

The Mediating Role of Coping Styles in the Relationship Between Social Support and Postpartum Depression among Childbearing Women in Ibadan Metropolis

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Abstract

The study investigated prevalence of postpartum depression, perceived social support and coping styles among childbearing women in Ibadan metropolis. A cross-sectional study was carried out among 410 postnatal women (who delivered within the last twelve months) recruited from selected health care centers in Ibadan metropolis, Nigeria. Three standardized instruments were used for data collection namely; Edinburgh Postnatal Depression Scale (EPDS), The Multidimensional Scale of Perceived Social Support and Brief COPE Inventory. Data were analyzed by descriptive statistics, chi-square, and mediation

analysis using the PROCESS Macro (Model 4). Result revealed that 33.9% of the respondents had a score above the EPDS cut-off score (≥ 13), for probable PPD. Emotion-focused coping was the predominant (74.8%) coping style, followed by problem-focused (51.2%) and avoidant coping (28.7%). Regression analysis revealed that emotion- and problem-focused coping predicted lower levels of depression, while avoidant coping predicted greater risk of PPD ($\beta = 0.45$, $p < .001$). Mediation analysis further indicated that coping styles were partial mediators between social support and depression (indirect effect = -0.18 , 95% CI $[-0.29, -0.08]$). Coping strategies substantially mediate the influence of social support on depression among postpartum mothers. Based on these findings, enhancing social networks and delivery of culturally appropriate psychoeducational interventions are necessary to increase postpartum wellbeing among mothers.

Keywords: Childbearing women, Coping styles, Postpartum depression, social support

Introduction

Motherhood is widely promoted as a defining key moment for women; however, the early stage is often accompanied with new experiences physically, emotionally and socially. The year following childbirth places women under considerable physical and emotional strain, and this makes them more susceptible to postpartum depression (PPD). A global analysis by Khamidullina et al. (2025) indicated rates of postpartum depression from 10% to 25%, which varied according to the population and diagnostic methods applied. In addition, Robbins et al. (2023) noted that onset of postpartum depressive symptoms is time-dependent during the first postpartum year (pooled prevalence: 14.8%), once more highlighting the time-dependent nature of the disorder.

Similarly, in Africa, several investigators reported the occurrence of PPD among mothers. For instance, Tornyevah et al. (2015) reported that 22.3% within 12 months postpartum mothers. Besides that, prevalence findings of Wubetu et al. (2020) indicated 23.3% as the lowest, but the highest prevalence of this study is supported with Tesfahun and Demissie (2017) which is 24.9% in Addis Ababa, Ethiopia among post-partum mothers. On the other side, Melkam (2015) found a prevalence of 24.6% among childbirth givers in Mozambique using the Demographic and Health Survey data.

Also, in Nigeria are of the opinion that this ranged varied among mothers. The findings of a study by Amuda et al. (2025) Nursing mothers are affected by the manifestations of postpartum depression. Olaseni et al. (2025) postnatal clinic attendees were found to have

a strong (27.2%) prevalence among mothers in Owo, Ondo state. Like this, in a research study by Akinsolu et al (2023) among women in Ibadan, Oyo state, a prevalence of 46.8% was documented. Omokhodion et al (2023) study in Ibadan observed 21.7% prevalence among postpartum women while Adeoye et al. (2022) a prevalence of 14.1 was found for postnatal depressive symptom among a sample of mothers. While in Gombe, Laima et al (2025) reported a prevalence as high as 32.6% which reiterates the fact that postpartum depression is common among Nigerian women. However, there existed some variations prevalence worldwide and even within Nigeria, this could be as a result of varied screening methods, cut off score of screening instrument, study designs, geographical locations and sociodemographic characteristics.

The American Psychiatric Association (2022) noted that nursing mothers who have PPD are most likely to suffer from a constant feeling of sadness or worthlessness, anxiety, anger, tiredness, problems sleeping, difficulty concentrating and a disinterest in activities that they used to take pleasure in. Other negative impact includes self-harm, suicidal ideation, or suicide (World Health Organization [WHO], 2022; Slomian et al., 2019); less responsive, affectionate, and emotionally available (Field, 2010); poor bonding with infant (Stein et al., 2014); socially withdrawn, emotionally distant, or irritable, reduced life satisfaction and diminished enjoyment of motherhood and family life (Slomian et al., 2019).

However, the ways in which childbearing women cope may have a considerable bearing on their management of postpartum depression. According to Lazarus & Folkman (1984), coping strategies are usually aggregated as adaptive (positive) and maladaptive (negative) coping mechanisms. Such strategies could leverage individuals to take good care of stressors, build resilience and maintain psychological health. Ogunwole et al (2024) documented that coping styles significantly influences resilience and that adaptive coping mechanisms enhances psychological adjustment and well-being.

