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Original Article

EXPLORING THE LIVED PSYCHOSOCIAL EXPERIENCES OF FIRST-TIME MOTHERS WITH POSTPARTUM DEPRESSION

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ABSTRACT

Postpartum depression (PPD) is a common mood disorder affecting approximately 10–20% of mothers worldwide, with a disproportionately higher burden in low- and middle-income countries. First-time mothers are particularly vulnerable because they face the physical, psychological, and social challenges of transitioning to motherhood for the first time. However, their lived experiences remain insufficiently explored, especially within non-Western contexts such as Pakistan. This qualitative study aimed to explore the psychosocial factors contributing to postpartum depression among first-time mothers. Data were collected through semi-structured interviews with seven first-time mothers experiencing postpartum depression. The interviews were analyzed using Interpretative Phenomenological Analysis (IPA). Five superordinate themes emerged from the analysis: the shattered expectations of motherhood, the isolation spiral, partner dynamics as either anchor or burden, the body and mind disconnect, and cultural and familial pressures. The findings reveal that postpartum depression is shaped by the complex interaction of individual, relational, and sociocultural factors. These insights highlight the need for culturally sensitive screening, family-centered interventions, and enhanced psychosocial support to improve maternal mental health during the transition to motherhood.

I. INTRODUCTION

One of the most serious, yet often underreported conditions that many new moms experience is called postpartum depression (PPD). Globally, PPD impacts approximately 10–20% of postpartum women, with prevalence influenced by genetic, hormonal, psychological, and socio-environmental factors (Khamidullina et al., 2025). Early detection is crucial, with screening tools such as the Edinburgh Postnatal Depression Scale (EPDS) commonly used in clinical practice (Cox et al., 1987). This serious mood disorder develops during the first year following giving birth. The symptoms of PPD include: hopelessness, emotional numbness, guilt, sadness, fatigue, irritability, and in severe cases, a desire to die or suicide (American Psychiatric Association, 2022). While the baby blues are experienced by up to 80% of new mothers during the first two weeks after birth, PPD is more severe, lasts longer and can be debilitating if untreated. It affects the mother's mental health, child's growth and development and family functioning (Stewart & Vigod, 2016). Motherhood is one of the most significant psychosocial changes that a woman faces in her life. The biological aspects are not the only ones to consider in a transition like this–there's also the mental transition to a new identity as a mom, social transition as a mother, learning task-intensive parenting skills, and adapting to the rigors of motherhood without previous experience (Hwang et al., 2022).

The prevalence rates of PPD varied widely from 18% to 63%, depending on the population studied and screening tools used (Ali et al., 2020; Husain et al., 2006). Although Pakistan has a high burden of PPD and other LMICs, few studies have been conducted in these countries, particularly in Pakistan, with the majority of studies taking place in Western, high income countries (Shorey et al., 2018). This results in a huge lack of understanding about how cultural aspects such as collectivist family systems, gender expectations, extended family involvement in childcare and stigma surrounding mental illness affects the experience of postpartum depression in non-Western settings. This study is based on three complementary theoretical frameworks that can be used to understand the psychosocial factors that contribute to postpartum depression in first-time mothers: Beck's cognitive theory of depression Beck, 2002) and Bronfenbrenner's bioecological model of human development (Bronfenbrenner & Morris, 2006).

II. METHOD

Participants

Participants for this observation are recruited using purposive sampling, a nonprobability sampling strategy in which contributors are selected intentionally because they have characteristics relevant to the research question (Smith et al., 2009). For IPA studies, purposive sampling is usually mixed with a dedication to homogeneity in paradigms: contributors are assessed according to their percentage of a selected experience or symptom set, which allows for a focused investigation of how that experience is experienced. The target sample length for this trial is 5 to 7 first-time mothers. IPA studies typically use small sample sizes because the technique emphasizes detailed, case-by-case analysis. However, the 7 samples also allow distinct styles to emerge in examples to allow sufficient intensity of analysis.

