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The Relationship between Women's Beliefs about Mental Illnesses in the Prenatal Period and Their Attitudes towards Seeking Psychological Help

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Abstract

Aim: This study was conducted as a descriptive and correlational study to examine the relationship between prenatal women's beliefs about mental illness and their attitudes towards seeking psychological help.

Methods: The study was conducted in a state hospital in Aksaray between March 18 and May 18, 2024. The population of the study consisted of pregnant women who applied to the gynecology and obstetrics outpatient clinics of the hospital, and the sample consisted of 215 pregnant women who met the research criteria and agreed to participate. Data were collected using the Information Form, Beliefs about Mental Illness Scale and Attitudes towards Seeking Psychological Help Scale. The data were collected using a questionnaire method previously tested by the researchers with a small group. After explaining the purpose of the study, data collection tools were distributed to the pregnant women who agreed to participate in the study and they were asked to fill them out. SPSS (Statistical Package for Social Sciences) 26 package statistical program was used to evaluate the data.

Result and Conclusion: It was found that beliefs about mental illness scale total score and helplessness sub-dimension scale scores were higher in the first trimester and attitude towards seeking psychological help scale total scores were higher in the second trimester. Identifying factors related to seeking psychological help during pregnancy may benefit the implementation of interventions, and identifying women who are less likely to seek help may increase the rates of diagnosis and treatment of pregnancy mental health problems.

Keywords: Pregnant; mental illness; psychological help.

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Introduction

The mental health of pregnant women has garnered significant attention in recent years, particularly in light of changes to the biopsychosocial model of medicine [1]. The period between the onset of pregnancy and the onset of labor is referred to as the prenatal period [2]. Pregnant women constitute a unique group with specific needs, given the challenging physiological processes associated with pregnancy and childbirth. In addition to these physical challenges, they undergo substantial changes in their living circumstances and social roles, which can render them more susceptible to psychological disorders such as anxiety, insomnia, and stress-induced depression [3].

Psychological disorders in pregnant women not only harm the mental well-being of the mother, but they also have long-term detrimental effects on the baby, including premature birth, low birth weight, and potential impairments in future development, cognition, behavior, and emotional health. These issues also extend to the family unit [4, 5]. Therefore, psychological help-seeking behavior and perinatal mental health literacy among pregnant women facing mental health challenges are critical for ensuring that they receive appropriate and effective psychological care. According to Fischer and Turner, help-seeking behavior is defined as "seeking solutions from external sources due to the inadequacy of individual resources when facing a problem that the individual perceives as directed towards themselves" [6]. It has been noted that many pregnant women rely on social support from those around them, without seeking medical assistance, and attempt to manage their mental health challenges independently [7].

Several barriers to seeking psychological help among pregnant women have been identified, including lack of time, trust, stigma, and the normalization of symptoms [8]. Other contributing factors include male dominance in marriages, religious beliefs, cultural practices, and financial constraints. Furthermore, limited access to services and the high cost of care have also been recognized as significant obstacles to seeking psychological support [8, 9]. Stigmatization, one of the negative factors that impede help-seeking behavior, typically involves the adoption of derogatory attitudes and beliefs that can result in discrimination against others [10]. Stigma is also associated with the concept of mental health literacy. Mental health literacy (MHL) was initially defined as " knowledge and beliefs about mental disorders which aid recognition, management or prevention". A more recent operationalization of the MHL concept includes the sub-components attitudes and help-seeking. This definition does not only add the concept of stigma but also the concept of help-seeking efficacy to the definition of MHL. Low MHL has been identified as one of the reasons for the limited use of mental health services. Stigmatization of pregnant women reduces their positive perception of professional medical support and contributes to a broader issue of social mistrust [11]. These emerging challenges may impact how pregnant women approach mental health concers and influence their attitudes toward seeking help. To proactively identify women who may be less inclined to seek treatment during this critical period, it is crucial to develop a more comprehensive understanding of the factors that influence the decision to seek psychological assistance during pregnancy. Attitudes toward mental illness are also shaped by negative views and beliefs. Research has shown that negative attitudes and beliefs about mental disorders significantly affect individuals' willingness to seek psychiatric help [12, 13].