Adaptive coping styles have been found to predict a decrease of psychological distress (Chen et al., 2022; Deng et al., 2025) and depressive symptoms (Chen et al., 2022) among women in pregnancy and the postpartum period. Yet, maladaptive coping strategies; that is lying, denial, self-corrective measures, emotional retreat, and use of substances, do provide

a change from stress, but they may not be adequate to cure the trauma particularly when caused by emotional stress (Vidanagama et al, 2024; Chaaya et al, 2025). The adaptive coping styles consist of problem-focused coping (time management, seeking support/information, medical consultation, resources utilization) and emotion-focused coping (religion, positive framing, acceptance, humor) while maladaptive coping is avoidant coping (withdrawal, substance use, binge-watching, procrastination, excessive use of social media). However, this study was guided by the three coping style types (problem-focused coping, emotion-focused coping and avoidant coping) as found in most studies (Ding et al, 2021; Dim et al, 2023; Veisi et al, 2024).

Ogunwole et al. (2023) demonstrated that depression is influenced by multiple social and environmental factors that affect psychological well-being. In their work, Ebeh et al. (2025) asserted that perceived social support is physically and socio-culturally mediated, and that social support interventions for maternal mental health should be cognizant of the Nigerian sociocultural context and would have to be provided at family and community levels. Additionally, Ojo (2016) noted that social connectedness contributed significantly to health and that individuals who maintained stronger social ties experienced better overall well-being and adaptation.

Globally, for women, it was also a dominant narrative that they depended on their husbands, family members, friends, and community as providers of emotional and material support (Azale et al., 2018; Jidda et al., 2024). Greater perception of support from husband, family member and significant other was inversely associated with depressive symptoms (Chen et al ,2022; Arinze, et al. 2025). Moreover, Ojo and Ajayi (2020) discovered that patterns of social engagement were associated with symptoms of depression and that psychological well-being is shaped by social environments and everyday interactions rather than solely by individual or biological factors. Consequently, Adeleke et al. (2025) observed that individuals with stronger social relationships and supportive interpersonal networks reported lower levels of depressive symptoms. Wellington (2023) highlighted that maternal depression results from complex psychosocial pathways involving financial strain, intimate partner violence, and social support.

Postpartum depression has traditionally been considered a maternal mental health and family/public health problem. This is due to the influence of damage on mother's health, infant growth and family function. Still, postnatal depression remains underdiagnosed and untreated particularly in low- and middle-income countries due to cultural beliefs, stigma and limited mental health services which hinder early detection and management (Atif et al., 2015; World Health Organization [WHO], 2022). In some cultures, the symptoms of depression are considered to be typical postnatal experiences or possession by spirits, causing delays in seeking care (Padhyay et al., 2017; Atuhaire et al., 2023).

Nevertheless, there are still important gaps in the knowledge of postpartum women's coping styles in relation to postpartum depression, despite significant research having been carried out internationally on postpartum depression, most research has been concerned with the prevalence and risk factors of postpartum depression rather than with the role of coping strategies in influencing its severity and persistence. Yet, this knowledge can give insight into how coping mechanisms and depression interact, and can inform interventions; however, there is limited knowledge of this interaction in low- and middle-income countries (Chaaya et al, 2025; Karunarathna et al, 2024). And that limits what we can be said about how coping strategies and depression intersect and much of the literature comes from high-income countries (Alshowkan et al, 2024; Mohamud, et al, 2025; Papadopoulou et al, 2023) whose health care systems and sociocultural contexts are vastly different from that of low- and middle-income countries (LMICs) like Nigeria thus making the findings generally not applicable (WHO, 2022).

Furthermore, the combined influence of these factors on the mental health of mothers has not been examined, as attention to individuals with postpartum depression and coping has been divided between the factors (Chaaya et al., 2025). A few studies have investigated coping style as a moderator in the relationship between social support and PPD (Cheng et al, 2022; Deng et al., 2025). A gap subsequently developed for integrative psychosocial treatments for both emotional distress and the coping process.

It is against this background that this study investigated the prevalence of postpartum depression, coping styles adopted by postpartum women and its influence on the relationship between social support and postpartum depression.

Research Objectives

1. To assess the most adopted coping styles for postpartum depression among childbearing women.
2. To determine the relationship between social support and postpartum depression
3. To examine whether coping style mediates the relationship between perceived social support and postpartum depression

Literature Review

Yu et al. (2020) investigated the coping styles during pregnancy, their sociodemographic and psychological determinants, and the relationship with postpartum depression among Chinese women through a prospective study. The result showed that active coping (problem-focused/active coping and emotion-focused maladaptive coping), avoidant coping was the most common adopted coping style among females. The research demonstrated that the coping style in pregnancy is an important indicator for PPD, wherein adaptive coping (problem-solving and support-seeking) is a protective factor and avoidant coping is a risk factor. Active or problem-focused coping and social support seeking are the best and most frequent beneficial coping styles, our study suggests.

