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A Structural Model of Stigma, Spiritual Coping, and Mental Health Literacy Influencing Postpartum Mothers' Mental Health Help-Seeking

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A B S T R A C T

Introduction: Postpartum mental health problems remain common, yet many mothers do not seek professional support. Stigma, limited mental health literacy, and reliance on coping strategies, including spiritual coping may jointly shape help-seeking decisions, but these factors are rarely tested within a single explanatory model. **Objective:** To examine a triadic model linking stigma, spiritual coping, and mental health literacy with postpartum mothers' help-seeking behavior, including the moderating role of spiritual coping. **Methods:** A cross-sectional analytical study was conducted among 100 postpartum mothers (≤12 months after delivery) recruited from maternal–child health clinics and online parenting communities in West Java, Indonesia. Validated questionnaires assessed stigma, spiritual coping, mental health literacy, and self-reported help-seeking behavior. Data were analyzed using Pearson correlations, hierarchical multiple regression, and structural equation modeling (SEM). Model fit was evaluated using χ^2/df, RMSEA, CFI, and TLI. **Results:** Stigma correlated negatively with help-seeking ($r = -0.42$, $p < .001$) and mental health literacy ($r = -0.34$, $p < .01$), while mental health literacy correlated positively with help-seeking ($r = 0.51$, $p < .001$). In regression analysis, stigma, spiritual coping, and mental health literacy explained 42% of the variance in help-seeking ($R^2 = 0.42$, $p < .001$), with mental health literacy as the strongest predictor ($\beta = 0.41$, $p < .001$), followed by stigma ($\beta = -0.33$, $p < .001$) and positive spiritual coping ($\beta = 0.25$, $p = .005$). SEM showed good fit (χ^2/df = 1.87; RMSEA = 0.052; CFI = 0.95; TLI = 0.93) and confirmed direct effects of stigma ($\beta = -0.31$, $p < .001$), mental health literacy ($\beta = 0.44$, $p < .001$), and spiritual coping ($\beta = 0.22$, $p = .015$) on help-seeking. Spiritual coping significantly moderated the stigma–help-seeking relationship ($\beta = 0.18$, $p = .024$), attenuating stigma's negative effect. **Conclusion:** Postpartum help-seeking is shaped by the combined influence of stigma, mental health literacy, and spiritual coping, with spiritual coping buffering stigma's harmful impact. Integrated interventions should reduce stigma, strengthen mental health literacy, and leverage adaptive spiritual resources.

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1. INTRODUCTION

Postpartum mental health problems, particularly postpartum depression (PPD), remain among the most common complications of childbirth, affecting approximately 10–15% of mothers worldwide (O'Hara & Wisner, 2019). Untreated PPD can lead to adverse outcomes for both mother and child, including impaired bonding, developmental delays, and increased risk of maternal suicide (Stein et al., 2019). Despite the availability of psychological services, help-seeking among postpartum mothers remains low, often due to stigma, limited mental health literacy (MHL), and reliance on non-professional coping strategies (Jones, 2022). Understanding the determinants of help-seeking behavior is therefore critical for improving maternal mental health outcomes.

Stigma has consistently been identified as a barrier to accessing psychological care. Mothers experiencing PPD often fear being judged as "weak" or "bad mothers," leading to concealment of symptoms and avoidance of professional help (Byatt et al., 2020). Stigma not only reduces service utilization but also perpetuates negative self-perceptions, further exacerbating psychological distress. Mental health literacy (MHL), defined as knowledge and beliefs about mental disorders that aid recognition, management, and prevention, plays a pivotal role in shaping help-seeking behavior (Jorm, 2012). Higher MHL is associated with earlier recognition of symptoms and greater willingness to seek professional care (Wei et al., 2020). However, studies show that postpartum mothers often have limited awareness of PPD symptoms and available services, which delays intervention (Jones, 2022). Spiritual coping represents another determinant of maternal mental health. In many cultural contexts, including Indonesia, mothers rely on prayer, religious rituals, or spiritual communities to manage distress (Koenig, 2020). While adaptive spiritual coping can provide emotional support, excessive reliance may discourage mothers from accessing professional psychological services, especially when spiritual interpretations frame PPD as a moral or faith-related issue (Pargament & Exline, 2021).