Health professionals play a critial role in supporting and empowering pregnant women to enhance their coping skills, self-confidence, and overall well-being [14]. Awareness and education can help communities adopt a more open and supportive approach to mental health issues. This, in turn, can reduce the stigma and taboos associated with mental illness, encourage individuals to seek help, and foster a healthier society. It is believed that pregnant women's awareness of their mental health challenges during the prenatal period, which significantly impacts their lives, and their recognition of the need for psychological support, will have a positive effect on both maternal and fetal mental health during pregnancy and after childbirth. A review of the literature revealed no studies addressing the attitudes of pregnant women toward seeking psychological help. Therefore, the aim of this study was to explore the relationship between prenatal women's beliefs about mental illness and their attitudes toward seeking psychological assistance.

Research Questions

• What is the level of women's beliefs in the prenatal stage about mental illnesses?

• What is the level of women's attitudes in the prenatal stage towards receiving psychological help?

• Do women's beliefs about mental illnesses change according to socio-demographic characteristics in the prenatal stage?

• Do women's attitudes in the prenatal stage towards receiving psychological help change according to socio-demographic characteristics?

• Do women's beliefs about mental illness in the prenatal stage affect their attitudes toward searchingfor psychological help?

Methods

Study Design

This study was conducted as a descriptive and correlational research to examine the relationship between prenatal women's beliefs about mental illness and their attitudes toward seeking psychological support.

Population and Sample

The population of this study consisted of pregnant women who visited the gynecology and obstetrics outpatient clinics of a public hospital. A random sampling method, which is one of the non-probability sampling techniques, was employed to determine the sample group for this study. In cases where the total population is unknown, the sample size was calculated using a sample size formula [15]. The mean score and standard deviation of the Attitudes Toward Seeking Psychological Help Scale in the study by Gül Yildiz and Sariçam (26.14±3.56) were used to estimate the population standard deviation [16]. The sample size was determined to be 195, with a 95% confidence level and an effect size of d=0.5 [17]. To account for potential data loss, the sample group for this study was formed with 215 pregnant women, considering a 10% increase over the calculated sample size [18].

n=t2. σ/d2

n= Number of people to be sampled

σ = Universe standard deviation. Since it is mostly unknown, their standard deviation is used.

t= Theoretical value in the table in the degree of freedom and the determined burning level.

d= The desired performance according to the event is symbolized as +. (ss=n-1) [15].

Data were collected by the researchers through a questionnaire method at a public hospital between March 18 and May 18, 2024. After explaining the purpose of the study, the data collection instruments were distributed to pregnant women who consented to participate and were asked to complete them.

Instrumentation

Research data were collected using the Information Form, Beliefs about Mental Illness Scale and Attitudes Towards Seeking Psychological Help Scale. The data collection forms were applied by the researcher to ten people outside the study population before the research, and the statements that were not understood in the information form not found.

1. Information Form

The information form was developed by the researcher based on the literature and consists of 13 questions [19, 20]. It includes inquiries regarding socio-demographic characteristics, as well as feelings, knowledge, and attitudes towards mental illness.

2. Beliefs towards Mental Illness Scale (BMI)

The scale developed by Hirai and Clum [21] was adapted into Turkish, and its validity and reliability were conducted by Bilge and Çam [22]. The scale consists of 21 items and three sub-dimensions: Dangerousness, Incurability and Disturbance in Interpersonal Relationships, and Shame. The Turkish validity and reliability study resulted in a Cronbach's alpha coefficient of 0.82 for the scale. The Beliefs about Mental Illness Scale uses a 6-point Likert type format, with scores ranging from "I completely disagree: 0" to "I completely agree: 5."

Incurability and Disturbance in Interpersonal Relationships: This subscale includes 11 items, specifically items 8, 9, 10, 11, 14, 16, 17, 18, 19, 20, and 21. The lowest possible score on this subscale is 0, and the highest is 55. A higher score indicates feelings of helplessness and obstacles in interpersonal relationships with individuals with mental health disorders.