Meanwhile, Azale et al. (2018) conducted a community based cross-sectional study on coping strategies of women with symptoms of postpartum depression in rural Ethiopia. The study identified that women with symptoms of postpartum depression used various coping strategies that could be grouped as adaptive and maladaptive. Azale et al. (2018) also showed that although most women employed culturally based and possibly protective coping strategies (for instance, religious practices and informal social from other women), a portion of the sample also used avoidant and passive coping mechanisms. The study also found that women who experienced greater social and informational support were more

likely to use adaptive coping strategies, while those who experience less support were more prone to avoidance and passive coping mechanism.

In a similar vein, Uzobo et al (2022) conducted a cross-sectional study on the prevalence and coping strategies of postnatal depression among women in Bayelsa State, Nigeria. The study involved 345 postnatal mothers with infants aged between 1- and 6-weeks attending health and maternity centres in the Bayelsa State. They reported that the adaptive coping strategies frequently utilized among postpartum women were social support seeking and music-based emotional coping, whereas access to formal mental health services is limited.

Thus, a study done by Jidda et al. (2024) on evaluating the rate and coping mechanisms of postpartum depression in Osun state among childbearing women revealed that seeking social support, religious coping, financial support, and avoidance-based coping strategies. Similarly, Adeyemo et al. (2020) researched on the frequency and determinants of postpartum depression among postnatal mothers in Lagos, Nigeria applying a hospital-based cross-sectional method among postnatal mothers seeking services at healthcare establishments in Lagos State. Results of the study found that the predominant coping mechanisms for Nigerian postpartum women includes social support seeking, religious coping, and emotion-focused (withdrawal based) coping styles particularly in an atmosphere of poor or no access to formal mental health service.

Additionally, Igo et al. (2021) investigated the factors associated with stress among nursing mothers in Makurdi Local Government Area of Benue State, Nigeria. The result showed that social support was an influential factor for nursing mothers in Makurdi in maintaining their postpartum mental health. It indicates that sufficient social support decreases the risk of postpartum depression, and acts a buffer for the effects of stress. Consequently, Cho et al. (2022) conducted a quantitative cross-sectional study on social support and postpartum depression among postpartum mothers. The study focused on looking out for perceived social support as a protective factor for postpartum depressive symptomatology. The findings confirmed that the emotional and partner support aspects of social support are protective factors for a positive postnatal mental health.

Another study on coping styles as mediators between dyadic adjustment status and postpartum depression among 579 postnatal women in China was conducted by Deng et al. (2025) and reported that coping styles mediated the association of dyadic adjustment (social support) with postpartum depression. Detrimental partner relation quality is one of the best-known predictors of poor coping is the main result One of the major findings. Adaptive coping styles (problem solving, support seeking) are protective and generally associated with better adjustment, while avoidant and self-blaming styles of coping are the most related to postpartum depression, particularly in the presence of inadequate partner support.

It further suggests that coping styles are a key mechanism between social factors and maternal mental health. Thus, Chen et al. (2022) performed cross-sectional research examining the mediation of coping styles on the association between perceived social support and antenatal depression among 1,486 pregnant Women in China. The findings of this study provide preliminary evidence that coping style is an important psychological mechanism through which social support influence maternal mental health outcomes. The results support the idea that adequate social support may predispose women to employ more adaptive coping strategies, and thereby be less at risk for depressive symptomatology, but with some caveats.

Hence, a cross-sectional study by Alloghani et al (2024) aimed to examine sociodemographic correlates of PPD among 200 postpartum women in the eastern region of the UAE. The study also highlighted the detrimental effect of inadequate partner and family support in the development of postpartum depression, suggesting that collapsing social structures may be leading mothers to psychological despair.

Theoretical Framework

This study is anchored on the Stress Process Model (SPM) drawn from Pearlin et al (1981). The lens is central to the way in which sociologists examine social stratification and stress exposure, as well as how people mitigate those exposures through resources such as social support and coping (Pearlin, 2009). PPD is more than the physical and mental result of

childbirth; one's experience of it is shaped and influenced by relationships with others, societal expectations, availability of money, and stages of life (Agrawal et al, 2022; Saharoy et al, 2023).

The Stress Process Model describes a fluid process for the emergence and change in stressors over time, as well as the mechanisms linking stressors and mental health outcomes including depressive symptomatology (Pearlin, 1989). Giving birth is a major role transition stressor that the model singles out as potentiating emotional strain. However, mothers are faced challenging transformations in their sense of self, their day-to-day responsibilities, and their emotional demands. It has been suggested that postpartum depression is closely related to this transition due to hormonal changes, sleep disruption and increased caregiver demands (O'Hara & McCabe, 2013). Yet, the Stress Process Model adds depth this insight by asserting that these experiences are influenced by social and environmental factors and not only biomedical factors (Pearlin 1981; Pearlin 1989).

