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More than Milk: The Educational Power of Social Support in Shaping Maternal Mental Health

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Abstract: *Background: The postpartum period involves significant physical, emotional, and psychological changes, including the responsibility of infant care and decisions about feeding. A central question in maternal health is whether breastfeeding protects against postpartum depression (PPD) or vice versa. While this association is commonly assumed, existing studies offer inconclusive findings. Few have examined the breastfeeding experience, mothers' attitudes toward breastfeeding, and their relationship with PPD, particularly across cultural groups. This study addresses that gap by exploring how breastfeeding attitudes, self-efficacy, and social support relate to maternal mental health in diverse populations. Aims: To examine associations between social support, breastfeeding self-efficacy, attitudes toward breastfeeding, and PPD among Jewish and Arab mothers in Israel. Design: A cross-sectional survey examined postpartum depression, self-efficacy, and social support among Jewish and Arab mothers in Israel. Methods: A total of 348 postpartum women (252 Jewish, 96 Arab) completed validated questionnaires assessing PPD (EPDS), perceived social support, breastfeeding self-efficacy, and attitudes toward breastfeeding. Data were analyzed using t-tests, Pearson correlations, and multiple regressions. Results: Arab mothers reported significantly higher PPD and lower social support than Jewish mothers. Familial pressure to breastfeed, especially from maternal figures, often conflicted with modern roles, contributing to stress. Jewish mothers reported greater autonomy in feeding decisions, shaped by personal and professional priorities. In both groups, higher social support and breastfeeding self-efficacy were associated with lower PPD symptoms. Conclusions: Cultural norms and support systems shape maternal mental health and feeding decisions. Culturally sensitive, autonomy-supportive education and care can enhance maternal well-being.*

Keywords: *breastfeeding; postpartum depression; self-efficacy; social support; culture; health education.*

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Introduction

Breastfeeding is widely recognized as a cornerstone of maternal and infant health, providing essential nutrition while fostering emotional bonding and long-term well-being. Despite its established benefits, the relationship between breastfeeding and maternal mental health—particularly postpartum depression (PPD)—remains complex and not fully understood. This relationship is shaped by biological, psychological, and social factors, all of which are influenced by cultural and environmental contexts. In Israel, Jewish and Arab mothers experience postpartum life within different socio-cultural frameworks. Jewish women often navigate a modern, individualistic society, whereas Arab women may encounter traditional, patriarchal norms that emphasize maternal roles and family expectations. These cultural differences affect not only infant feeding practices but also women's emotional experiences during the postpartum period. Understanding how personal resources, social support, and attitudes toward breastfeeding influence PPD is critical for developing effective health education strategies. Health education plays a key role in equipping mothers with the knowledge, confidence, and support they need to make informed decisions about infant feeding, while also addressing mental health challenges. This study focuses on the mediating role of breastfeeding attitudes—an underexplored factor that could inform more tailored and culturally sensitive educational interventions. By examining these dynamics, the study contributes to a broader understanding of how culturally adapted health education and supportive counselling can promote maternal well-being. Its findings have implications for the design of programs within maternal and child health services, emphasizing the need for culturally appropriate education that supports both breastfeeding and maternal mental health.

Hypotheses

This study explores how breastfeeding attitudes influence the relationship between personal resources, social support, and postpartum depression (PPD) among postpartum mothers. The following hypotheses were formulated: Sectoral Differences: Jewish and Arab mothers will differ significantly in social support, breastfeeding attitudes, and PPD tendencies. Arab mothers are expected to report higher social support, more positive breastfeeding attitudes, and lower PPD risk, shaped by cultural norms and reliance on informal family support (Radwan et al., 2021). Self-efficacy differences are posed as a research question due to limited evidence. Correlations with Background Factors: Self-efficacy, social support, and

breastfeeding attitudes will be positively correlated with religiosity, education, and socioeconomic status, as religious norms promote breastfeeding (Carlin et al., 2019), and education and financial stability influence related decisions (Rahmani et al., 2024).Predictors of Breastfeeding Attitudes: Self-efficacy and social support will predict breastfeeding attitudes beyond demographic factors, reflecting the impact of psychosocial and experiential influences (Farías-Antúnez, 2020).Predictors of PPD: Self-efficacy, social support, and breastfeeding attitudes will predict PPD tendencies beyond background factors, in line with evidence that psychosocial factors affect maternal mental health (Saur & Dos Santos, 2021).The study also tests whether breastfeeding attitudes mediate the relationship between self-efficacy, social support, and PPD, based on the premise that attitudes formed before birth influence postpartum outcomes.

Literature review

Breastfeeding provides significant health, nutritional, and emotional benefits for both mothers and infants. It strengthens maternal–infant bonding and supports early childhood development (Penacoba & Catala, 2019). From a women's health perspective, breastfeeding is not only a maternal responsibility but also a public health priority, with long-term implications for physical and mental well-being. The World Health Organization recommends exclusive breastfeeding for the first six months of life (WHO, 2023). However, postpartum depression (PPD), which affects approximately 15% of women globally, can disrupt breastfeeding and infant care, with severe cases potentially resulting in maternal morbidity or suicide (Branquinho et al., 2021).In Israel's multicultural context, the two major demographic groups—Jews and Arabs—demonstrate culturally distinct maternal experiences. As of the end of 2024, Jews comprised 76.9% of the population, Arabs 21%, and others 2.1% (Central Bureau of Statistics, 2025). Understanding breastfeeding in this context requires recognition of the social and cultural norms that shape maternal health. Arab society is influenced by patriarchal and collectivist traditions that emphasize familial roles and often limit women's autonomy (Meller & Marnin-Distelfeld, 2023). Despite progress in women's education and employment, many Arab women continue to bear primary responsibility for household and child-rearing tasks, while men typically manage economic decisions (Gabaren, 2020; Shabbah-Karkabi, 2021; Hadad Haj-Yahya et al., 2018). These cultural dynamics directly impact women's breastfeeding behaviors and emotional well-being.