Dangerousness: This subscale contains 8 items, numbered 1, 2, 3, 4, 5, 6, 7, and 13. The maximum score for this subscale is 40. It measures the perceived dangerousness of individuals with mental illness.

Shame: This subscale consists of items 12 and 15, with the highest possible score being 10. It addresses the perception that mental illness is a shameful condition. A lower score on this subscale indicates that the participant does not view mental illness as something to be ashamed of.

3. Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPHS-SF)

The Attitudes Toward Seeking Psychological Help Scale-Short Form (ATSPPHS-SF) was developed by Fischer and Farina [23]. This version of the scale is a revised form of the original 29-item scale [6]. The Cronbach's alpha coefficient of the scale was found to be 0.76. The adaptation of the Short Form of the PSRAS into Turkish was carried out by Topkaya [24]. The scale items are rated on a 4-point Likert scale, ranging from (3) agree to (0) disagree. Four items on the scale are reverse-scored: items 2, 8, 9, and 10. During the validity and reliability analyses of the scale, it was noted that the item-total test correlation for item 4, "It is an admirable attitude for a person to want to deal with his/her conflicts and fears without seeking support from an expert when needed," was below 0.30, and the t-statistic for the item was not significant in the confirmatory factor analysis. The scale consists of a total of 9 questions and a single dimension. The lowest possible score on the scale is 0, and the highest score is 27. A higher score on the scale indicates more positive attitudes toward seeking psychological help.

Data Analysis

The data obtained from the research were statistically analyzed using the SPSS (Statistical Package for the Social Sciences) version 26 software. Descriptive statistics, including percentages, means, and standard deviations, were employed for data evaluation. The normal distribution of the data used depends on the skewness and kurtosis values being between ±2 [15]. It was observed that the scales showed normal distribution. Therefore, parametric tests were used. Parametric tests, including one-way analysis of variance (ANOVA) and independent samples t-test, were applied. The Tukey HSD test was used to identify differences between groups. Pearson correlation analysis, a parametric test, was utilized to examine the relationship between two continuous variables that did not follow a normal distribution. The results were evaluated at a 95% confidence interval with a significance level of $p<0.05$.

Ethical Considerations

Prior to the study, ethical approval was obtained from the Necmettin Erbakan University Health Sciences Scientific Research Ethics Committee, with decision number 2024/690, dated 06.03.2024, as well as official approval from the institution where the research was conducted. Permissions were granted for the use of the Beliefs Towards Mental Illness Scale and the Attitudes Toward Seeking Psychological Help Scale. Informed consent forms were obtained from pregnant women who agreed to participate in the study. Pregnant women who chose not to participate were not pressured to take part. This study is limited to data collected from 215 pregnant women who attended the gynecology and obstetrics outpatient clinics of a state hospital.

Results

Overall, among the 227 women who participated in the study, 215 had complete data and were included in the data analysis. The average age of the expectant mothers was 27.56±5.49 years, 34.4% had completed high school, 80.9% did not have a job, and 80.5% thought their income was moderate. 53% had been married for less than 5 years, 35.8% had their first pregnancy and 44.7% were in the third trimester.11.2% of pregnant women were found to have applied to a psychiatrist clinic throughout their pregnancy, 71.6% shared their mental problems with their families and 28.8% felt pity, 44.2% felt uneasiness, 19.1% felt fear, 5.1% felt embarrassment, 69.3% felt compassion and 22.3% felt curiosity towards individuals with mental illness. The main cause of mental illnesses; 68.4% of the pregnant women stated that they thought that they were caused by events experienced in childhood (Table 1).