Measures

Potential participants were initially approached with the assistance of the researcher, who gave a brief verbal explanation about the study. The Edinburgh Postnatal Depression Scale (Cox et al., 1987) was completed by participants to check for clinically significant symptoms of depression. The women with a higher score of 13 or more in the EPDS were invited to participate further. These eligible mothers were then handed a detailed participant information sheet in Urdu language that included information regarding the aim of the study, procedures involved, possible risks and benefits, and rights of the participants. An informed consent was obtained in writing prior to scheduling an interview. The data were collected from gynecology clinics and hospitals of Faisalabad city. Interviews were held in a separate meeting room in the clinical context in order to maintain confidentiality and comfort of participants in discussing sensitive experiences. An interview protocol was used in a semi-structured format to allow flexibility in discussing the participant experiences with an in-depth interview and to maintain consistency for the interviews. Interviews were conducted for a period of about 30-40 minutes and, with the participants' permission, were audio-taped. All the recordings were transcribed word for word in Urdu (the participants' native language) then translated into English by a professional translator in consultation with the researcher to highlight the contextual meaning of the participants' responses and ensure accuracy. The English translations were also double checked using a second independent bilingual researcher to further ensure the translation was accurate.

Procedure

This study complied with the ethical concepts outlined in the Declaration of Helsinki and within the American Psychological Association Ethical Principles and Code of Conduct for Psychologists. Informed consent: All participants have been given detailed written and verbal data about the exposure, including the rationale, availability, risks and blessings, and their rights. Participants were informed that their participation was completely voluntary and that they could withdraw at any time without penalty or lack of access to offers. Written informed consent was obtained from all members.

III. RESULTS

Table 1: Thematic Structure of Findings

Superordinate Theme	Subordinate Themes
1. The Shattered Expectations of Motherhood	1.1 Idealized versus reality disconnect
	1.2 Loss of pre mother hood identity
	1.3 Overwhelming responsibility
2. The Isolation Spiral	2.1 Social withdrawal
	2.2 Lack of emotional validation
	2.3 Technological connection without genuine support
3. Partner Dynamics as Either Anchor or Anchor	3.1 Perceived abandonment versus engaged fatherhood
	3.2 Financial strain as relationship mediator
	3.3 Communication breakdown
4. The Body and Mind Disconnect	4.1 Physical recovery challenges
	4.2 Sleep deprivation as a catalyst
	4.3 Feeding difficulties and self-doubt
5. Cultural and Familial Pressures	5.1 Intergenerational conflict over infant care
	5.2 Gender expectations and disappointment
	5.3 Stigma and silence surrounding PPD

IV. DISCUSSION

This study employed Interpretative Phenomenological Analysis (IPA) that was used to elucidate the meaning of PPD in the first moms' life lived experiences in Pakistan. The participants' accounts were used to build five superordinate themes and three subordinate themes for each superordinate theme. Five superordinate themes and three subordinate themes were constructed from the participants' accounts: (1) The Shattered Expectations of Motherhood, (2) The Isolation Spiral, (3) Partner Dynamics as Either Anchor or Anchor, (4) The Body and Mind Disconnect, and (5) Cultural and Familial Pressures. As with IPA (Smith et al., 2009) the discussion below oscillates between the particular (verbatim extracts) and the general (convergence with and divergence from the wider empirical literature) before placing the findings in an integrated theoretical framework.

Superordinate Theme 1: The Shattered Expectations of Motherhood

The first superordinate theme was the clash between the participants' antenatal images of motherhood (which were nearly all instinctual, happy, and fulfilling) and the disorientating, hard work-oriented experience that took place after birth, which was rarely described as joyful, though it was often very hard work. This theme is described as a psychological disconnection between the woman's internalized cultural script of the "good", naturally competent mother, and her postpartum experience that leaves her feeling guilty, doubtful and sad about her and her life before the baby (Beck, 1993; Choi et al., 2005). This disconnect was the most common across the seven who mentioned it in some capacity, and was referenced across the entire dataset.