Although spiritual coping may theoretically function through multiple pathways, the present study conceptualizes spiritual coping as a moderator rather than a mediator. A mediating model assumes that stigma or mental health literacy directly alters individuals' coping responses, which subsequently determine help-seeking behavior. However, coping theory and previous literature suggest that spiritual coping often operates as a contextual and adaptive resource that influences how individuals interpret and respond to psychological distress rather than serving as a direct consequence of stigma or literacy levels (Koenig, 2012; Pargament & Exline, 2021). Positive spiritual coping strategies, such as meaning-making, religious support, and acceptance, may buffer the emotional and cognitive burden associated with stigmatizing beliefs and increase openness toward professional psychological support. Therefore, spiritual coping was hypothesized to moderate the relationship between stigma and help-seeking by attenuating the negative influence of stigma, rather than acting as an intermediate mechanism linking these constructs (Koenig, 2012; Pargament & Exline, 2021).

Recent studies have examined stigma and MHL in postpartum help-seeking separately (Byatt et al., 2020; Jones, 2022), while others highlight the role of spirituality in coping with maternal distress (Koenig, 2020). However, few have integrated these three dimensions into a single explanatory framework. A triadic model that considers stigma, spiritual coping, and MHL simultaneously may provide a more comprehensive understanding of postpartum mothers' decision-making processes. Existing literature has established the individual effects of stigma, MHL, and spiritual coping on maternal mental health outcomes. However, there is limited evidence on how these factors interact to shape postpartum mothers' help-seeking behavior. Most studies treat stigma and MHL as independent predictors, while spiritual coping is often examined in isolation or as a protective factor. This fragmented approach overlooks the possibility that spiritual coping may moderate or mediate the relationship between stigma, literacy, and help-seeking. Furthermore, research in low- and middle-income countries, where cultural and religious influences are particularly strong, remains scarce (Rahman et al., 2021). Addressing this gap, the present study proposes a triadic model that integrates stigma, spiritual coping, and MHL to explain postpartum mothers' decisions to seek psychological care.

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2. METHODS

Research Design

This study adopted a cross-sectional analytical design to investigate the triadic relationship among stigma, spiritual coping, and mental health literacy in postpartum mothers' help-seeking behavior. A quantitative approach was selected to allow for statistical modeling of associations and potential moderating effects among the three constructs, providing a comprehensive understanding of decision-making processes in maternal mental health (Jones, 2022).

Sample

The study population consisted of postpartum mothers within twelve months after delivery, recruited from maternal and child health clinics and online parenting communities in West Java, Indonesia. Inclusion criteria were mothers aged between 18 and 45 years, within twelve months postpartum, able to read and understand Bahasa Indonesia, and willing to provide informed consent. Exclusion criteria included mothers with severe psychiatric diagnoses such as schizophrenia or bipolar disorder documented in medical records, and mothers with medical complications requiring intensive care such as prolonged hospitalization due to postpartum hemorrhage.

Sample size was calculated using G*Power 3.1 for multiple regression analysis with three predictors. Assuming a medium effect size ($f^2 = 0.15$), $\alpha = 0.05$, and power = 0.80, the required sample size was 77 participants. To account for potential attrition and incomplete responses, the target recruitment was set at 100 mothers (Faul et al., 2009; Rahman et al., 2021). A purposive sampling technique was employed to ensure representation from both urban and rural clinics, capturing cultural diversity in stigma and spiritual coping practices (Byatt et al., 2020).

Although the sample size was determined primarily using G*Power for multiple regression analysis, SEM was conducted as a complementary confirmatory approach using an observed-variable model with a limited number of parameters. Given the relatively simple model structure and the exploratory nature of the analysis, the sample size of 100 was considered acceptable for preliminary SEM estimation and model evaluation. Nevertheless, the findings should be interpreted cautiously and require confirmation in larger samples.

Instruments

Stigma was measured using the Depression Stigma Scale (DSS), originally developed by Griffiths and colleagues and adapted for postpartum populations. The DSS consists of 18 items divided into personal stigma and perceived stigma subscales. Items are scored on a five-point Likert scale ranging from strongly disagree to strongly agree, with higher scores indicating greater stigma. The original version demonstrated Cronbach's α of 0.82, while the Bahasa Indonesia version showed α of 0.80 (Wei et al., 2020; Jones, 2022).

Spiritual coping was assessed using the Brief RCOPE developed by Pargament and colleagues. The instrument consists of 14 items measuring positive and negative religious coping strategies. Items are scored on a four-point Likert scale ranging from not at all to a great deal. Higher positive coping scores indicate adaptive spiritual coping, while higher negative coping scores indicate maladaptive coping. The original version demonstrated Cronbach's α of 0.87, and the Bahasa Indonesia version showed α of 0.84 (Koenig, 2020; Rahman et al., 2021).