Table 1 Socio-demographic Characteristics of Pregnant Women (n=215)

Variables		**Mean ±SD**	**Min-Max**
Age		**27.56±5.49**	**18-44**
		n	%
Education Status	Primary school	28	15.0
	Middle school	46	21.40
	High school	74	34.40
	Undergraduate and above	67	31.20
Employment Status	Working	41	19.10
	Not Working	174	80.90
Duration of marriage	Less than 5 years	114	53.0
	5 years and more	101	47.0
Income status	Low	23	10.70
	Middle	173	80.50
	High	19	8.80
Place of residence	Village	51	23.70
	City Center	164	76.30
How many pregnancies	1st pregnancy	77	35.80
	2nd pregnancy	61	28.40
	3rd and more pregnancies	77	35.80
Pregnancy week	1-13 weeks (1st trimester)	39	18.10
	14-26 weeks (2nd trimester)	80	37.20
	27-41 weeks (3rd trimester)	96	44.70
Feelings for individuals with mental illness	Pity	62	28.80
	Anxiety	95	44.20
	Fear	41	19.10
	Shame	11	5.10
	Compassion	149	69.30
	Curiosity	48	22.30
The cause of mental illness	Hereditary predisposition	52	24.20
	Events in childhood	147	68.40
	Supernatural powers such as magic	6	2.80
	Traumatic events	127	59.10
	Family conflicts	129	60.0
	Previous infectious diseases	23	10.70
Referral to a psychiatric clinic	Yes	24	11.20
	No	191	88.80
Family psychiatric history	Yes	29	13.50
	No	186	86.50
The person with whom he shares the most mental problems	Family	154	71.60
	Friend	56	26.00
	Mental health specialist	5	2.30

SD: Standard Deviation;
Min: Minimum;
Max: Maximum

Pregnant women's ATSPPHS-SF scores ranged between 8-27, with a mean of 20.68±3.85, and their BMI scores ranged between 0-105, with a mean of 44.89±18.11. The mean scores of the subscales of BMI were 22.64±10.62 for incurability and disturbance in interpersonal relationships, 20.70±8.09 for dangerousness and 1.53±2.28 for shame (Table 2).

Table 2 Means cores of the pregnant women in the ATSPPHS-SF, BMI and subscales (n=215)

Scales		Mean±SD	Min-Max
ATSPPHS-SF		20.68±3.85	8-27
BMI Subscales	Incurability and Disturbance in Interpersonal Relationships	22.64±10.62	0-55
	Dangerousness	20.70±8.09	0-40
	Shame	1.53±2.28	0-10
BMI Total		44.89±18.11	0-105

According to the gestational age of the pregnant women, the mean total score (51.94±18.60; p=0.023) and the mean incurability and disturbance in interpersonal relationships subscale score (26.59±10.34; p=0.029) of the BMI of those in the first trimester were statistically significantly higher than those in the other trimesters. The scores of pregnant women in the second trimester (22.10±3.29) were significantly higher than those in the first and third trimesters (p=0.05) between the mean scores of the expectant mothers on the ATSPPHS-SF and BMI and their employment status, educational status, duration of marriage, perceived income level, place of residence, psychiatric clinic referral status, family history of psychiatric treatment and the person with whom they shared their mental problems the most (Table 3)

Table 3 Comparison of the means cores of the ATSPPHS-SF, BMI and subscale scores according to the socio-demographic characteristics of pregnant women (n=215)