1.1 Idealized versus reality disconnect

This is a secondary theme; the one that described the cognitive and emotional disconnect that participants felt between what they had been told and what they told themselves about motherhood and how it would feel like, and how it felt once they became a mother of a crying, unpredictable infant. *“My idea of becoming a mother was the most magical thing my life had to offer, everyone told me, 'You are going to know such love, such happiness. But when she showed up I felt... nothing. Just a void. Then the guilt that I didn't feel that I'm supposed to feel.” (Participant 1, age 24, EPDS 17)*. Respondent: *"I can't get it, usually moms in movies they're smiling, they know what to do, my baby keeps crying, I feel like I'm not built for it. (P2, age 23, EPDS 21).*

This is not a surprising finding as it is very similar to previous qualitative research. Choi and her colleagues identified that women with preconceived ideas about the "ideal" mother experienced a range of negative reactions when faced with the realities of infant care, with disappointment, shock and failure being linked directly with the onset of

postpartum depressive symptoms (Choi et al., 2005). Similar results have been observed in Iranian samples, for example, when the authors of a grounded theory study of mothers in the UK identified "unmet expectations" as one of six main themes that women used as an explanation for their own postnatal depression, and in yet another Iranian study where the authors found that this was one of the major organizing themes in mothers' accounts of the transition to parenthood when their experiences did not match their expectations. The perception of the gap between expectation and reality also led some women to feel overwhelmed by loss and a "downward spiral" after giving birth, as revealed in a meta-synthesis of qualitative PPD studies (Epifanio et al., 2015), and in a qualitative meta-interpretive synthesis of marginalized mothers, which showed that women's own perception of their own mothers' experiences were often blamed for their depression (Maxwell et al., 2019) when their imagined experience is different from the reality. Collectively, these studies indicate that the voice of the Participants 1 and 2 is not specific to one culture, but is a near universal trigger for PPD, with the nature of the 'ideal' being dependent on the availability of media in the region and family stories.

1.2 Problem: Loss of pre-motherhood identity

This sub-theme is about the loss of the pre-birth personal, social and occupational identity and how this left the participants feeling one-dimensional and depersonalized as a mother. "*Before the baby, I had a calling. I had a title, I had friends, I read novels, I had hobbies, I met my university friends for tea... Now I'm just 'Ammi' (mother')… I look at myself and I don't understand myself" (Participant 4, age 28, EPDS 15)*. This is what has more recently been called a "matrescence" (Trinko et al., 2025) and refers to a psychological, relational, and social transformation to motherhood that is as intense as adolescence, in terms of reorganization of identity. In this transition, career aspirations, personal autonomy and previous relational roles are often disrupted, often due to lack of support, which increases the risk of a postpartum depression (Trinko et al., 2025). Qualitative studies conducted earlier also found that loss of autonomy, time, appearance and identity of occupation were experiential aspects of postnatal depression (Coates et al., 2014) which are described by Beck as a "loss of former self" (Beck, 1993). For one sample, the description by Participant 4 of no longer being able to see her own reflection has been described as not just a nuisance, but a disruption of self-continuity.

1.3 Overwhelming responsibility

This secondary theme represents the constant state of being "on call" to live up to the expectations of an infant's survival and wellbeing; forever with no respite, no clear-cut rules of success and always with the fear of failing. According to respondent, *"I really try my very best to feed, change, rock her and she still cries, I feel like I'm not being successful at the process that I'm supposed to be, I'm supposed to be good at this. Respondent: "I really just want to fade away... I look in the mirror and I just don't know who I am. (Participant 4, age 28, EPDS 15)*. The overwhelming and unshareable responsibility described here is similar to the "role strain" as described by Mercer in the transition to motherhood (2004) and to "feeling overwhelmed with new responsibility" and negative self-evaluation that was identified as a central experiential theme of postnatal depression in previous phenomenological research (Coates et al., 2014). This "teetering on the edge" perspective on postpartum depression as an internal struggle to be a competent mother and a fear of being exposed as incompetent was also evident in the narratives of Participants 1, 2, and 4, and is supported by Beck's (1993) grounded theory of postpartum depression.

Superordinate Theme 2: The Isolation Spiral

The second superordinate theme can be summarized as how participants' social world narrows after the birth of their children, with a component of withdrawal, dismissal from other people's social circles, and a replacement of in-person interactions with shallow digital interactions, creating increased, not reduced, emotional distress (de Choudhury et al., 2013). Theme 2 is about the interpersonal context of the interpersonal rupture, and how the interpersonal context fails to buffer the interpersonal rupture, unlike Theme 1 that focuses on an internal, cognitive-emotional rupture.