Health education can play a role in helping to address these gaps. By providing culturally sensitive education and counseling, health professionals can empower mothers with knowledge, reduce stigma, and support informed decision-making. Educational programs that recognize and respect cultural norms while promoting autonomy can improve breastfeeding outcomes and reduce emotional distress in the postpartum period. Breastfeeding self-efficacy—the mother's belief in her ability to breastfeed successfully—is a critical factor influencing breastfeeding duration and maternal adjustment (Bandura, 1977b). High self-efficacy is linked to longer breastfeeding and greater confidence, while low self-efficacy may lead to early weaning and increased emotional vulnerability (Nilsson et al., 2020; Gerhardsson et al., 2014). Health education interventions that enhance self-efficacy through skill-building, peer support, and positive reinforcement can strengthen maternal resilience and reduce the risk of PPD (Mikšić et al., 2020).

The association between breastfeeding and PPD remains inconclusive. Some studies show that breastfeeding challenges may increase the risk of depression (Figueiredo et al., 2021; Abdul Raheem et al., 2019; Chiu, 2020), while others suggest breastfeeding can protect against depressive symptoms (Brown et al., 2015; Groër, 2005). Still, other research finds no significant relationship (Chaudron, 2001; Suzuki, 2019). These mixed findings highlight the need to investigate mediating factors, such as culture, attitudes toward breastfeeding, self-efficacy, and social support, which health education can influence.

Social support is another critical determinant of maternal mental health and breastfeeding success. Strong social networks, especially those aligned with cultural expectations, reduce stress and enhance emotional well-being (Nisa, 2021; Purnell, 2005; Gutierrez, 2022). In Arab communities, for example, postpartum care often involves extensive family support for 40 days—a cultural practice that is thought to help reduce PPD (Daoud & Shoham-Verdi, 2015). According to Bandura's (1977a) social learning theory, supportive environments reinforce positive attitudes toward breastfeeding and maternal competence. Health education can complement this support by providing accurate information and guidance to mothers, their families, and strengthening shared responsibility and existing support systems.

Cultural norms significantly shape perceptions of social support, influencing both breastfeeding patterns and emotional outcomes, often reinforcing gendered expectations that may either support or constrain mothers (Tomori, 2022; Meler & Marnin-Distelfeld, 2023). These dynamics can exacerbate feelings of stress, guilt, or inadequacy—particularly when

women are not empowered to express their preferences or make autonomous choices (Bachrach et al., 1990).

From an interactionist perspective (Gergen, 2009), socioeconomic status (SES) is not just a static background variable but a dynamic part shaped by cultural meanings and social expectations. In Arab communities, for example, lower socioeconomic status may signify more than material hardship, it can also constrain access to culturally meaningful emotional support, the ability to make autonomous decisions, and the social validation of one's choices. In contrast, in Jewish communities where individualism is more prevalent, high SES may facilitate access to vocational guidance and autonomy-supportive environments that are consistent with modern maternal ideals.

This aligns with feminist critiques of breastfeeding ideology, which warn that the moralization of breastfeeding—framing it as a marker of good motherhood—can burden women with unrealistic expectations and emotional distress, especially in cases of difficulty or perceived failure (Tomori, 2022). Such events may cause undermining maternal autonomy, particularly in traditional or collectivist cultures where societal and familial expectations around infant feeding are strong.

This study explores the intersection of breastfeeding, postpartum depression, and women's health in Israeli society, highlighting how self-efficacy, social support, and sociocultural influences interact. It underscores the vital role of culturally adapted health education in reducing maternal morbidity, supporting informed feeding decisions, and promoting postpartum health.

Methodology

Design

This study utilized a cross-sectional, correlational design to explore associations between postpartum depression, maternal self-efficacy, social support, and breastfeeding attitudes among Jewish and Arab mothers in Israel. Data were collected between November 7, 2023, and November 7, 2024, through self-administered survey questionnaires. Recruitment took place via multiple channels to enhance cultural and geographic diversity, including TipatHalav maternal and child health centers, postpartum WhatsApp support groups, and private coaching sessions for new mothers. Approximately 20% of the participants were recruited through snowball sampling, in which respondents were encouraged to share the survey with peers. The use of professional healthcare and peer networks, particularly those accessed by the researcher, a licensed nurse and lactation consultant, further contributed to the inclusion of a wide range of postpartum women from various backgrounds across Israel.

Setting & Sample

Study size: The sample size for this study was determined based on the demographic composition of the population in Israel. As a multicultural society. The distribution of participants in this study was designed to reflect these proportions, while ensuring representation consistent with the broader population of Jews and Arabs.

Participants*:* Jewish (72.4%) and 96 Arab (27.6%) participants. All had given birth within the past three months following a full-term pregnancy (≥37 weeks) and delivered a healthy child.

To maintain a homogeneous sample and avoid confounding variables related to medical complications, only healthy mothers of full-term, healthy infants were included. Including mothers or infants with health issues might have introduced additional factors that influence both maternal emotional state and breastfeeding decisions, thereby limiting the ability to isolate the effects of psychosocial variables such as self-efficacy, social support, and attitudes.

Participants were at least one month postpartum to distinguish between the "baby blues"—a common, self-limiting condition affecting about 80% of new mothers—and postpartum depression (PPD), a more serious mood disorder affecting 10–15% of mothers, typically diagnosed from four weeks postpartum (American Psychiatric Association, 2013). This timing improves the accuracy of PPD identification and reduces misclassification. Mothers provided background information on religiosity, marital status, education, employment, and socioeconomic status. As the study focused on postpartum depression and breastfeeding, they also answered questions about pregnancy and breastfeeding characteristics.

Participants' Sociodemographic Profile

Table 1 presents the sociodemographic characteristics of the 348 postpartum mothers who participated in the study. Participants ranged in age from 19 to 43 years, with a mean age of 30.80 (SD = 5.33). The majority were married (97.7%), and most identified as religious (43.1%) or traditional (33.0%), while 23.9% described themselves as secular.