Mental health literacy was measured using the Postpartum Depression Literacy Scale (PoDLiS), validated for perinatal populations. The instrument consists of 29 items covering domains of recognition, knowledge, attitudes, and help-seeking efficacy. Items are scored on a five-point Likert scale, with higher scores reflecting greater literacy. The original version demonstrated Cronbach's α of 0.89, and the Bahasa Indonesia version showed α of 0.86 (International Journal of Public Health Science, 2021; Jones, 2022).

Help-seeking behavior was operationally defined as participants' self-reported responses regarding seeking or willingness to seek professional psychological support when experiencing emotional or psychological difficulties during the postpartum period. In this study, help-seeking was assessed using a questionnaire-based self-report approach and interpreted as perceived help-seeking tendencies rather than observed service utilization.

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In the current study. Cronbach's α coefficients confirmed acceptable internal consistency for all scales: Depression Stigma Scale (α = 0.81), Brief RCOPE (α = 0.85), and Postpartum Depression Literacy Scale (α = 0.87). These values are consistent with prior validation studies (Wei et al., 2020; Koenig, 2020).

Procedure

Ethical approval was obtained from the Institutional Review Board of Universitas Padjadjaran. Recruitment through both clinic-based and online approaches was intended to improve accessibility and capture variation in participant experiences. However, this strategy may have introduced selection bias, as mothers engaged in online parenting communities may differ from clinic attendees in digital access, health awareness, and willingness to discuss mental health concerns. Therefore, the findings may not fully represent all postpartum mothers in the study setting.

Data Analysis

Data were analyzed using SPSS version 29 and AMOS version 24. Descriptive statistics summarized demographic and clinical characteristics. Reliability analysis using Cronbach's α confirmed internal consistency of instruments. Pearson correlations examined bivariate associations. Hierarchical multiple regression tested the predictive effects of stigma, spiritual coping, and mental health literacy on help-seeking behavior. Structural Equation Modeling (SEM) was employed to examine the triadic model and test the potential moderating role of spiritual coping in the relationship between stigma and help-seeking behavior.. Model fit was evaluated using χ^2/df, RMSEA, CFI, and TLI indices, following established criteria (Hu & Bentler, 1999; Wei et al., 2020).

3. RESULT

Demographic Characteristics

A total of 100 postpartum mothers participated in the study. The mean age was 29.4 years (SD = 5.2), with the majority aged between 25 and 34 years. Most participants were married (96%), had completed secondary education (58%), and were multiparous (62%). Approximately 55% resided in urban areas, while 45% lived in rural settings.

Table 1. Demographic Characteristics of Participants (N = 100)

Variable	Category	n	%
Age (years)	18–24	22	22
	25–34	48	48
	35–45	30	30
Marital status	Married	96	96
	Single/divorced	4	4
Education level	Primary	12	12
	Secondary	58	58
	Tertiary	30	30
Parity	Primiparous	38	38
	Multiparous	62	62
Residence	Urban	55	55
	Rural	45	45

Correlation Analysis

Pearson correlation analysis revealed significant associations among the three constructs. Stigma was negatively correlated with help-seeking behavior ($r = –0.42$, $p < .001$). Mental health literacy was positively correlated with help-seeking behavior ($r = 0.51$, $p < .001$). Positive spiritual coping was positively correlated with help-seeking ($r = 0.36$, $p < .01$), while negative spiritual coping was negatively correlated ($r = –0.28$, $p < .05$) (Table 2).

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Table 2. Correlation Matrix of Study Variables

Variable	1. Stigma	2. Spiritual Coping	3. Mental Health Literacy	4. Help-Seeking
1. Stigma	1	–0.21*	–0.34**	–0.42***
2. Spiritual Coping		1	0.29**	0.36**
3. Mental Health Literacy			1	0.51***
4. Help-Seeking				1

Note: *= p < 0.05; ** = p < 0.01, *** = p < 0.001

Regression Analysis

Hierarchical multiple regression indicated that stigma, spiritual coping, and mental health literacy together explained 42% of the variance in help-seeking behavior ($R^2 = 0.42$, $F(3,96) = 23.1$, $p < .001$). Mental health literacy emerged as the strongest predictor ($\beta = 0.41$, $p < .001$), followed by stigma ($\beta = –0.33$, $p < .001$) and positive spiritual coping ($\beta = 0.25$, $p < .01$).