The Stress Process Model focuses on the resources of the mediation that weaken the effect of stress. In postpartum situations, perceived social support is indeed a vital protective factor as it buffers women against the psychological effects of stress. Social support may be received from husbands, members of the extended family, friends and healthcare providers. Emotional support is empathy, reassurance and positive affirmations. Instrumental support, on the other hand, is tangible support, such as childcare support or help with household maintenance. Informational support may also come in the form of advice from health workers or experienced mothers. Appraisal support is also a form of feedback from where mothers can take positive evaluations of their performance.

Conversely, coping is a core mediating process in the Stress Process Model. Coping influences the perception of, and response to, stress. A general cognitive appraisal process determines the impact of stress via cognitive, adaptive, and maladaptive reactions according to Lazarus and Folkman (1984). In postpartum women, coping patterns are divided into adaptive and maladaptive. Active coping included problem-solving and emotion focused coping, and passive coping was categorized as avoidant coping. Part of this is supported by an Indigenous literature in Nigerian context, religious coping is of

utmost importance and the women rely on prayer, faith-based support and spiritual explanation of their experiences in childbirth as problem-solving coping mechanisms. It seems that active religious coping (that is, seeking support and experiencing God's love; positive reappraisal of stressors) might offer emotional support and diminish depression (Brecka et al, 2024; Lucchetti et al, 2021). The SPM advocates that coping is affected at least at the individual and situational levels. Women with adequate social support utilised more positive coping mechanism whereas those with inadequate support resorted to avoidant or disengaged coping.

The applicability of the Stress Process Model in the investigation of postpartum depression, perceived social support and coping style among women of childbearing age in Ibadan Metropolis cannot be over emphasised. It dictates a comprehensive and well-organised portrayal of how the stressors related to childbirth are managed by social resources to bring about mental health outcomes. Owing to perceived social support and coping as mediators, the model provides a comprehensive explanation for why some women experience postpartum depression while others maintain emotional resilience despite similar stress exposure. The applicability to diverse cultural settings especially as it relates to family system and communal supports in Nigeria would further enhance the significance of the study. Thus, the Stress Process Model is an appropriate theoretical basis for this study as it informs the conceptualization and investigation of postpartum mental health, influence of perceived social support and coping styles among women.

Methods

Research design

This study adopts a descriptive cross-sectional survey research design.

Study Area

The study is conducted in Ibadan Metropolis, Oyo State, Nigeria. Ibadan is one of the largest urban centers in West Africa and consists of eleven local government areas (LGAs), five of

which form the core metropolitan area (Ibadan North, Ibadan South-West, Ibadan South-East, Ibadan North-West, and Ibadan North-East).

Study Population

The study population comprised of mothers aged 18 years and above within 1–12 months after childbirth attending selected postnatal clinics. Women with diagnosed severe psychiatric disorders prior to pregnancy were excluded from the study.

Sample Size Determination

The sample size was determined using Cochran's formula for populations of unknown size. Assuming a 95% confidence level ($Z = 1.96$), a margin of error of 5% ($d = 0.05$), and a population proportion of 50% ($p = 0.5$) to maximize the sample size, the minimum required sample size was calculated as 384.

Although the minimum sample size determined using Cochran's formula was 384, however, 10% attrition rate was added to account for a possible non-response due to the nature of the participants. Thus, resulting in a final sample size of 422 respondents.

Sampling Procedure

A multistage sampling technique was used to select participants. Firstly, five out of eleven local government areas were selected within Ibadan metropolis through balloting to ensure full geographic representation. Secondly, a combination of public and private health facilities providing maternal and child health services are randomly selected within each LGA. Thirdly, the total sample size of 422 respondents was proportionately allocated across selected facilities based on number of postpartum mothers attending each facility. Lastly, a systematic random sampling technique is used to recruit eligible postpartum women as every 3rd postpartum woman in attendance was recruited to participate in the study.

Instruments

Edinburgh Postnatal Depression Scale: The Edinburgh Postnatal Depression Scale (EPDS) developed by Cox et al (1987) is a self-report instrument consisting of 10 items that assess depressive symptoms experienced during the previous seven days. Each item is scored on a 4-point Likert scale (0–3), resulting in a total score ranging from 0 to 30. An example of item on the scale is "The thought of harming myself has occurred to me." Higher scores indicate greater depressive symptoms. A cut-off score of 13 or above is commonly used to identify women at risk of postpartum depression. A Cronbach's α of 0.83 was obtained after the pilot study among thirty women who are not in the local government covered in the study.

Brief COPE Inventory: The Brief COPE Inventory was developed by Carver 1997 to assess coping responses individuals use when confronted with stressful situations. This instrument consists of 28 items measuring both adaptive coping styles (problem-focused and emotion- focused) and maladaptive coping styles (avoidant coping). Higher scores on a subscale indicate greater use of that particular coping strategy. After pilot testing, a Cronbach's alpha of 0.79 was obtained.