2.1 Social withdrawal

This is a sub-theme which represents participants' own withdrawal from friends and in some instances family, where this withdrawal is often directly related to the fact that previous attempts to help them were made to dismiss or minimize their distress. "*When I tried to tell them how hard it was, they said, "But you've got a beautiful baby, you should be grateful" (Participant 6, age 25, EPDS 18).* Participant 7's story is a striking example of loneliness in the

context of being surrounded by family members, of which the majority are her relatives, but not having the right kind of contact: “But I felt lonely even though I was surrounded by my family, most of whom were relatives, because they were not the right kind of contacts. (Qadir et al., 2013). This is also similar to the results of the marginalized-mothers study where women who felt unsupported despite their family members being physically present were left with a 'do it all' narrative of motherhood (Maxwell et al., 2019).

2.2 Lack of Emotional Validation

This is a sub-theme which concerned the subject in each instance being minimized, moralized or simply ignored by the husband, in-laws and peers who in each instance were denying the legitimacy of their distress. The respondent replied: *“I said, ‘I feel sad all the time, I don't feel like myself. He replied, ‘I said, 'You're just tired... Other women have babies and they are satisfying. Why can't you be like them? I was taken aback by her husband's reaction, 'It broke my heart. ' (Participant 1, age 24, EPDS 17*, recounting her husband's reaction). *When I had children, I didn't have time to feel sad,” said my mother-in-law, “you women are so vulnerable,” said respondent, “Maybe I'm not meant to be a mother.”* (Participant 2, age 23, EPDS 21). This subtheme aligns with the treatment-gap literature on PPD in Pakistan, which highlights that minimizing symptoms often be interpreted as being ungrateful, weak or just plain tired by the family and community, as a major obstacle for disclosure and help-seeking (Sajjad et al., 2024). The results of a qualitative study of awareness and help-seeking among parents in Islamabad also revealed high levels of emotional exhaustion, pressure to seem in control and happy, and a high level of stigma in both parents' interpretations (Sultan et al., 2025). This dismissive framing, as expressed by Participant 1's husband and 2's mother-in-law, is a common cultural approach, as observed in Pakistani participants that attempt to explain psychological distress in moral, not medical, terms (Ahmad & Koncsol, 2022; Shahzad et al., 2025).

2.3 Technological connection without genuine support

This sub theme relates to participants' efforts to fight loneliness through the use of their smartphones and social media, and the paradoxical feelings of inadequacy that arose when they encountered idealised images of other mothers. “*I have been following groups on Facebook where new moms discuss their babies, but no one talks about their not so perfect kids, their not so perfect home, their not so perfect life; are they lying or am I just damaged” (Participant 2, age 23, EPDS 21).* According to respondent: *“I follow these mommy bloggers and everything they do looks so clean, like my reality is, I have spit all over my clothes, my apartment looks like a disaster, I can't stop looking.”* (Participant 5). The current literature on social media and postpartum mental health provides good support for this subtheme. A large scale study of shared Facebook data revealed that greater isolation and less social capital in terms of Facebook activity was one of the strongest predictors of PPD among mothers (de Choudhury et al., 2013), while a qualitative content analysis of highly viewed TikTok videos about maternal-infant bonding, found that the internalized experience of comparison and self-blame was a common accompaniment to mothers' engagement with postpartum content online, even as this content normalized the experience for some viewers (Sobowale et al., 2025). The double-edged nature of this "connection without support" that emerges from both studies, de Choudhury et al. (2013) and Sobowale et al. (2025), is illustrated in the accounts of Participants 2 and 5: platforms are used because of their promise of connection to others, but this social comparison is carefully curated and upward-looking, and it feels less like social support and more like an extra source of inadequacy and shame.