In terms of education, 43.4% held a bachelor's degree, 21.3% had a master's degree or higher, 17.8% completed a higher education diploma, and 14.7% had a high school education or less. Most participants were employed (75.6%), while 17.8% were homemakers and 6.6% were students.

Regarding socioeconomic status, nearly half (47.7%) of the participants rated their status as below average or much below average, 25.3% as average, and 27.0% as above average or much above average.

Table 1. Sociodemographic Characteristics of the Participants (N = 348).

Characteristics	Value	n (%) or M (SD)
Age (years)	Mean (SD)	30.80 (5.33)
Religiosity	Secular	83 (23.9%)
	Traditional	115 (33.0%)
	Religious	150 (43.1%)
Marital Status	Married	340 (97.7%)
	Not married	8 (2.3%)
Education	Elementary school	2 (0.6%)
	High school	51 (14.7%)
	Higher education diploma	62 (17.8%)
	B.A.	151 (43.4%)
	M.A.	74 (21.3%)
	Ph.D.	8 (2.3%)
Employment Status	Homemaker	62 (17.8%)
	Student	23 (6.6%)
	Employed	263 (75.6%)
Socioeconomic Status	Much below average	76 (21.8%)
	Below average	90 (25.9%)
	Average	88 (25.3%)
	Above average	74 (21.3%)
	Much above average	20 (5.7%)
Number of Children	Mean (SD)	2.23 (1.31)*
Number of Pregnancies	Mean (SD)	2.64 (1.76)*
Weeks of Pregnancy	Mean (SD)	39.19 (1.36)*

* Averages calculated by combining the means from both groups, weighted by sample size.
Source: authors' own analysis

These data provide an overview of the mothers' general background characteristics and serve as the basis for further comparison between the Jewish and Arab sectors, as presented in Tables 2–4.

Table 2. *Mother's background, characteristics by sector (N = 348).*

		Sector		
Characteristics	**Values**	Jewish (*n* = 252)	Arab (*n* = 96)	χ^2
Mother's background characteristics				
Religiosity[1]	Secular	78 (31.0%)	5 (5.2%)	
	Traditional	80 (31.7%)	35 (36.5%)	
	Religious	94 (37.3%)	56 (58.3%)	8387.00***
Family status	Not married	8 (3.2%)	0 (0.0%)	
	Married	244 (96.8%)	96 (100.0%)	3.12
Education[1]	Elementary school	1 (0.4%)	1 (1.0%)	
	High school	27 (10.7%)	24 (25.0%)	
	Higher education diploma	45 (17.9%)	17 (17.7%)	
	B.A.	116 (46.0%)	35 (36.5%)	
	M.A.	59 (23.4%)	15 (15.6%)	
	Ph.D.	4 (1.6%)	4 (4.2%)	10069.50*
Job	Homemaker	21 (8.3%)	41 (42.7%)	56.10***
	Student	18 (7.1%)	5 (5.2%)	.42
	Worker	213 (84.5%)	50 (52.1%)	39.63***
Socioeconomic status[1]	Much below average	34 (13.5%)	42 (43.8%)	
	Below average	62 (24.6%)	28 (29.2%)	
	Average	73 (29.0%)	15 (15.6%)	
	Above average	65 (25.8%)	9 (9.4%)	
	Much above average	18 (5.2%)	2 (2.1%)	6821.00***

Source: authors own analysis

Table 3. Pregnancy and breastfeeding characteristics by sector (N = 348).

		Sector		
Characteristics	**Values**	Jewish (n = 252)	Arab (n = 96)	χ^2
Pregnancy	Costly pregnancy - treatments	31 (12.3%)	4 (4.2%)	5.09*
	Costly pregnancy – illness	5 (2.0%)	1 (1.0%)	.36
	Normal, unplanned	37 (14.7%)	18 (18.8%)	.86
	Normal, planned	179 (71.0%)	73 (76.0%)	.87
Are you breastfeeding?	No	53 (21.0%)	8 (8.3%)	
	Yes	199 (79.0%)	88 (91.7%)	7.75**
Are you supplementing formula for breastfeeding?	No	133 (66.8%)	43 (48.9%)	
	Yes	66 (33.2%)	45 (51.1%)	8.31**
Have you breastfed in the past?	No	111 (44.0%)	37 (38.5%)	
	Yes	141 (56.0%)	59 (61.5%)	.86
Do you have positive experience with breastfeeding?	No	68 (28.6%)	14 (15.1%)	
	Yes	155 (71.4%)	79 (84.9%)	6.43*
How long did you breastfeed in previous births	Did not breastfeed	111 (44.0%)	37 (38.5%)	
	Few days to a month	17 (6.7%)	8 (8.3%)	
	Between 1-3 months	32 (12.7%)	15 (15.6%)	
	Up to six months	24 (9.5%)	9 (9.4%)	
	Up to a year with solids	39 (15.5%)	7 (7.3%)	
	Over a year with family nutrition	29 (11.5%)	20 (20.8%)	11300.00
How long are you planning to breastfeed	Not planning to breastfeed	53 (21.0%)	8 (8.3%)	
	Up to 3 months	12 (4.8%)	5 (5.2%)	

	Up to six months	31 (12.3%)	17 (17.7%)	
	Up to a year	28 (11.1%)	13 (13.5%)	
	Over a year	18 (7.1%)	11 (11.5%)	
	As long as the child wants	86 (34.1%)	25 (26.0%)	
	As long as the child cooperates	24 (9.5%)	17 (17.7%)	10718.50

*p < .05, ***p < .001; [1]Variable in an ordinal scale – Mann-Whitney was conducted. *Source: authors own analysis*

As depicted in Tables2, the two sectors show significant differences in background characteristics. More Jewish mothers work salaried jobs than Arab mothers (84.5% vs. 52.1%, $\chi 2 = 39.63$, $p < .001$), while more Arab mothers are homemakers (42.7% vs. 8.3%, $\chi 2 = 56.10$, $p < .001$). Arab mothers reported being more religious, less educated, and of lower socio-economic status than Jewish mothers (all $p < .05$). No significant differences were found in family status or student percentages.