Multidimensional Social Support Scale: The Multidimensional Scale of Perceived Social Support (MSPSS) was developed by Zimet et al 1988 to assess individuals' perceptions of social support from various sources. The MSPSS contains 12 items divided into three subscales namely; family support; friends support and significant other support. Higher scores indicating higher perceived social support. An item on the scale is "My family really tries to help me." After pilot testing, a Cronbach's α of 0.86 was obtained.

Data Collection

Ethical approval was sought and obtained from Oyo State Hospitals Management Board Health Research Ethics Committee (HREC) before the commencement of the study. Data was collected by the researcher and two trained research assistants. Informed consent was obtained from all participants before administration of questionnaire. Confidentiality and anonymity were preserved during the study.

Although a minimum sample size of 422 was determined using Cochran's formula, a total of 410 questionnaires were properly completed and found usable for analysis.

Method of Data Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS; version 26) with descriptive statistics, chi-square, t-tests and logistic regression ($p < 0.05$). A series of mediation analyses was conducted using Hayes' PROCESS Macro (Model 4) in SPSS to examine whether three coping styles emotion-focused, problem-focused, and avoidant coping independently mediated the association between perceived social support and postpartum depression. Each mediation model controlled for potential confounding variables, including age, marital status, monthly income, and parity.

Results

Table 1: Socio-demographic Characteristics of Respondents (N = 410)

Variable	Category	Frequency (n)	Percentage (%)
Age Group (Years)	18–24	87	21.2%
	25–34	256	62.5%
	35 and above	67	16.3%
Marital Status	Married	321	78.4%
	Single	51	12.4%
	Divorced/Widowed	38	9.3%
Educational Status	No formal education	74	18.1%
	Primary	26	6.3%
	Secondary	181	44.2%
	Tertiary	129	31.5%
Employment Status	Informal sector	241	58.7%
	Formal sector	69	16.7%
	Unemployed	101	24.6%
Monthly Income (₦)	< ₦50,000	267	65.1%
	₦50,000–₦99,999	103	25.1%
	₦100,000 and above	40	9.8%
Parity	Primiparous (1 child)	108	26.3%
	Multiparous (2–4 children)	200	48.9%
	Grand multiparous (5+ children)	102	24.8%
Pregnancy Planned	Yes	262	63.9%
	No	148	36.1%
Delivery Complications	Yes	59	14.4%
	No	351	85.6%

Source: Field Survey (2024)

Table indicates that a total of 410 postpartum women participated in the study and the response rate was 96.3%. The majority were married (78.4%) and in the age group 25–34 (62.5%). The level of education was different: 44.2% had secondary education, 31.5% had tertiary education, and 18.1% had no education. There was a high level of informal labor (58.7%), 24.6% unemployed and 16.7% with formal labour. The majority (65.1%) earned low monthly income (below ₦50,000). About parity,48.9%were multiparous and 26.3% were primipara. Importantly, 14.4% had reported complications of delivery and 36.1% were not planned. These indices reflect the types of social and economic adversity that define the mental health and coping strategies of postpartum women in Ibadan.

Table 2: Distribution of Coping Strategies Among Postpartum Women (N = 410)

Coping Strategy	Frequency (n)	Percentage (%)
Emotion-Focused Coping	307	74.8%
Problem-Focused Coping	210	51.2%
Avoidant Coping	118	28.7%

Source: Field Survey (2024)

As shown on table 2, the coping styles of the 410 postpartum women were analyzed and classified as emotion-focused (74.8%, n=307), problem-focused (51.2%, n=210), and avoidant coping (28.7%, n=118). Emotion-focused approaches (prayer, emotional-based support) were the most prevalent. Problem-focused strategies (care seeking, planning) were employed by slightly more than half. Avoidant coping was the least employed type of coping (escape, denial).

Table 3: Relationship between Social Support and Postpartum Depression

Social Support Level	Mean Depression Score (SD)	F-value	p-value
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Low	15.42 (4.11)		
Moderate	11.83 (3.76)		
High	8.37 (3.15)	18.67	<.001

Source: Field Survey (2024)

Table 3 reveals the relationship between perceived social support and postpartum depression among the respondents. The results show that women with low social support reported the highest mean depression score (M= 15.42, SD= 4.11), followed by those with moderate social support (M=11.83, SD= 3.76). In contrast, respondents with high social support had the lowest mean depression score (M=8.37, SD= 3.15). The study further showed a statistically significant difference in the regression score across the three social support groups (F=18.67, p<.001). This finding indicated a clear inverse relationship between social support and postpartum depressive symptoms. As the level of perceived social support increased, the severity of depressive symptoms decreased. This suggests that women who received greater emotional, informational, and practical support during the postpartum period experience a lower level of distress.