Superordinate Theme 3: Partner Dynamics as Either Anchor or Anchor

The third superordinate theme was determined to be the buffering and/or exacerbating function of the marital relationship in either protecting against or elevating postpartum distress when husbands were emotionally present, practically involved, and validating, the same relationship was described as a stabilizing "anchor" and, when husbands were withdrawn, financially stressed, and dismissive, it became an additional source of psychological weight (Adil et al., 2021).

3.1 Perceived abandonment versus engaged fatherhood

This is a sub-theme that compares the description of physically and emotionally present and involved husbands with husbands who were physically present, but were not involved or emotionally present in infant care. Participant 7 (age 31, EPDS 13): *"My husband is my rock. When I cry he holds me, he gets up with the baby at night so I can sleep, I don't know how women manage without a supportive partner”.* According to respondent, "*He's in the house but he's not always with me, I feel like a ghost in my own marriage”* (Participant 4, 28, EPDS 15). Both these accounts

are in line with the increasing body of Pakistan-specific literature that directly associates spousal involvement with mental health outcomes of mothers. Little involvement from the husband in the birth process was associated with more depressive symptoms, while little support from family members was among the most powerful predictors of postpartum depression, as depression was seen as a private matter for women to deal with on their own (Mukhtar et al., 2025). In the same manner, an SEM study of Pakistani mothers indicated that perceived spousal support had a protective impact on maternal-infant bonding partly due to its impact on the reduction of postpartum depressive symptoms (Adil et al., 2021). The continuum of 'marriage' as described by Participant 7 ("a rock") and Participant 4 ("a ghost in my own marriage") together capture the extremes of the continuum quantitatively identified across the wider literature (Mukhtar et al., 2025; Adil et al., 2021).

3.2 Financial strain as relationship mediator

This sub theme reflects the economic burden - the cost of caring for an infant, visiting doctors, and everyday expenses - as a stressor that not just affected marital communication and closeness, but actively eroded it. According participant: *"when respondent is overburdened, he is short-tempered with me when it comes to paying bills, and when it comes to anything else, we don't even keep each other in the loop"* (Participant 2, age 23, EPDS 21). "*If he doesn't work we don't eat. I understand that. But I have a crying baby with me, for fourteen hours alone*" (Participant 3, age 22, EPDS 19). Financial hardship was found to be a strong correlated of marital displeasure and postnatal depression in Pakistani samples and in the South Punjab sample, half of the depressed mothers were financially challenged and a large number reported no marital support or poor social relations (Mukhtar et al., 2025). Qualitative results also suggest that the necessity to earn a living is used, implicitly, as a justification for the husband's long absences, with the mother having to take care of the family's needs for most of the day, a situation that aligns with the quantitative data which indicates that nuclear family structure and lower family resources are related to greater maternal psychological distress (Qadir et al., 2013).

3.3 Communication breakdown

This is a secondary theme as the woman and man can't talk about the mother's emotional state without taking offense, without it being perceived as a complaint, ingratitude or exaggeration, which makes it hard for them to communicate their emotions to their husband. "*He is angry with me now and he says, 'why can't you just be happy?'... When he is around I'm like, 'Yeah, I'm pretty happy'*" (Participant 2, age 23, EPDS 21). This denial of distress within the marriage also reflects results from the qualitative study of symptoms explanations of Pakistani couples, where husbands often blamed their wife's problems on tiredness, weak faith, or ingratitude, rather than a true mental health disorder and discouraged further disclosure of symptoms (Shahzad et al., 2025; Sultan et al., 2025). An in-depth qualitative research of the support systems available to women after childbirth in Lahore also revealed that absence of husband was a significant gap in the nuclear family context even in those families where other types of support systems were available. The concealment strategy outlined by Participant 2: doing wellness to avoid conflict is echoed by wider research on the emotional stoicism of strictures on emotional expression in gendered contexts, which undercuts women's propensity to express psychological distress even with their intimate partner (Sultan et al., 2025).

Superordinate Theme 4: The Body and Mind Disconnect

The fourth superordinate theme, "Breaking of the body, 'I don't feel safe' and increased psychological distress," described the feeling of their own bodies as being unreliable, painful, or distant during the postpartum period, as well as how this physical disconnection contributed to and exacerbated psychological distress (Trinko et al., 2025). Theme 1 deals with losing a psychological self, Theme 4 with losing a trusted physical self.

