychosocial care, they cannot provide the supportive responses women need [48]. The absence of mental health content in routine postnatal care represents a significant missed opportunity for early identification and intervention.

The indigenous explanatory models identified in this study "thinking too much," spiritual causation, physical depletion, and relational discord represent culturally specific idioms of distress [49] that do not map directly onto Western psychiatric diagnostic categories. The "thinking too much" framework documented here parallels findings from other African contexts. Patel, Simunyu, Gwanzura, Lewis, and Mann (1997) described "kufungisisa" (thinking too much) as a central idiom of distress in Zimbabwe, characterized by rumination, worry, and physical symptoms [50]. Similar concepts have been documented in Ghana ("adwene ho bore") [51], Rwanda ("guhahamuka") [52], and across East Africa [53]. These local idioms serve important functions: They provide culturally meaningful ways to express and legitimize depression, they reduce stigma by framing symptoms as understandable responses to circumstances rather than mental pathology, and they imply contextual interventions (addressing stressors) rather than individual treatment (fixing disordered thinking) [54]. However, reliance on these frameworks may also delay recognition that depression has reached clinical severity requiring professional intervention. The prominence of spiritual explanations reflects the central role of religion and spirituality in Yoruba cosmology and healing traditions [55]. While biomedical psychiatry might view spiritual attributions as obstacles to appropriate care, from an emic (insider) perspective, these explanations provide meaning, mobilize social support through religious communities, and offer culturally congruent treatment pathways [42]. The challenge for maternal mental health interventions is not to eliminate spiritual frameworks but to integrate them with evidence-based approaches through culturally adapted interventions and collaboration between healthcare providers and faith leaders [56].

The physical depletion model, emphasizing bodily weakness and blood loss, reflects traditional humoral concepts of health common across many cultures [33]. While not entirely inaccurate nutritional deficiencies and physical exhaustion do contribute to mood disturbances, exclusive focus on physical restoration may neglect psychological and social dimensions requiring attention. This finding suggests that interventions emphasizing nutritional support and physical recovery, while valuable, must be complemented by psychosocial components.

The findings of this study can be interpreted through the lens of Postpartum Depression Theory (PDT), which conceptualizes PPD progression through four stages: encountering terror, dying of self, struggling to survive, and regaining control [57,58]. However, the theory requires cultural adaptation to fit the Yoruba context. The "encountering terror" stage in this population is shaped by cultural expectations of stoicism that prevent women from acknowledging or expressing fear. The "dying of self" manifests not only as loss of previous identity but specifically as failure to meet cultural ideals of strong, selfless motherhood. "Struggling to survive" in this context involves navigating multiple systems traditional practices, family expectations, spiritual explanations without clear pathways to appropriate help. "Regaining control" is complicated by women's limited autonomy and the need for family and community support to facilitate recovery.

This cultural adaptation of PDT suggests that theory developed in Western contexts requires substantial modification to account for collectivist cultures where distress is understood and managed communally rather than individually, where spiritual dimensions are central rather than peripheral, and where recovery depends on social relationship repair rather than only individual psychological work.

Strengths and limitations

This study possesses several methodological strengths. The combination of focus groups and in-depth interviews captured both shared cultural meanings and unique personal experiences. The substantial sample size for qualitative research (N=52) and achievement of thematic saturation enhances confidence in findings. Involvement of bilingual, culturally grounded interviewers facilitated authentic communication and cultural nuance. Rigorous analytical procedures including team triangulation, member checking, and detailed audit trails support trustworthiness. Finally, the study's grounding in prior quantitative work allows integration of epidemiological patterns with lived experience data.

However, limitations must be acknowledged. The cross-sectional design captures only one temporal point in women's postpartum trajectories; Longitudinal qualitative work could illuminate how explanatory models and experiences evolve over time. Geographic restriction to one local government area limits transferability to other Nigerian regions with different cultural contexts. Self-selection bias may have influenced participation, with women experiencing severe depression or facing extreme family restrictions potentially less likely to participate. Social desirability bias may have shaped responses, particularly regarding topics like traditional practices or family relationships. Finally, while translation procedures followed best practices, linguistic and cultural nuances may have been lost in Yoruba (the indigenous language)-to-English translation [57-67].

CONCLUSION

This study shows that postpartum depression among rural Yoruba women arises from the interaction of cultural expectations, restrictive postpartum practices, spiritual interpretations, and limited access to mental-health support. The exceptionally high PPD prevalence previously documented reflects not only individual vulnerability but broader social and

cultural pressures that shape how distress is experienced and concealed. Improving maternal mental health in this setting requires culturally informed education, strengthened family and community support, and better integration of mental-health care into routine postnatal services. Interventions will be most effective when they respect cultural strengths, address harmful norms, and build partnerships with families, community leaders, and trusted traditional or faith-based actors. Continued research and context-specific programme development are needed to translate these insights into sustainable improvements in postpartum wellbeing.

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AUTHOR CONTRIBUTIONS

BOJ and OO conceptualized the study, led data collection, conducted primary analysis, and drafted the manuscript. DT contributed to study design, data analysis, and critical manuscript revision. LAN provided methodological expertise, supervised the research process, and contributed substantially to manuscript development. All authors read and approved the final manuscript.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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