Regarding pregnancy and breastfeeding, Jewish mothers more frequently reported costly pregnancies due to fertility treatment (12.3% vs. 4.2%, $\chi 2 = 5.09$, $p = .024$). Arab mothers had higher rates of breastfeeding, formula supplementation, and positive breastfeeding experiences (all $p < .05$). No significant differences were found in costly pregnancies due to illness, planned or unplanned pregnancies, past breastfeeding, breastfeeding duration, or intention to breastfeed.

Age and reproductive history also differed. Jewish mothers were significantly older ($p = .009$), while Arab mothers had more children and pregnancies (marginal significance, $p = .052$ and $p = .073$, respectively). Pregnancy duration did not differ between groups ($p = .796$). [See Table 4]. Mean, SD, and t-values of the mothers' age, number of children, pregnancies they have had, and the week they gave birth to their baby according to sector.

Table 4. Pregnancy duration did not differ between groups (p = .796).

	Group								
	Jewish (*n* = 252)			**Arab (*n* = 96)**			**t-values**		
Study measures	***M***	***SD***		***M***	***SD***		***t***	***p***	***d***
Age	31.26	5.21		29.60	5.47		2.62**	.009	.31
Number of children	2.14	1.26		2.45	1.41		1.95	.052	.23
Number of pregnancies	2.54	1.71		2.92	1.90		1.80	.073	.22

Pregnancy weeks	39.20	1.33		39.16	1.42		.26	.796	.03

**$p < .01$; d = Cohens' d effect size. *Source: authors own analysis*

Procedure: Participants were recruited through convenience sampling, targeting easily accessible mothers via "TipatHalav" medical centres, postpartum WhatsApp groups, and private coaching sessions.

Additionally, 20% of the sample was collected through a snowball method, where participants shared the questionnaire with acquaintances. The researcher, a nurse and lactation consultant, leveraged professional networks, including colleagues' postpartum training groups, to ensure diverse representation across Israel.

Research tools

New General Self-Efficacy (NGSE): Developed by Chen et al. (2001) based on Bandura's (1977a) social learning theory, this questionnaire assesses perceived self-efficacy. It was translated into Arabic by Mulhem (2018) and Hebrew by Grant-Plomin (1998).

Iowa Infant Feeding Attitude Scale (IIFAS): Measures maternal attitudes toward infant feeding, predicting breastfeeding intentions (Mora & Russell, 1999). Previously used with Arabs in Lebanon (Charafeddine et al., 2016). Translated into Hebrew using back translation.

Multidimensional Scale of Perceived Social Support (MSPSS): Assesses perceived support from family, friends, and significant others (Zimet et al., 1988). Arabic translation by Merhi & Kazarian (2012); Hebrew by Statman (1995). High internal consistency ($\alpha = .91$). Translation by Merhi & Kazarian (2012); Hebrew by Statman (1995). High internal consistency ($\alpha = .91$).

Edinburgh Postnatal Depression Scale (EPDS): Screens for postnatal depression (Cox et al., 1987), validated in Israel (Cox & Holden, 2003; Glasser & Barell, 1999; Kandel-Katznelson et al., 2000). High internal consistency ($\alpha = .89$).

Demographic, Pregnancy, and Breastfeeding Questionnaire: Covers maternal background, pregnancies, and breastfeeding practices.

Limitations

This study is subject to a variety of biases, including selection bias due to convenience and snowball sampling, self-report bias due to social desirability and recall effects, and cultural bias in the interpretation of validated research instruments. However, steps were taken to mitigate some of these issues. The study focused exclusively on healthy women after an

uncomplicated pregnancy and birth, whose infants were also healthy, thereby reducing bias from medical or psychological complications. In addition, the questionnaires were carefully translated from Hebrew to Arabic and vice versa, with the assistance of a bilingual Arabic public health nurse, to ensure linguistic accuracy and cultural appropriateness, thereby helping to minimize bias in language-based interpretation.

Data collection, ethics approval

Prior to data collection, the study received ethical approval from the Helsinki Committee at the Ministry of Health in Jerusalem (Institutional Committee Approval Number: MOH-017-2023). The research titled "Sociocultural Aspects of Breastfeeding in Israel" was approved on November 30, 2023, by the Director General of the Ministry of Health, following the Helsinki Committee's recommendation dated November 2, 2023. The committee granted an exemption from signing an informed consent form, determining that "completing the questionnaire constitutes consent." The approval is valid until November 7, 2024, in accordance with the Procedure for Medical Experiments on Humans (2020) and the Public Health and Medical Experiments on Humans Regulations (1980).

Participation in the study was voluntary, and participants were informed that they could withdraw at any time without providing a reason and without consequences. By completing the questionnaire, participants provided their informed consent to participate in the study.

Most participants were recruited from Tefat Halav Family Health Centers while awaiting treatment. Additional participants were recruited through postpartum WhatsApp groups and private postpartum support groups for new mothers. Approximately 20% of the participants were recruited using a snowball sampling method, whereby initial participants shared the questionnaire with acquaintances who then participated and further expanded the sample (Bhardwaj, 2019).

The survey was distributed via a digital link to participants who agreed to participate. All responses were submitted electronically and recorded anonymously in a secure, password-protected database. No identifying information was collected. The data were stored in full compliance with data protection regulations to ensure confidentiality, prevent unauthorized access, and protect participants' privacy.

The study involved minimal risk to participants and adhered to the ethical principles outlined in the Declaration of Helsinki.

Data analysis

Statistical analyses were conducted using IBM SPSS Statistics (version XX) and the PROCESS macro by Hayes (2018) for mediation analysis. Descriptive statistics were calculated for all study variables. Independent samples **t-tests** were used to examine sectoral differences between Jewish and Arab mothers in levels of social support, self-efficacy, breastfeeding attitudes, and postpartum depression.