Variables		N	ATSPPHS-SF	BMI Subscales			BMI Total
				Incurability and Disturbance in Interpersonal Relationships	Dangerousness	Shame	
Education Status	Primary School	28	21.46±2.85	24.32±11.39	21.25±8.78	1.39±2.47	46.96±20.02
	Middle School	46	20.30±4.15	21.24±11.39	19.50±8.74	1.50±2.04	42.24±18.55
	High School	74	20.16±4.36	24.69±10.92	21.71±8.12	1.68±2.61	48.08±18.98
	Undergraduate and above	67	21.19±3.32	20.65±9.001	20.19±7.29	1.46±2.01	42.31±15.52
	F		1.383	2.235	0.855	0.154	1.686
	P		0.249	0.085	0.465	0.927	0.171
Employment Status	Working	41	21.24±3.57	20.66±8.94	19.22±7.61	1.71±1.81	41.58±16.28
	Not Working	174	20.55±3.91	23.11±10.95	21.05±8.18	1.49±2.39	45.66±18.46
	T		1.035	-1.334	-1.311	0.536	-1.301
	P		0.302	0.223	0.743	0.478	0.968
Duration of marriage	Less than 5 years	114	20.82±3.51	22.46±11.15	21.30±7.47	1.51±2.25	45.28±18.25
	5 years and more	101	20.52±4.21	22.85±10.05	20.03±8.72	1.56±2.34	44.44±18.02
	T		0.569	-0.266	1.156	-0.178	0.337
	P		0.570	0.696	0.328	0.525	0.658
Income status	Low	23	20.30±4.26	26.26±12.58	21.04±8.20	2.04±2.74	49.34±20.91
	Middle	173	20.85±3.64	22.25±10.38	20.94±8.14	1.44±2.19	44.64±17.79
	High	19	19.58±5.07	21.84±9.98	18.10±7.43	1.79±2.59	41.73±17.34
	F		1.065	1.511	1.080	0.838	1.002
	P		0.346	0.223	0.342	0.434	0.369
Place of residence	Village	51	20.47±3.63	24.31±11.68	20.25±8.06	1.80±2.69	46.37±16.59
	City Center	164	20.75±3.93	22.12±10.25	20.84±8.12	1.45±2.14	44.42±17.65
	T		-0.451	1.285	-0.456	0.963	0.669
	P		0.652	0.302	0.690	0.268	0.547
How many pregnancies	1st pregnancy	77	20.64±3.61	21.32±11.30	21.27±7.55	1.55±2.25	44.14±18.09
	2nd pregnancy	61	20.52±3.76	24.28±10.21	20.54±8.39	1.34±2.02	46.16±18.41
	3rd and more pregnancies	77	20.84±4.18	22.67±10.18	20.27±8.44	1.68±2.53	44.62±18.06
	F		0.121	1.320	0.310	0.356	0.223
	P		0.886	0.269	0.734	0.701	0.800
Pregnancy week	1st trimester	39	19.97±3.75	26.59±10.34	23.43±8.32	1.92±2.73	51.94±18.60
	2nd trimester	80	22.10±3.29	21.19±10.83	20.06±8.08	1.36±2.17	42.61±18.42
	3rd trimester	96	19.79±4.01	22.26±10.27	20.13±7.86	1.52±2.19	43.92±17.08
	F		**9.311**	**3.590**	2.756	0.791	**3.834**
	P		**0.000**	**0.029**	0.066	0.455	**0.023**
Referral to a psychiatric clinic	Yes	24	21.58±3.45	23.21±8.24	18.41±7.67	1.75±3.01	43.37±16.75
	No	191	20.57±3.89	22.57±10.90	20.99±8.11	1.51±2.19	45.07±18.30
	T		1.215	0.274	-1.475	0.488	-0.434
	P		0.226	0.237	0.353	0.122	0.590
Family psychiatric history	Yes	29	19.65±4.88	22.34±9.93	19.58±6.54	1.38±1.82	43.31±14.86
	No	186	20.84±3.65	22.69±10.75	20.88±8.31	1.56±2.35	45.13±18.58
	T		-1.551	-0.164	-0.801	-0.393	-0.504
	P		0.122	0.686	0.113	0.403	0.237
The person with whom he shares the most mental problems	Family	154	20.64±4.04	21.80±10.43	20.49±8.30	1.45±2.09	43.74±17.87
	Friend	56	20.75±3.43	24.93±11.27	21.30±7.53	1.75±2.67	47.98±18.78
	Mental health specialist	5	21.00±2.55	23.00±4.85	20.80±8.87	1.60±3.58	45.40±16.89
	F		0.031	1.791	0.208	0.343	1.127
	P		0.969	0.169	0.812	0.710	0.326

SD: Standard Deviation;
t: Dependent Sample t Test
F:One-Way Anova

Table 4 Correlation test results for the relationship between age and ATSPPHS-SF, BMI and BMI subscales

Parameter		ATSPPHS-SF	BMI Subscales			BMI Total
			Incurability and Disturbance in Interpersonal Relationships	Dangerousness	Shame	
Age	r	0.119	-0.100	-0.099	-0.061	-0.111
	p	0.083	0.142	0.149	0.370	0.105

r: Analysis of Pearson Correlation

The mean scores of BMI and its subscales did not show a statistically significant correlation with age (p>0.05). The ATSPPHS-SF and BMI did not significantly correlate, according to the correlation test results (Table 4).