4.1 Physical recovery challenges

This sub theme explores the participants' experiences of childbirth, including physical recovery, which was often described as being painful, long-drawn out and poorly anticipated, both for a cesarean section and vaginal delivery. "*After 18 hours of labour, it was an emergency C-section, and for weeks I wasn't able to walk properly, I couldn't do the one thing that my body was meant to do"* (Participant 4, age 28, EPDS 15). "*When I sat, it hurt for two months, and I had to get the tear sewn up... no one told me anything like this?* (Participant 3, age 22, EPDS 19). The results confirm those of Trinko et al. (2025) who conducted their study specifically on the matrescence and pointed out that the suffering or complicated birth could trigger existential questioning and interfere with a woman's own sense of

competence in her body, which is already undergoing other changes in the transition to motherhood. The superordinate themes of embodied purpose and identity-level rupture experienced by Participants 4, which is a felt failure of purpose in their body, consist of a felt failure of embodied purpose that is not simply a post-natal discomfort. The interconnection of the superordinate themes is illustrated in Participant 4's statement that her body "could not do the one thing it was designed to do", which is a felt failure of embodied purpose that extends beyond a mere post-natal discomfort to the identity-level rupture described under Theme 1 (Beck, 1993; Trinko et al., 2025).

4.2 Sleep deprivation as a catalyst

The subordinate theme, which follows the above in the episode, is a compounding of cognitive and emotional effects of chronic sleep loss, from memory lapses to irritability, loss of emotional control and, in one instance, a transient hallucinatory experience. *"I have been unable to sleep more than 3 hours in a row"* (Participant 1, age 24, EPDS 17); "*I forget things; I put milk in the cupboard and cereal in the fridge – I am scared, I am so tired. As one other participant said: "On one occasion I was really exhausted, and I saw a shadow on the wall and thought it was a person, and screamed, because it was just my tired brain playing tricks on me*" (Participant 2, age 23, EPDS 21). In the quantitative literature, sleep disruption, particularly chronic sleep disruption is one of the most consistently replicated correlates of postpartum depression; poor quality, sleep efficiency, and daytime dysfunction are each among the most consistently reported correlates of depressive symptomology in systematic reviews of sleep in the perinatal period. Rouzafzoon et al., (2023) also propose that this relationship between subjective sleep perception, infant feeding and mood is complex, rather than linear, such that depressed mothers endorsed more negative perceptions of their own sleep and their infant's sleep regardless of actual sleep measures (Rouzafzoon et al., 2023). Although the second participant's experience was clearly not a psychotic process, but was a consequence of extreme sleep deprivation, it highlights the importance of examining sleep quantity and quality in the clinical screening for PPD.

4.3 Feeding difficulties and self-doubt

This sub-theme resonates with the difficulties that participants had with breastfeeding, whether getting them started or continuing to do so when problems arose and pain got in the way, and with the uncertainty this caused about the mothers' basic competence. It is of note that according to the respondent, "*Everyone said the baby would know what to do but my baby did not latch, she screams and retreats, my body could not even feed my baby*" (Participant, age 30 EPDS 14). "*Heard the mother say that she breastfed successfully but it was difficult, I had mastitis twice... I can't leave the baby for more than two hours... sometimes I feel my body is not mine anymore, it is the baby's*" (Participant 4, age 28, EPDS 15). Difficulty with breastfeeding is one of the known correlates of postpartum depressive symptoms. In a study of postpartum depression, Rouzafzoon et al. (2023) reported that depressed mothers had more negative perceptions of their infant-feeding challenges, even when the challenges were rated objectively as either not a challenge or a mild challenge. This indicated that depressive symptoms and infant-feeding doubt may be reinforcing. The participant whose body could not even feed her baby, as mentioned in the account, evokes disconnect between idealized and reality, which directly relates to Theme 1 (Beck, 1993; Choi et al., 2005) that described disconnect between idealized and reality.