Pearson and Spearman correlations were employed to explore relationships between maternal characteristics (e.g., education, religiosity, socioeconomic status) and key variables such as breastfeeding attitudes and postpartum depression. The choice between Pearson or Spearman was based on the distribution and scale of the variables.

Hierarchical multiple regression analyses were used to identify predictors of breastfeeding attitudes and postpartum depression within each group. These models were adjusted for demographic and experiential variables (e.g., education, current breastfeeding, planned pregnancy, breastfeeding experiences).

Finally, **mediation analysis** was conducted using the **PROCESS macro (Model 4)** to test whether breastfeeding attitudes mediated the relationship between personal and environmental resources (i.e., self-efficacy and social support) and postpartum depression, particularly among Arab mothers.

Results

The first hypothesis examined sectoral differences in personal and environmental resources, breastfeeding attitudes, and postpartum depression (PPD) [Table 5].

Table 5. Mean, SD, and t-values of the mothers' personal and environmental resources, their attitudes towards breastfeeding, and their tendency to postpartum depression according to sector.

	Sector							
	Jewish (*n* = 252)			**Arab (*n* = 96)**			**t-values**	
Study measures	***M***	***SD***		***M***	***SD***		***t***	***d***
Resources								
Personal resources – Self-efficacy	5.78	0.93		5.74	1.09		.37	.05
Environmental - Social support	6.12	1.00		5.36	1.31		5.11***	.69

Family support	6.17	1.20		5.80	1.39		2.28*	.29
Friends support	5.68	1.50		4.22	1.91		6.75***	.90
Significant other support	6.50	0.82		6.06	1.64		2.52**	.40
Attitudes								
Attitudes towards breastfeeding	5.05	0.85		5.49	0.86		4.36***	.52
Tendency to postpartum depression								
Tendency to postpartum depression	6.66	6.66		10.51	8.00		4.81***	.58

*p < .05, **p < .01, ***p < .001; d = Cohens' d effect size. T-tests showed Jewish mothers had significantly higher social support (p < .01) across family, friends, and significant others, while Arab mothers had more positive breastfeeding attitudes and a higher tendency toward PPD. No significant difference was found in self-efficacy. *Source: authors own analysis*

The second hypothesis explored correlations [Table 6].

Table 6. Pearson correlation coefficients between the study measures and Spearman and Pearson correlation coefficients between participants' religiosity level, education, socio-economic status, age and the study measures within each sector.

	Self-efficacy	Social support	Attitudes towards breastfeeding	Tendency to postpartum depression
Pearson correlation coefficients between the study measures				
Jewish (*n* = 252)				
Self-efficacy	1	.25***	.22***	-.26***
Social support			-.12*	-.21***
Attitudes towards breastfeeding				.02
Tendency to postpartum depression				1
Arab (*n* = 96)				
Personal resources – Self-efficacy	1	.26*	.51***	-.38***
Social support			.42***	-.29**
Attitudes towards breastfeeding				-.46***
Tendency to postpartum depression				1
Spearman and Pearson correlation coefficients between participants' religiosity level, education, socio-economic status and age and the study measures				
All sample (*N* = 348)				

Religiosity level	.06	-.10	.15**	.04
Education	.01	.00	.26***	.03
Socioeconomic status[1]	.03	.08	-.04	-.10
Age[1]	.04	.01	-.04	.01
Jewish (*n* = 252)				
Religiosity level	.07	-.03	.02	.01
Education	-.03	-.07	.31***	.04
Socioeconomic status[1]	.06	-.06	.13*	-.04
Age[1]	.05	-.01	.03	.18
Arab (*n* = 96)				
Religiosity level	.06	-.07	.25*	-.11
Education	.09	.04	.31***	.07
Socioeconomic status[1]	.00	.05	-.05	.01
Age[1]	.02	-.05	-.02	-.03

*p < .05, **p < .01, ***p < .001; [1]Pearson correlation test was conducted – variable in ratio scale. *Source: authors own analysis*

In both groups, higher self-efficacy correlated with more positive breastfeeding attitudes, while greater resources (personal and environmental) were linked to lower PPD risk. Among Arab mothers, positive breastfeeding attitudes were associated with lower PPD, but this correlation was absent in Jewish mothers. Environmental support positively correlated with breastfeeding attitudes in Arab mothers but negatively in Jewish mothers.

To examine associations with maternal characteristics, Spearman and Pearson correlations [See Table 6] revealed that religiosity positively correlated with breastfeeding attitudes only among Arab mothers. Education was positively linked to breastfeeding attitudes in both groups, while socioeconomic status had a weak positive correlation in Jewish mothers only.

Hierarchical regression analyses [Table 7]

Table 7. Hierarchical regression results for attitudes towards breastfeeding and for propensity to postpartum depression within each sector

Block	Explanatory variables	B	SE.B	β	R^2	ΔR^2
Attitudes towards breastfeeding						
Jewish (*n* = 252)						
1	Breastfeeding now[1]	.75	.19	.29***	.248	----
	Positive experience with breastfeeding[2]	.27	.09	.17**	.291	.043
	The time the mother wishes to breastfeed	.09	.03	.23***	.327	.036
	Education	.13	.05	.15**	.351	.025
	Job – student[3]	-.38	.15	-.14*	.371	.019