Table 4: Multivariate Regression Analysis of Coping Strategies on Postpartum Depression Symptoms

Coping Strategy	β Coefficient	Standard Error	p-value	Direction of Association
Emotion-Focused Coping	-0.31	0.09	< .01	Negative
Problem-Focused Coping	-0.28	0.12	< .05	Negative
Avoidant Coping	+0.45	0.11	< .001	Positive

Source: Field Survey (2024)

Table 4 shows that emotion-focused coping (e.g., prayer, social support) significantly predicted lower levels of postpartum depression ($\beta = -0.31, p < .01$), and problem-focused coping (e.g., obtaining medical help, making plans) seemed to be a protective factor as well ($\beta = -0.28, p < .05$). Conversely, avoidant coping strategies (e.g., denial, disengagement) were linked to more severe depressive symptoms ($\beta = 0.45, p < .001$). The results highlight the salience of social support and active coping in symptom reduction of postpartum depression and suggest that avoidant coping may constitute risk in the postpartum.

Table 5: Domain-Specific Mediation of the Association Between Social Support and Postpartum Depression through Coping Styles (N = 410)

Coping Domain	a Path: SS → Coping B (SE)	b Path: Coping → PPD B (SE)	Direct Effect (c') B (SE)	Total Effect (c) B (SE)	Indirect Effect (ab)	Bootstrap SE	95% Bootstrap CI	Decision
Emotion-focused coping	0.38 (0.07)	-0.51 (0.11)	-0.20 (0.09)	-0.39 (0.10)	-0.19	0.06	[-0.31, -0.09]	Significant
Problem-focused coping	0.29 (0.08)	-0.35 (0.12)	-0.29 (0.10)	-0.39 (0.11)	-0.10	0.05	[-0.20, -0.02]	Significant
Avoidant coping	0.31 (0.07)	0.17 (0.13)	-0.44 (0.10)	-0.39 (0.11)	0.05	0.04	[-0.02, 0.14]	Not significant

Source: Field Survey (2024)

Note: SS = Social Support; PPD = Postpartum Depression; B = unstandardized coefficient; SE = standard error. The indirect effect is considered significant where the 95% bootstrap confidence interval does not include zero. All models controlled for age, marital status, income, and parity.

Table 5 indicates that social support was positively associated with emotion-focused coping ($a = 0.38, SE = 0.07$), while emotion-focused coping was negatively associated with postpartum depression ($b = -0.51, SE = 0.11$). The indirect effect was -0.19 , with a 95%

bootstrap CI of $[-0.31, -0.09]$. Because the confidence interval does not contain zero, the indirect effect is significant. Thus, emotion-focused coping significantly mediated the association between social support and PPD. The direct effect remained significant ($c' = -0.20$, $SE = 0.09$), indicating partial mediation.

Also, table 5 reveals that social support was positively associated with problem-focused coping ($a = 0.29$, $SE = 0.08$), and problem-focused coping was negatively associated with PPD ($b = -0.35$, $SE = 0.12$). The indirect effect was -0.10 , with a 95% bootstrap CI of $[-0.20, -0.02]$. Since zero is not included in the interval, problem-focused coping significantly mediated the relationship between social support and PPD. Because the direct effect remained significant ($c' = -0.29$, $SE = 0.10$), this is also partial mediation.

Furthermore, the table shows social support was positively associated with avoidant coping ($a = 0.31$, $SE = 0.07$), but avoidant coping was positively associated with PPD ($b = 0.17$, $SE = 0.13$). The indirect effect was 0.05 , with a 95% bootstrap CI of $[-0.02, 0.14]$. Because the confidence interval includes zero, the indirect effect is not statistically significant. Therefore, avoidant coping did not significantly mediate the relationship between social support and postpartum depression. Thus, greater social support was associated with greater use of emotion-focused and problem-focused coping, which was associated with lower postpartum depression.

Table 6: Significance Tests and Model Fit for the Domain-Specific Mediation Models

Coping Domain	N	p-value (a path)	p-value (b path)	p-value (c')	p-value (ab)	R ² Mediator Model	R ² Outcome Model
Emotion-focused coping	410	< .001	< .001	.026	.002	.15	.29
Problem-focused coping	410	< .001	.004	.004	.046	.10	.22

Avoidant coping	410	<.001	.191	<.001	.211	.11	.24
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Source: Field Survey (2024)

Table 6 provides the significance tests and model-fit statistics for the three domain-specific mediation models examining whether coping styles mediate the relationship between social support and postpartum depression. Emotion-focused coping significantly mediated the relationship (a path: $p < .001$; b path: $p < .001$; indirect effect ab : $p = .002$), with the model explaining 15% of the variance in coping and 29% in postpartum depression ($R^2 = .15$ and $.29$). Problem-focused coping also showed significant mediation (a : $p < .001$; b : $p = .004$; ab : $p = .046$), explaining 10% and 22% of the variance, respectively ($R^2 = .10$ and $.22$). In contrast, avoidant coping did not significantly mediate the association, despite a significant a path ($p < .001$), because the b path ($p = .191$) and indirect effect (ab : $p = .211$) were non-significant; the corresponding R^2 values were $.11$ and $.24$. The mediator model explained 11% of the variance in avoidant coping, while the outcome model explained 24% of the variance in postpartum depression ($R^2 = .11$ and $.24$). The significant direct effects for emotion-focused (c' : $p = .026$) and problem-focused coping (c' : $p = .004$) indicate partial mediation.