Table 3. Hierarchical Regression Predicting Help-Seeking Behavior

Predictor	β	SE	t	95% CI	p-value
Stigma	–0.33	0.08	–4.12	–0.49, –0.17	<.001
Spiritual Coping (positive)	0.25	0.09	2.89	0.08, 0.42	.005
Mental Health Literacy	0.41	0.08	5.21	0.25, 0.57	<.001

Structural Equation Modeling (SEM)

Structural Equation Modeling was conducted using composite scores derived from validated instruments rather than latent constructs estimated from individual questionnaire items. Therefore, the analysis was performed as an observed-variable path model and did not include a separate confirmatory factor analysis (CFA) stage or estimation of standardized factor loadings. Construct reliability was supported through previously established validation studies and internal consistency testing in the current sample using Cronbach's α coefficients.

The triadic model was examined using observed-variable SEM. Fit indices indicated acceptable model fit ($\chi^2/df = 1.87$, RMSEA = 0.052, CFI = 0.95, TLI = 0.93). Stigma showed a negative association with help-seeking ($\beta = -0.31$, $p < .001$), whereas mental health literacy demonstrated a positive association ($\beta = 0.44$, $p < .001$). Moderation analysis was conducted by estimating an interaction term between stigma and spiritual coping using standardized composite scores. The significant interaction effect ($\beta = 0.18$, $p = .024$) indicated that higher levels of positive spiritual coping attenuated the negative association between stigma and help-seeking (Table 4). Spiritual coping moderated the relationship between stigma and help-seeking, weakening the negative impact of stigma when positive coping strategies were employed (Figure 1).

Table 4. Structural Equation Modeling Results for the Triadic Model

Pathway	Standardized β	SE	CR (t)	p-value
Stigma → Help-Seeking	–0.31	0.07	–4.43	<.001
Mental Health Literacy → Help-Seeking	0.44	0.08	5.50	<.001
Spiritual Coping → Help-Seeking	0.22	0.09	2.44	.015
Stigma → Mental Health Literacy	–0.34	0.06	–5.67	<.001
Spiritual Coping × Stigma → Help-Seeking (moderation)	0.18	0.08	2.25	.024

Note: Model Fit Indices $\chi^2/df = 1.87$, RMSEA = 0.052, CFI = 0.95, TLI = 0.93.

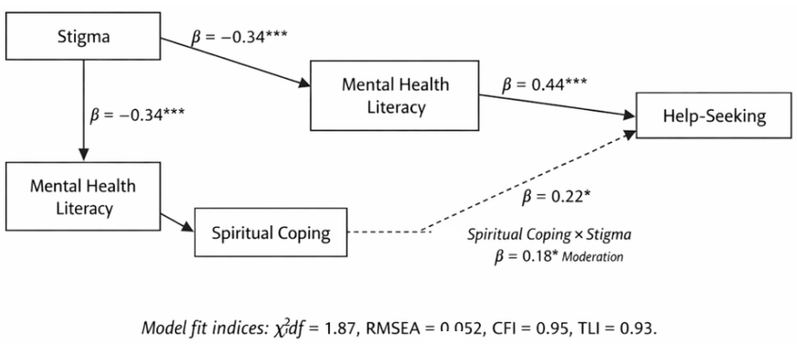

Figure 1. Path Diagram of the Triadic Model Linking Stigma, Mental Health Literacy, Spiritual Coping, and Help-Seeking

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4. DISCUSSION

This study provides empirical support for a triadic structural model in which stigma, mental health literacy, and spiritual coping are associated with postpartum mothers' help-seeking behavior. The findings suggest that higher stigma was related to lower help-seeking, whereas greater mental health literacy and positive spiritual coping were associated with more favorable help-seeking tendencies. In addition, spiritual coping moderated the association between stigma and help-seeking, indicating that adaptive spiritual coping may attenuate the negative association between stigma and help-seeking. Collectively, these findings contribute to existing models of mental health service utilization by integrating psychosocial, cognitive, and spiritual dimensions within a single explanatory framework. Given the cross-sectional design, the findings should be interpreted as associations rather than causal pathways.

Consistent with a large body of evidence, stigma emerged as a strong barrier to help-seeking behavior. The negative association observed in this study aligns with prior research demonstrating that perceived and internalized stigma reduce individuals' willingness to seek professional mental health care (Clement et al., 2015; Henderson et al., 2013). Stigma has been shown to operate through fear of social judgment, concerns about discrimination, and threats to self-identity, all of which discourage disclosure and formal help-seeking (Corrigan & Rao, 2012). The present findings reinforce stigma as a critical upstream determinant of help-seeking and underscore the necessity of addressing stigma at both individual and community levels.