Discussion

In this study, the majority of pregnant women (69.3%) expressed compassion toward individuals with mental illness. It is suggested that those who demonstrate compassion toward individuals with mental disorders may also extend the same compassion for themselves and their unborn children, thereby increasing their willingness to seek psychological help. More than half of the participants attributed mental health issues to family conflicts and childhood trauma. Notably, psychiatric problems during pregnancy were found to be five times more prevalent among women with a history of childhood trauma compared to those without [25]. These findings underscore the critical role of familial emotional bonds in mental health.

The majority of pregnant women (71.6%) shared their mental health concerns with family members. Research suggests that individuals with strong social support, particularly from spouses or family, are more likely to seek psychological help [26]. Consequently, pregnant women with such support may be more inclined to actively utilize mental health services.

Although not statistically significant, 68.8% of the pregnant women had an education level below undergraduate, and 80.9% were unemployed. Research indicates that higher maternal education levels are associated with more positive attitudes toward seeking psychological help [27]. In this study, the absence of a significant relationship may be attributed to limited access to mental health resources among women with lower education levels.

The mean total ATSPPHS-SF score among pregnant women was 20.68±3.85, consistent with findings from other studies using the same scale [28]. Although no specific research has focused on pregnant women's attitudes toward psychological seeking help, these findings suggest that social support from family facilitates help-seeking behavior. Identifying factors influencing this behavior could enhance the early diagnosis and treatment of mental health issues. Research indicates that prenatal depression rates range from 7% to 20% in high-income countries and exceed 20% in low- and middle-income countries [29]. Despite the high prevalence of mental illness, only 11.2% of participants had visited a psychiatric clinic, and just 2.3% had sought help from a specialist, highlighting a gap in mental health service utilization. Notably, one study suggests that consulting a spiritual counselor may be as important as seeking support from a psychologist or social worker [30].

Pregnant women in the second trimester had higher ATSPPHS-SF scores than those in the first and third trimesters. Seeking psychological help may not be a priority during early pregnancy due to the initial excitement and the process of adapting to pregnancy. In later stages, increasing physical discomfort and concerns about childbirth may take precedence. [31]. By the second trimester, women may have adjusted to pregnancy and experienced reduced distress, making them more likely to seek psychological help. Previous research indicates that just over one-third of women seek professional mental health care during the first trimester [32]. Hamilton and Lobel observed that pregnant women often rely on spiritual coping strategies in the first and second trimester [33]. Additionally, Nordin-Remberger et al. identified several barriers to seeking psychological help during pregnancy, including stigma, previous negative experiences with healthcare providers, fear of not being believed, and discomfort in confronting personal fears. Notably, more than half of those who received treatment reported finding it ineffective or only minimally helpful [34]. Furthermore, Arslantaş et al. found that lack of social support during pregnancy, combined with increased knowledge about childbirth, contributed to greater fear of childbirth, which may be a risk factor for postpartum depression [35].

The average BMI total score for pregnant women in our study was 44.89±18.11. This score was comparable to findings from other studies using the same measure in different populations [36]. Our results, which align with previous research, suggest that pregnant women hold relatively positive attitudes toward mental illnesses, despite the lack of studies specifically examining their beliefs on this topic. It is suggested that the psychological distress experienced during pregnancy may influence levels of shame and stigmatization. Additionally, societal prejudices against mental illness may shape pregnant women's perspectives on this issue.