2	Breastfeeding now[1]	.74	.18	.29***		
	Positive experience with breastfeeding[2]	.24	.09	.15**		
	Education	.09	.03	.22**		
	Sector[4]	.12	.04	.15**		
	The time the mother wishes to breastfeed	-.38	.15	-.14**		
	Mothers' personal resources	.12	.04	.15**	.391	.021
Arab (n = 96)						
1	Education	.25	.07	.35***	.117	----
	Religiosity	.44	.13	.30**	.204	.086
	Positive experience with breastfeeding[2]	.51	.22	.22*	.250	.046
2	Education	.19	.05	.26***		
	Religiosity	.34	.11	.23**		
	Positive experience with breastfeeding[2]	.35	.18	.15*		
	Mothers' personal resources	.31	.06	.40***	.460	.210
	Social resources	.18	.05	.28***	.528	.068
Propensity to postpartum depression						
Jewish (n = 252)						
1	Costly pregnancy – illness[5]	6.27	2.81	.15*	.023	----
2	Costly pregnancy – illness[5]	5.66	2.72	.14*		
	Mothers' personal resources	-1.87	.47	-.26***	.091	.068
Arab (n = 96)						
1	Normal, planned pregnancy[6]	-4.15	1.86	-.23*	.052	----
2	Normal, planned pregnancy[6]	-3.87	1.66	-.21*		
	Mothers' personal resources	-2.71	.68	-.37***	.231	.180
	Social resources	-1.14	.57	-.19*	.265	.033

*p < .05, **p < .01, ***p < .001; [1]Breastfeeding now: 0 = No, 1 = Yes;[2]Positive experience with breastfeeding:[3]Job – Student: 0 = Not a student, 1 = Student;0 = No, 1 = Yes; [4]Sector: 0 = Arab, 1 = Jewish; [5]Costly pregnancy - illness: 0 = No, 1 = Yes; [6]Normal, planed pregnancy: 0 = No, 1 = Yes. *Source: authors' own analysis.*

Table 7 showed that:

Jewish mothers' breastfeeding attitudes were influenced by education, employment, current breastfeeding, and positive breastfeeding experiences.

Arab mothers' attitudes were shaped by education, religiosity, and breastfeeding experiences.

Personal resources predicted breastfeeding attitudes in both groups, but social support significantly contributed only among Arab mothers (27.8% variance explained vs. 2.1% in Jewish mothers).

To examine PPD predictors, hierarchical regression [See Table 7] indicated:

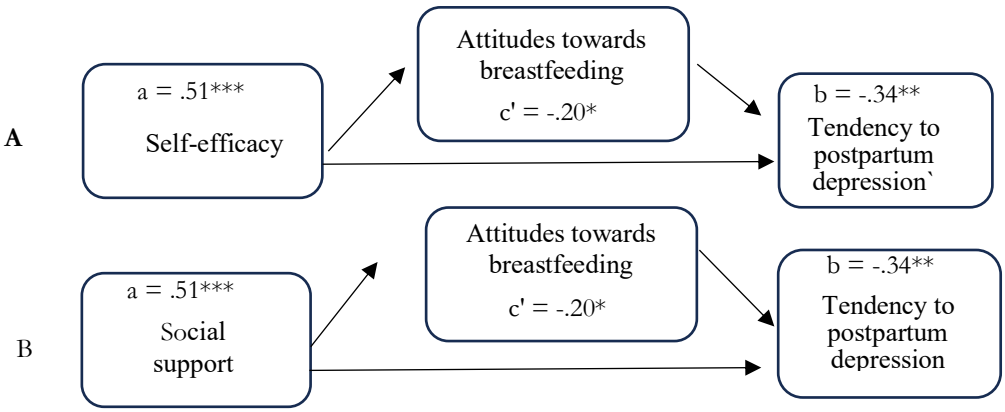
Jewish mothers: PPD risk was higher when pregnancy was complicated by illness.

Arab mothers: PPD risk was higher when pregnancy was unplanned.

Lower personal resources increased PPD risk in both groups, while social support significantly buffered against PPD in Arab mothers (21.3% variance explained vs. 6.8% in Jewish mothers).

Mediation analysis (Figure 1) using PROCESS (Hayes, 2018) found that breastfeeding attitudes mediated the relationship between personal resources, social support, and PPD risk, emphasizing the protective role of positive breastfeeding attitudes in mental health.

Figure 1. The role of Arab mothers' attitudes towards breastfeeding as a mediating variable in the association between their self-efficacy (a) and social support (b) resources and their tendency to experience postpartum depression. Source: authors' own analysis.



Discussion

This study provides new insights into the cultural and sectoral differences that shape postpartum mental health and breastfeeding attitudes among Jewish and Arab mothers in Israel. It highlights that while Arab mothers experience greater cultural pressure to breastfeed and are more vulnerable to postpartum depression, social support plays a significantly stronger protective role in this group. Breastfeeding attitudes were found to be a key mediator linking resources to mental health, highlighting their

psychological importance beyond nutrition. These findings underscore the need for culturally sensitive health education interventions that enhance maternal self-efficacy and promote positive breastfeeding experiences as a public mental health strategy (Gutierrez, 2022).

Maternal self-efficacy and mental health

Consistent with Bandura's (1977a, 1977b) self-efficacy and social learning theories, the study found that mothers with higher confidence in their ability to breastfeed and care for their infants reported lower rates of postpartum depression. This is aligned with self-determination theory (Deci & Ryan, 1985), which highlights autonomy and competence as central components of psychological well-being.

Health education plays a vital role in strengthening self-efficacy by providing mothers with evidence-based knowledge, practical breastfeeding skills, and emotional validation. Prenatal classes, postpartum workshops, and peer-led support groups can create structured learning environments that promote observational learning, reduce anxiety, and empower mothers to make informed feeding decisions. Community health professionals, especially nurses, are uniquely positioned to deliver these interventions and reinforce maternal confidence through personalized, empathetic care.

It is important that breastfeeding promotion efforts do not inadvertently compromise women's autonomy or emotional well-being. While breastfeeding offers well-documented health and psychological benefits, its promotion should not be presented as a moral imperative or the sole marker of good motherhood. As feminist scholars have noted (Tomori et al., 2022), presenting breastfeeding as an ideological ideal can increase feelings of guilt or inadequacy among women who struggle with breastfeeding or who choose alternative feeding methods. Therefore, breastfeeding advocacy must prioritize maternal autonomy and emotional safety alongside public health goals, ensuring that all mothers feel respected, supported, and empowered in their infant feeding decisions.