Mental health literacy showed the strongest positive direct effect on help-seeking behavior in the model. This finding is consistent with earlier studies indicating that greater knowledge of mental disorders, symptom recognition, and awareness of treatment options facilitate timely and appropriate help-seeking (Jorm, 2012; Kutcher et al., 2016). Importantly, stigma was negatively associated with mental health literacy, suggesting that stigmatizing beliefs may hinder the acquisition or acceptance of accurate mental health information. This pathway supports prior evidence that stigma and mental health literacy are reciprocally related and jointly shape help-seeking decisions (Wei et al., 2015).

Spiritual coping demonstrated a significant positive association with help-seeking behavior, consistent with studies showing that positive spiritual coping strategies, such as meaning-making, hope, and trust are associated with better psychological adjustment and greater openness to support (Pargament et al., 2013; Ano & Vasconcelles, 2005). Unlike negative spiritual coping, which has been linked to avoidance and distress, positive spiritual coping may encourage adaptive appraisal of mental health problems and reduce self-blame, thereby facilitating help-seeking.

However, the role of spirituality in help-seeking may be context dependent and should not be interpreted as uniformly facilitating professional service utilization. In some cultural and religious contexts, spiritual coping may complement formal psychological care, while in others it may function as an alternative coping pathway that delays or substitutes professional help-seeking. Mothers who interpret emotional distress primarily through spiritual or moral frameworks may prioritize prayer, religious guidance, or community support over formal mental health services. Therefore, the positive association observed in this study should be interpreted cautiously and does not imply that spiritual coping consistently increases utilization of professional care.

A novel contribution of this study is the identification of spiritual coping as a moderator of the stigma–help-seeking relationship. The moderation effect indicates that individuals with higher levels of positive spiritual coping experience a weaker negative impact of stigma on help-seeking behavior. This finding extends previous work suggesting that spirituality can serve as a resilience resource in the context of psychological stress and social adversity (Koenig, 2012). By buffering stigma, spiritual coping may help individuals reframe mental health challenges in ways that support adaptive action rather than concealment or avoidance.

Clinical and Practical Implications

These findings have important implications for mental health practice and intervention design. First, stigma-reduction strategies remain essential and should be embedded in community-based mental health promotion efforts. Second, improving mental health literacy through culturally sensitive education may directly enhance help-seeking while also mitigating the harmful effects of

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stigma. Third, integrating positive spiritual coping into psychoeducation and counselling, particularly in culturally and religiously oriented settings may strengthen resilience and promote service utilization. Mental health professionals should therefore consider collaborative approaches that engage community leaders, faith-based organizations, and culturally grounded coping resources to enhance the acceptability and effectiveness of interventions.

Study Limitations

Several limitations should be acknowledged. The cross-sectional design precludes causal inference, and longitudinal studies are needed to confirm the temporal ordering of the observed relationships. Self-reported measures may be subject to social desirability bias, particularly in assessing stigma and spirituality. Additionally, the findings may not be generalizable beyond the specific sociocultural context of the study population. Future research should examine these relationships across diverse populations and explore additional moderators, such as social support or access to mental health services.

5. CONCLUSION

In conclusion, this study suggests that postpartum mothers' help-seeking behavior is associated with the interplay of stigma, mental health literacy, and spiritual coping. Higher stigma was associated with lower help-seeking tendencies, whereas greater mental health literacy and positive spiritual coping were associated with more favorable help-seeking responses. The moderating role of spiritual coping indicates that adaptive spiritual resources may attenuate the negative association between stigma and help-seeking and may represent a culturally meaningful resilience factor. These findings support the potential value of integrated approaches that address stigma, strengthen mental health literacy, and incorporate adaptive spiritual resources in maternal mental health initiatives. However, given the cross-sectional nature of the study, the findings should not be interpreted as causal relationships. Future longitudinal and intervention studies are needed to validate the proposed triadic model and clarify the temporal and causal pathways underlying postpartum help-seeking behavior.

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8. AUTHOR CONTRIBUTIONS

Conceptualization: RNS, FNS
Methodology: RNS, FNS, SNEH
Literature search and screening: RNS
Data collection: RNS
Data analysis and interpretation: RNS, SNEH
Writing—original draft preparation: RNS
Writing—review and editing: FNS, SNEH
Supervision: FNS, SNEH
All authors have read and approved the final manuscript and agreed to be accountable for all aspects of the work.

9. CONFLICT OF INTEREST

The authors declare that they have no conflict of interest related to this study.

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10. DATA AVAILABILITY STATEMENT

The datasets generated and/or analyzed during the current study are available from the corresponding author upon reasonable request. Data sharing is subject to ethical considerations and protection of participant confidentiality.

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