In our study, pregnant women in the first trimester had higher BMI scores as well as higher subscale scores for incurability and interpersonal relationship disturbance, compared to those in the second and third trimesters. Various biological, psychological, and social factors may contribute to stronger perceptions of mental illness during early pregnancy. Hormonal fluctuations, coupled with the need to adapt to new responsibilities, may heighten emotional sensitivity during this period. Additionally, uncertainty regarding the baby's health, the progression of the pregnancy, and the future may contribute to feelings of incurability. Previous research has shown that pregnant women often experience profound shame and stigmatization related to mental health issues, leading to reluctance in discussing their psychological difficulties [5]. One study reported that some pregnant women believed they were vulnerable to harm through spiritual attacks, such as witchcraft [37]. However, in our study, only 2.8% of participants attributed mental illness to supernatural causes, suggesting cultural variations in beliefs about mental health. These findings highlight the importance of incorporating belief systems into prenatal mental health prevention and intervention programs.

A review of the literature suggests that depression screening in pregnant women can reduce depression prevalence and improve treatment outcomes [38, 39], while psychosocial

or psychological interventions, such as cognitive behavioral therapy and interpersonal psychotherapy, can significantly lower the risk of postpartum depression, particularly for those at higher risk [40].

The mean total scores of the BMI and the ATSPPHS-SF were found to be unaffected by the following factors: age, educational attainment, employment status, length of marriage, perceived income level, place of residence, admission status to a psychiatric clinic, family history of psychiatric treatment, and the people with whom the pregnant women shared their mental problems the most. This study has some limitations that should be acknowledged. First, the data were collected only in one state hospital, which resulted in the similarity of the low level of education of the pregnant women. Second, it was seen that the fact that the pregnant women shared a common culture and had similar social support networks could affect their belief systems and lead to similar results in terms of psychological help-seeking behavior.

The ATSPPHS-SF and BMI did not significantly correlate, according to the correlation test results (Table 4). Overall, this result suggests that the factors influencing help-seeking behavior may be more complex and multifaceted than simply being determined by one's beliefs about mental illness. Further research could explore additional variables or more specific subcomponents of both scales to gain a deeper understanding of the relationship.

Conclusion and recommendations

BMI total scores and helplessness subscale scores were higher in the first trimester, whereas the total scores of the ATSPPHS-SF total scores were higher in the second trimester.

These findings provide valuable insights into psychological help-seeking behaviors during pregnancy and inform the development of targeted supportive interventions. Accordingly, cognitive-behavioral therapy (CBT)-based group interventions could be implemented in the first trimester to enhance psychological resilience. Specifically, structured educational programs focused on stress management and coping strategies may help mitigate feelings of helplessness among pregnant women. In the second trimester, regular psychoeducation sessions led by healthcare providers could be beneficial in promoting help-seeking behaviors. These sessions should include information on accessing mental health services and the potential benefits of such support.

In addition, psychological screening tests can be administered to pregnant women at family health centres to identify at-risk groups and referral mechanisms to mental health professionals can be strengthened for high-risk pregnant women [41]. To enhance healthcare professionals' awareness, training modules on psychological help-seeking behaviors can be developed for obstetricians, nurses, and family physicians and implemented periodically. Furthermore, integrating mental health assessments into pre-pregnancy counseling services and expanding early intervention programs, such as mindfulness-based stress reduction programs, may help reduce the risk of postpartum depression and anxiety. Regarding this; Bukhali practices, which begin in the pre-pregnancy period and include the post-pregnancy period, are seen as an important guide for optimizing mental health [42]. Considering the relationship between pre-pregnancy, during pregnancy and postpartum psychological distress and birth outcomes and subsequent behavioural problems in mothers and children, there is a need to investigate women's mental health before pregnancy planning and to provide interventions aimed at improving mental health. According to Lim et al. (2023), by monitoring the mental health of young women in the pre-pregnancy, pregnancy or postpartum period, high-risk or treatment-requiring groups can be discovered and appropriate management can be provided to prevent or improve mental health and quality of life [43]. A more comprehensive study is needed to understand the mental health outcomes and experiences of women who contacted mental health services during pregnancy and to bring more context to this discussion. It is recommended to be re-studied in different sample groups.

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