Social support and cultural expectations

While social support is a well-established protective factor against postpartum depression (Cohen & Wills, 1985), the paradoxical finding that Arab mothers—despite belonging to a collectivist society, reported lower levels of perceived support than Jewish mothers suggests that the quality and cultural appropriateness of support are more critical than its presence. According to Purnell (2005), support must align with a woman's cultural

values and expectations to be experienced as helpful, otherwise, it may feel intervenes, controlling, or emotionally unsupportive.

This paradox can be better understood through role stress theory (Bachrach, 1980) and role theory (Goode, 1960), which suggest that rigid or conflicting expectations within family structures, such as the strong involvement of mothers-in-law and minimal paternal engagement in Arab families, may lead to emotional overload and reduced autonomy. These dynamics can exacerbate feelings of pressure, guilt, or inadequacy, particularly when women are not empowered to assert their preferences (Bacharach et al., 1990).

Intersecting Identities and Their Impact on Maternal Mental Health and Breastfeeding in Minority Population

The findings of the study indicate that, in addition to the differences between Jewish and Arab women, there is a need to deepen our understanding of the impact of the intersection of variables such as gender, socioeconomic status, and education on the experiences of mothers after childbirth. Arab women are part of a minority group in Israel, many of whom belong to disadvantaged socioeconomic groups and have relatively low education and are often at the center of an intersection between gender, ethnic, and social exclusion. This experience may increase their vulnerability to postpartum depression, especially when they are required to meet high cultural expectations for breastfeeding and the ideal of the "good mother." This intersection creates situations of emotional burden, a sense of failure, and limited access to support resources, whether formal (such as health systems) or informal (such as family and social networks).

Understanding women's experiences through the intersection of variables allows us to identify risk groups that are not necessarily revealed by standard demographic analysis. It highlights the need for culturally appropriate support programs that take into account not only ethnic identity, but also levels of education, economic resources, and access to services. This approach can contribute to better prevention of postpartum depression and encouragement of breastfeeding while maintaining the well-being of the woman.

These intersectional effects can also be viewed through a symbolic interactionist aspect, which highlights how individuals interpret social roles within cultural contexts. Socioeconomic status is not just material but also tied to identity and meaning (Gergen, 2009). For Arab women, economic disadvantage may be amplified by cultural ideals of motherhood, limiting

access to support that aligns with their values. This reveals how structural inequality, and cultural norms jointly shape maternal experience.

Health education can play an assisting role in addressing these tensions. By targeting not only mothers but also fathers and extended family members, education programs can challenge rigid gender roles, promote shared caregiving, and normalize open communication about emotional needs. Community nurses can design culturally tailored sessions that foster understanding among family members about the importance of maternal mental health, respectful support, and cooperative parenting.

Furthermore, integrating mental health education into maternal health services can help normalize discussions around postpartum emotional challenges, reduce stigma, and encourage early help-seeking. Health educators can equip mothers with coping strategies, stress management techniques, and information on when and where to seek professional support. Such interventions are especially important in communities where mental health is stigmatized or where women may feel silenced by traditional norms.

These findings indicate that public health strategies must account for not only the presence of support, but its perceived quality and cultural alignment, in order to effectively reduce postpartum distress.

Implications for practice and policy

This study supports the development of health education initiatives that are contextually and culturally informed, with a dual focus on emotional well-being and breastfeeding promotion. Training programs for nurses and maternal health workers should emphasize cultural competence, family dynamics, and the psychological dimensions of breastfeeding. In addition, integrating health education into national maternal and child health policies can ensure that interventions reach all segments of the population, reducing disparities in maternal outcomes.

In conclusion, culturally sensitive, autonomy-supportive health education, delivered through community health professionals—can strengthen personal and social resources, reduce postpartum depression, and promote positive breastfeeding experiences across diverse populations.

In light of these findings, maternal health strategies must shift from merely promoting breastfeeding to actively supporting the mother's emotional experience. Public health campaigns should adopt a dual message: Breastfeed if you can, but care for yourself.

Ultimately, promoting maternal mental health and breastfeeding success requires not just clinical care, but a broader public health commitment to equity, empathy, and culturally sensitive support systems.

These findings are relevant beyond Israel, reflecting global challenges faced by women navigating motherhood in contexts where traditional norms intersect with modern pressures. In many parts of the world, the dual burden of meeting cultural expectations and pursuing individual autonomy can affect maternal well-being. Culturally responsive health education, designed to empower women while engaging their families, has the potential to improve outcomes in both traditional and modern societies.

Limitations

Like any empirical study of social phenomena, this study has limitations. Recognizing them does not diminish its scientific value, but rather highlights the complexity of examining psychological and cultural dynamics within diverse populations. This study offers a unique contribution to understanding the interrelationships between social support, breastfeeding attitudes, and postpartum depression among Jewish and Arab women in Israel. A critical reflection on its limitations aims to guide future research in expanding and deepening these insights.

1. Self-report bias:

The study is based on self-report questionnaires, which may lead to bias arising from social desirability, especially among groups with collectivist norms, such as Arab women. It is possible that participants underreported emotional difficulties or negative experiences, such as postpartum depression symptoms or breastfeeding difficulties, in order to maintain a positive image in the eyes of themselves and society. This situation may lead to an underestimation of the challenges of the postpartum period, and this must be taken into account when interpreting the findings.

2. Sampling bias:

The study uses non-probability sampling (a combination of convenience sampling and "snowball" sampling), which limits the ability to generalize the findings to the general population of postpartum women in Israel. This approach, despite its advantages in recruiting participants from different groups and in natural relationships, constitutes an epistemological limitation, as the characteristics of the participants may not be representative of all postpartum women in terms of socioeconomic status, level of religiosity, area of residence, etc.