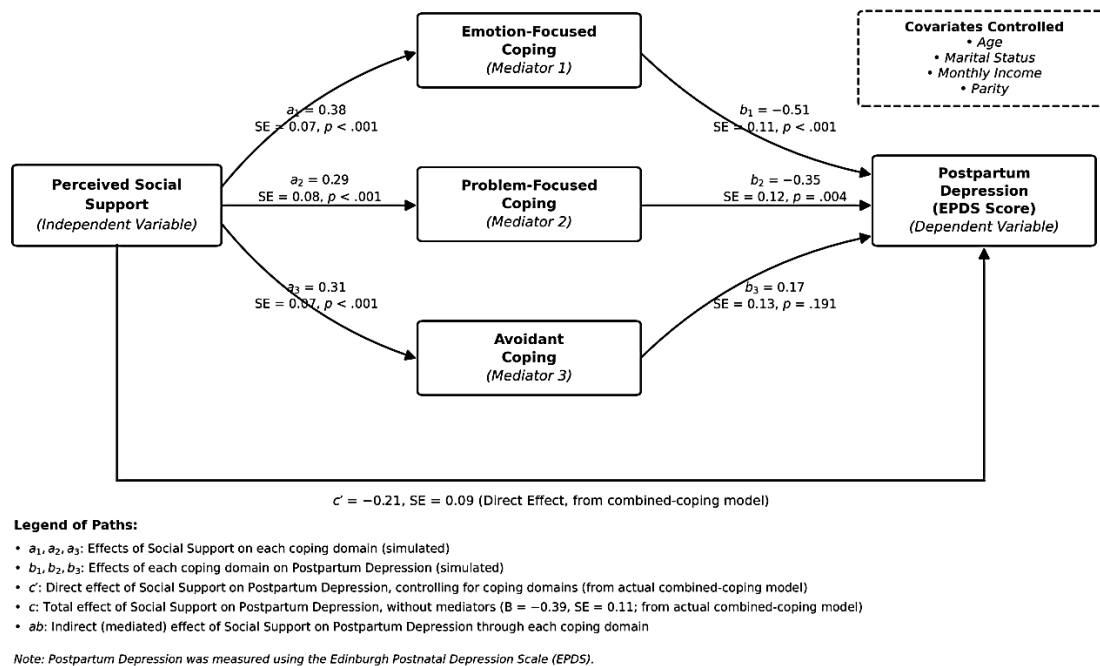


Figure 1: Domain-Specific Path Analysis of the Mediating Role of Coping Styles in the Relationship between Social Support and Postpartum Depression (N = 410)

As shown in Figure 1, emotion-focused and problem-focused coping both significantly mediated the effect of social support over postpartum depressive symptoms. In addition, emotion-focused coping had a significant indirect effect ($B = -0.19$, 95% CI $[-0.31, -0.09]$, $p = .002$), and the same was true for problem-focused coping ($B = -0.10$, 95% CI $[-0.20, -0.02]$, $p = .046$). However, avoidant coping was not a significant mediator of the association ($B = 0.05$, 95% CI $[-0.02, 0.14]$, $p = .211$), as zero was contained within its confidence interval.

Taken as a whole, Figure 1 suggests that coping style functions as a domain-specific mediator in the relationship between social support and postpartum depression. The significant indirect pathways through emotion-focused and problem-focused coping indicate that higher perceived social support is associated with lower postpartum depressive symptoms partly through these coping domains. In contrast, the indirect pathway through avoidant coping was not statistically significant, suggesting that avoidant coping did not significantly mediate the association between social support and postpartum depression in this sample. Thus, the findings indicate that the mediating role of

coping is specific to particular coping domains rather than a general effect across all coping styles.

Discussion of Findings

The result obtained from this study indicated that emotion-focused was the most adopted coping strategy found among postpartum women, followed by problem-solving coping while avoidant coping is rarely used. This corroborates the result indicated in the work of Yu et al (2021) that problem-focused coping and support seeking are the most adopted and commonly beneficial coping styles among postpartum women. Also, this finding supports the submission of Uzobo et al (2022) that the most adopted coping strategies among postpartum women are support seeking and music-based emotional coping, while formal mental health interventions remain limited. Furthermore, studies have revealed that most common coping responses among postpartum women in Nigeria include support seeking, religious coping, and emotion-focused coping styles, especially in the context of limited access to formal mental health service (Adeyemo et al. 2020; Jidda et al 2024).