Superordinate Theme 5: Cultural and Familial Pressures

The fifth superordinate theme is the collection of extended-family expectations, gendered cultural norms and religious or moral frames of mental distress that helped to interpret, navigate or ignore participants' postpartum struggles (Chung et al., 2022; Ahmad & Koncsol, 2022). Themes 2 deals with the interpersonal character of the interactions of participants within their relationships, while Theme 5 deals with the larger normative and cultural scripts through which these relationships—and the participants' own sense of self—were processed.

5.1 Intergenerational conflict over infant care

This is a sub-theme that captures the subversive and supervisive experiences of mothers' competence in being continually second guessed and overruled by other mothers, especially in the context of joint families. "*My mother-in-law is the one that knows everything because she had five children; she criticizes everything that I do, whatever I do, it's wrong"* (Participant 6, age 25, EPDS 18). Other respondents: "*Every time my baby cries, my mother-in-law takes her from me, I feel so useless, why can't I calm out my baby?* (Participant 3, age 22, EPDS 19). The findings of the cohort study carried out by Chung et al. (2022) in rural Pakistan, on mother-in-law childcare involvement and perinatal depression, support this subtheme, by showing that mother-in-law childcare, on average, was protective

during the very early postpartum stage; however, high maternal involvement in the households of mothers with family conflict was associated with higher, not lower, prevalence of maternal depression at 12 months postpartum (Chung et al., 2022). As daughters-in-law become more self-assured with their caregiving, ongoing high involvement in their mothers-in-law is experienced as interference, which resonates with Participant 3's description of feeling "useless" every time she was involved in her mother-in-law's life (Chung et al., 2022). This is significant because it undermines a straightforward understanding of the relationship between living in a joint family and its overall effect; as a whole, it is not necessarily protective or harmful.

5.2 Gender expectations and disappointments

This secondary theme is about how participants' birth of a daughter was perceived as a disappointment or deficiency to be fixed by a future son, whether by their husband, in-laws, or the community. *When the doctor said 'It's a girl', I saw my husband's face fall... In our culture, a woman's worth is her having sons, if she doesn't have a son, she has failed* (Participant 3, age 22, EPDS 19). One respondent (Participant 2, age 23, EPDS 21): *"Everyone always asks me when we're going to try for a son, no one ever celebrates my daughter, she's a stepping stone towards a son"*. The preference for males and the psychological pain of having a daughter has been reported in both South and East Asian settings. In sociocultural contexts like those in Pakistan, high expectations for a specific gender of a child can add to the emotions of distress and exacerbate symptoms of postpartum depression, while the mothers often feel guilty, secretive, and a "cone of silence" in relation to the disappointment or disappointment directed towards them (Jamal & Loona, 2026). Clinical commentary also has suggested that these experiences of gender disappointment, along with the postpartum symptomatology, can present as guilt and feeling "maternal incompleteness," or as a "grief-like response" to "something you never had. Participant 2's comment about her daughter being "just a stepping stone to the goal" is an example of how this cultural preference can be internalized by the mother as a sentence of her own worth, that has nothing to do with the child (Jamal & Loona, 2026).

5.3 Stigma and silence surrounding PPD

This theme is a subtheme which emerged as the participants' perceived fear of being described as being “crazy” or spiritually weak or morally flawed if they spoke out with their psychological discomfort and hence their tendency to resort to silence or religious healing rather than treatment by doctors or psychopathologists. *“"In our culture, if you have a mental illness, people say you're crazy... they'll say I'm not fit to be a mother. So I keep quiet. I smile. I pretend" (Participant 2, age 23, EPDS 21).* (Participant 2, age 23, EPDS 21). According to another respondent: *"My mother took me to a pir, he gave me a taweez, but I still felt that way, stopped saying to anybody that I felt that way"* (Participant 7, EPDS 13, age 31). This is well supported by the mental health literature in Pakistan. When asked about causes of mental illness, more than half of the adults in Pakistan surveyed said that mental illness was caused by spirits or sorcery, and about fifty percent of them said that if they thought they had a mental illness they would go to a religious healer rather than go to a mental health professional (Ahmad & Koncsol, 2022).