3. Inability to infer causality:

The cross-sectional study design allows for the examination of correlational relationships only, but does not allow for the determination of a causal direction between the variables. Therefore, it cannot be determined whether a lack of social support causes postpartum depression or whether depressive symptoms affect the perceived sense of support. The findings are based on existing theoretical models, but further longitudinal studies are needed to examine the directionality and dynamics between the variables over time.

4. The apparent homogeneity of cultural groups:

The categories "Jewish women" and "Arab women" include diverse cultural subgroups (e.g., Haredi women versus secular women, or Bedouin women versus urban Arab women), each of which has a different set of values, practices, and community support. The study analysis did not distinguish between these subcultures, and therefore the findings should be considered a general reflection of cultural trends and not a generalization to all subpopulations.

5. Lack of other relevant variables:

The study did not include important variables that could influence postpartum emotional adjustment, such as the participant's psychiatric history, the quality of the relationship with the partner, or other factors such as past trauma. The lack of these data is a limitation in the ability to fully understand all the factors that influence postpartum depression, and indicates a need for future studies that include these parameters.

6. While the issues examined, social support, cultural norms, and maternal mental health, are relevant at a global level, Israel's unique sociocultural and health context may limit the generalizability of the findings. Factors such as the TipatHalav system, the status of Arab citizens, and Jewish religious diversity may shape mothers' experiences differently than in other settings. Therefore, the study's insights are transferable, but should be applied with contextual caution.

Despite these limitations, the study provides valuable insights into the interplay between cultural norms, social support, maternal self-efficacy, and postpartum mental health—insights that are relevant not only within the Israeli context but also in diverse international settings. While certain aspects

of the local healthcare system and cultural composition are unique, the core psychological and social processes explored are widely applicable.

While this paper focuses exclusively on the quantitative phase of a larger mixed-methods study, it is worth noting that qualitative data, collected through interviews and focus groups have already been analyzed and were found to be broadly supportive of the quantitative findings. These data will be presented in a separate publication designed to explore the cultural and emotional dimensions of postpartum experiences in greater depth.

Acknowledging the methodological and epistemological constraints of this study allows for a more nuanced interpretation of the findings and highlights the need for future research using longitudinal and probabilistic approaches to further explore these universal themes.

Conclusions

This study highlights the complex interplay between cultural norms, social support, and postpartum mental health among Jewish and Arab mothers in Israel. The findings suggest that higher maternal self-efficacy and stronger social support are associated with lower levels of postpartum depression in both groups. Among Arab mothers, this protective effect is partially mediated by more positive attitudes toward breastfeeding. However, in traditional societies, cultural expectations around breastfeeding may also contribute to emotional strain, potentially increasing vulnerability to postpartum depression even when breastfeeding rates are high.

Arab mothers reported lower levels of perceived social support and higher postpartum depression compared to their Jewish counterparts, yet expressed stronger breastfeeding attitudes and higher breastfeeding rates. This paradox reflects the powerful influence of cultural and familial expectations, which can override personal preferences or educational background. These findings underscore that while the promotion of breastfeeding offers clear health and psychological benefits, it must also be approached with sensitivity to maternal autonomy, emotional well-being, and sociocultural pressures.

Although conducted in Israel, the themes explored such as maternal mental health, breastfeeding education, and culturally shaped support systems, are relevant across global contexts. The dynamics observed here are felt across diverse populations around the world, navigating tensions between tradition, modern ideals of parenting, and emotional health. The

findings contribute to a growing international body of research calling for culturally appropriate, education-based interventions in maternal care.

From an educational standpoint, these results highlight the need for tailored health education programs that empower mothers through evidence-based knowledge, foster informed decision-making, and recognize the emotional and cultural dimensions of early motherhood. Educational interventions should routinely integrate postpartum depression screening (e.g., EPDS), promote respectful dialogue about infant feeding, and support family involvement without coercion. These programs must be sensitive to variations in beliefs, literacy, and community dynamics, making them adaptable across healthcare systems and cultural environments.

Health professionals, especially nurses, educators, and lactation consultants, play a key role in delivering this support. Their training should include not only clinical and pedagogical skills but also cultural competence, communication techniques, and awareness of family systems. They must also be supported institutionally to prevent burnout and provide person-centered care.

Furthermore, family-focused education should encourage partner involvement, healthy boundaries with extended family members, and emotionally supportive environments, ensuring that mothers can make autonomous decisions about infant care, regardless of whether they choose to breastfeed.

This study also takes a cross-cultural lens., offering insight into how multiple identities, gender, ethnicity, socioeconomic status, and cultural tradition, interact to shape maternal health experiences. While the Israeli setting provides one context for this exploration, the patterns observed reflect broader global challenges faced by postpartum women in culturally diverse societies.

The findings provide nuanced support for the study's hypotheses. Sectoral differences were partially confirmed: Arab mothers exhibited more positive breastfeeding attitudes and higher breastfeeding rates, yet reported lower perceived support and higher postpartum depression, challenging assumptions about the uniformly protective nature of collectivist support systems.

In addition, it was found that more educated and more religious mothers tended to hold more positive attitudes toward breastfeeding. However, psychological and social resources, specifically self-efficacy and perceived social support, were more robust predictors of both breastfeeding attitudes and postpartum depression across groups, underscoring their

central role in shaping maternal well-being. Among Arab mothers, breastfeeding attitudes also mediated the relationship between psychosocial resources and depression, emphasizing their dual role as both a cultural ideal and a potential source of emotional resilience.

By viewing SES as a socially constructed and context-dependent experience, as interactionist theory suggests (Gergen, 2009), we can better understand why similar levels of financial hardship or education may have different implications across cultural groups. Maternal well-being is not only a function of resources, but also of the meanings and expectations attached to them within specific cultural and familial systems. For instance, in collectivist societies, education may not automatically translate into greater personal power to choose and act or emotional support if traditional gender roles remain strong. In contrast, in more individualistic contexts, the same resources may foster autonomy and psychological resilience.

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