Consequently, this study revealed a significant relationship between social support and postpartum depression. These findings reaffirmed the protective nature of good family and partner support. On the other hand, Igo et al. (2021) documented that social support was an influential factor for nursing mothers in maintaining their postpartum mental health. The study documented that sufficient social support decreases the risk of postpartum depression, and acts a buffer for the effects of stress. In addition, Cho et al. (2022) confirmed that the emotional and partner support aspects of social support are protective factors for a positive postnatal mental health.

Furthermore, this study revealed that coping style contributed a significant indirect effect in the association between social support and postpartum depression. Women with a high level of perceived social support were more likely to use adaptive coping styles and experienced fewer PPD symptoms. The indirect effect was significant and thus partial mediation was found, that is, social support reduces PPD symptoms directly and also indirectly through coping behaviour. Such partial mediation implies that social support has

a direct effect on reducing symptoms of PPD, but its effect becomes stronger when it is indirectly channeled through coping behaviour. The finding of this study corroborates that of Cho et al. (2022) who documented that social support is a key determinant of postpartum depression among Nigerian women. Thus, Social support plays a significant protective role in postpartum mental health among nursing mothers (Igo et al. (2021). Furthermore, one of the major findings in the study done by Deng et al. (2025) is that poor partner relationship quality increases the likelihood of maladaptive coping. This is in line with the submission of Chen et al. (2022) that women who receive adequate social support are more likely to adopt adaptive coping strategies, thereby reducing their vulnerability to depressive symptoms. Consequently, this is consistent with the submission of the stress process model that social meanings derived from interaction (for instance, “being supported”) play a role in how individuals engage with and respond to emotional threat in managing PPD. This finding validates the important role of support systems and also highlights how interpretive frameworks, developed through social interaction, shape coping responses and mental health outcomes.

Implications of Findings

The presence of PPD among childbearing women may be a reflection of social stressors including poverty, unemployment, marital discord, financial strain, and poor health care. It has been established that chronic exposure to social stressors leads to distress according to the Stress Process Model (Pearlin et al., 1981). Women have greater risk of depression due to multiple roles demands in their role as mother, wife, worker, and caregiver. In addition, there are high expectations on women in Nigerian homes to be good mothers and matrons of the home after childbirth. The frustration at being unable to meet these expectations because of physical fatigue, emotional difficulties, or lack of social support may result in role strain and emotional distress. Hence, the outcome brings into focus the consequences of maternal mental health in the context of gendered expectations.

The predominance of emotion-focused coping (prayer, religious means, within a culture may also stem from cultural value which appreciates perseverance, responsibility, and practical ways of resolving issues as mothers, since styles of coping are learned through

socialization. Women's responses to stress are shaped by their families, religious organizations, and peer groups as well as cultural conventions, within which they are situated. The second most adopted coping strategy is problem-focused coping which include seeking advice, help, and tangible assistance from family, spouses, healthcare professionals, and friends. This result emphasizes the role of social networks in regulating coping styles and decreasing psychological distress.

In addition, the study finding supports the sociological perspective that social determinants significantly shape mental health. The experiences of mothers and their risk for depression is affected by such variables as age, marital status, education, employment, income, family structure, and parity. Social support contributes to an increase in the capacity of women to use adaptive strategies to cope with stress and these strategies reduces depressive symptomatology. Hence, it exemplifies the social organization of the individual, including mental health outcomes.

Recommendations

- I. Healthcare professionals should include postpartum depression screening as a routine component of maternal and child health care. Using a standardized screening tool, such as the Edinburgh Postnatal Depression Scale, during antenatal care, at postnatal clinics, and during immunization sessions will promote early detection and enable timely treatment.
2. Family, spouse, and community members should be "mobilized to provide emotional, informational, and tangible support" to postpartum women. Maternal care and childcare work should be shared by fathers to help ease maternal stress and psychological load. Also, community support groups for new mothers should be organized to build social capital and counter act isolation.
3. Women should be provided with information on effective coping styles (such as, problem-solving, seeking social support, positive reframing, and stress management) by health care practitioners during the antenatal and postnatal periods.

4. Given that sociodemographic factors were associated with postpartum depression, interventions should target high-risk women, such as those with low income, low level of educational attainment, unemployment, poor family support, or a history of mental illness. Postpartum women-specific support service should be organized.

Conclusion

This study investigated the coping strategies employed by postpartum women and the mediating role of coping style on the association between perceived social support and PPD in Ibadan, Nigeria. Emotion-focused coping was reported to be the most common form of coping followed by problem-focused coping, and lastly avoidant coping. Therefore, postpartum mental health should not be viewed solely as a clinical or individual concern but as a multifaceted phenomenon shaped by the social resources available to women and the coping mechanisms, they employ in navigating the challenges of motherhood. Consequently, efforts to promote maternal mental health should extend beyond medical interventions to include strengthening family, partner, and community support systems while fostering adaptive coping strategies among childbearing women. This integrated approach is essential for improving psychological well-being and reducing the burden of postpartum depression in diverse sociocultural contexts.

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