A similar qualitative study by Rashid and Mir (2025) in rural South Punjab revealed that most women who suffered from PPD had sought spiritual solutions (visiting pirs, wearing amulets or reciting specific prayers) and that most of them believed that their depression was a consequence of a test from God or the evil eye, and that their primary concern was to protect the family honour rather than seek medical or psychiatric help. Other findings from the review by Sajjad et al. (2024) on treatment gap for PPD in Pakistan include stigma as one of the main factors leading to low uptake of formal care along with limited services and gender expectations (Sajjad et al., 2024; Shahzad et al., 2025). Spiritual coping, which was an important step in the pathway and was seen as a source of comfort to participants, but did not happen until after participant 7 encountered a religious healer, was a critical consequence of this stigma-driven pathway (Rashid & Mir, 2025; Ahmad & Koncsol, 2022): spiritual coping, important as it was to respondents and often genuinely comforting, in some cases displaced contact with mental health services capable of treating the underlying depressive disorder.

Limitations and Future Directions

This study has a number of strengths. The use of Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009) enabled the exploration of the first-person meaning-making of the newly-mother Pakistani women in detail, filling a major gap in the existing literature on postpartum depression, which was overwhelmingly quantitative and based on Western, high-income countries (Coates et al., 2014; Maxwell et al., 2019). The detailed, systematic line-by-line

coding, building of subordinate themes close to the participants' own words, and focus on convergence and divergence across the cases deepens the confidence in the credibility of the thematic structure resulting from the qualitative procedure. However, there are a few caveats that should be noted. First, the sample was small and limited geographically and socio-economically, as this was in line with the idiographic objective of IPA (Smith et al., 2009), but limits the generalizability of the findings for first time mothers from other parts of Pakistan, other socioeconomic backgrounds, rural and urban locations, and other family structures. Second, the cross-sectional, retrospective design of the interviews may lead to recall bias as participants are asked to recall emotionally challenging experiences, and precludes statements about how these themes change over time in the first postpartum year, as noted by Chung et al. (2022) in their longitudinal study of this population. Thirdly, data were self-reported and no attempt was made to seek independent confirmation of participants' behaviour from, for example, partner, in-laws or clinicians, so results reflect those of participants' interpretations of others' behaviour rather than a third party's interpretation. Lastly, as in all IPA studies, the analysis will be always done through the lens of the researcher's own understanding (Smith et al., 2009); although this is a strength of the study as it allows for a rich insight to emerge, it also means that a different research team could reasonably focus on a different set of themes that can be drawn from the same transcripts.

There is a need for future research that will advance these findings in a number of directions. Extending the six months to one-year postpartum window used by Chung et al. (2022), with a follow-up of first-time mothers from pregnancy through the first postpartum year would assess if the themes explored here (most notably the isolation spiral and the body-mind disconnect) were a stable clinical trajectory or a transitional period that resolved over time and with support. Comparative research is required among the various socio-economic groups, rural and urban areas and various provinces and ethnic-linguistic groups of Pakistan as cultural and familial pressures are not likely to be homogeneous across the country (Shahzad et al., 2025; Sajjad et al., 2024). The protective factors of financial strain or cultural pressure which could protect women from the isolation spiral as outlined in this study, for instance, individual resilience, marital communication skills and structured social supports should also be explored in the future (Adil et al., 2021; Mukhtar et al., 2025). Third, there is a need for intervention research to test culturally adapted psychological treatments for PPD, such as adaptations of CBT that explicitly engage husbands and mothers-in-law, and that take into consideration many women's spiritual frameworks as they already utilize them. (Rashid & Mir, 2025; Sultan et al., 2025).

V. CONCLUSION

This study shows that the experience of postpartum depression among new mothers is complex and is influenced by psychological, interpersonal, and sociocultural factors. These results underscore the role of unmet expectations of motherhood, social isolation, lack of partner support, physical fatigue and cultural pressures in the postpartum phase as indicators of emotional distress. PPD can be seen as a normal reaction to the challenges of transitioning into motherhood within challenging social contexts, not a personal weakness. The results highlight the need for early detection, family engagement, culturally responsive mental health services, and nurturing care to enhance the well-being of mothers and support a healthier motherhood experience.

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