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LIVED EXPERIENCES OF POSTPARTUM DEPRESSION AND MATERNAL MENTAL HEALTH AMONG POSTPARTUM MOTHERS IN SOUTHEAST NIGERIA: A QUALITATIVE STUDY

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Abstract

Postpartum depression (PPD) is one of the most common maternal mental health disorders and contributes substantially to maternal morbidity and adverse child outcomes worldwide. Despite the growing recognition of maternal mental health as a public health priority, qualitative evidence exploring women's lived experiences of PPD in sub-Saharan Africa, particularly Nigeria, remains limited. This study explored the lived experiences of postpartum depression and maternal mental health among postpartum mothers in Southeast Nigeria to generate context-specific evidence for improving maternal healthcare services.

A qualitative descriptive study was conducted in 2024 among 36 postpartum mothers attending **a** private Hospital, Awka, Anambra State, Southeast Nigeria**.** Eligible participants were women within six months postpartum who were purposively selected based on their experiences of postpartum emotional and psychological challenges. Data were collected through four focus group discussions using a semi-structured interview guide. Each discussion lasted approximately 60 minutes and was audio-recorded with participants' informed consent. Audio recordings were transcribed verbatim,

anonymized, and analyzed using Braun and Clarke's six-phase thematic analysis. The study was conducted and reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ).
Three interconnected themes were identified. First**,** participants described diverse mental health challenges characterized by persistent sadness, emotional distress, anxiety, social withdrawal, sleep disturbances, and reluctance to disclose their symptoms because of stigma and fear of negative judgment. Second**,** mothers reported that depressive symptoms adversely affected the mother–infant relationship through reduced emotional attachment, diminished caregiving confidence, feelings of guilt, and perceived changes in infant behaviour. Third, women adopted multiple coping strategies, including emotional and practical support from family members, religious faith and prayer, music, peer support groups, and personal resilience to manage psychological distress. Participants also highlighted important gaps in professional mental health support within routine postpartum care.
Postpartum depression substantially affects maternal psychological wellbeing, mother–infant relationships, and daily functioning among postpartum mothers in Southeast Nigeria. The findings highlight the need to integrate routine mental health screening, culturally appropriate psychosocial counselling, family-centred support interventions, and strengthened referral pathways into routine maternal and postnatal healthcare services. This study provides context-specific qualitative evidence to inform maternal mental health policy, clinical practice, and future intervention development in Nigeria.

Keywords: Postpartum depression; Maternal mental health; Lived experiences; Mother–infant relationship; Qualitative research; Focus group discussions; Nigeria; Social support.

Introduction

Postpartum depression (PPD) is one of the most common mental health disorders affecting women during the postnatal period and is recognized as a major public health concern worldwide. It is a non-psychotic depressive disorder that typically develops within the first year after childbirth and is characterized by persistent sadness, loss of interest in previously enjoyable activities, feelings of hopelessness, anxiety, fatigue, sleep disturbances, impaired concentration, and difficulties in establishing emotional bonds with the newborn (American Psychiatric Association, 2022; World Health Organization, 2022). Although the postpartum period is often regarded as a joyful transition to motherhood, many women experience significant psychological distress that adversely affects both maternal and infant health if left unrecognized and untreated (Howard & Khalifeh, 2020).

Globally, postpartum depression affects approximately one in every seven women after childbirth, although prevalence estimates vary across settings because of differences in screening instruments, diagnostic criteria, and sociocultural contexts (Shorey et al., 2018; Wang et al., 2021). The burden is disproportionately higher in low- and middle-income countries (LMICs), where poverty, inadequate maternal healthcare services, gender inequality, intimate partner violence, food insecurity, and limited access to mental health services increase women's vulnerability to psychological disorders during the postpartum period (Gelaye et al., 2016; Hahn-Holbrook et al., 2018). The World Health Organization estimates that nearly one in five women in LMICs experience common perinatal mental disorders, with depression accounting for a substantial proportion of this burden (WHO, 2022).

The consequences of postpartum depression extend well beyond maternal emotional wellbeing. Untreated PPD has been associated with impaired mother–infant attachment, reduced breastfeeding initiation and continuation, poor maternal functioning, relationship difficulties, and diminished quality of life (Stein et al., 2014; Slomian et al., 2019). Infants of mothers experiencing postpartum depression are more likely to exhibit emotional dysregulation, behavioural problems, impaired cognitive development, delayed language acquisition, and insecure attachment patterns that may persist into childhood and adolescence (Stein et al., 2014; Netsi et al., 2018). At the family level, maternal depression contributes to increased caregiving stress, marital conflict, reduced family functioning, and substantial economic costs associated with reduced productivity and increased healthcare utilization (Slomian et al., 2019).

Despite its significant health implications, postpartum depression remains substantially underdiagnosed and undertreated, particularly in sub-Saharan Africa. Multiple barriers contribute to delayed recognition and treatment, including widespread stigma surrounding mental illness, inadequate mental health literacy, cultural expectations that women should cope silently with motherhood, shortages of trained mental health professionals, and limited integration of mental healthcare into routine maternal and child health services (Atif et al., 2015; WHO, 2022). In many African societies, emotional distress following childbirth is frequently interpreted as a normal aspect of motherhood rather than a treatable mental health condition, discouraging women from seeking professional support (Nakku et al., 2016).

Nigeria faces similar challenges. Existing studies indicate that postpartum depression affects approximately 10–35% of Nigerian mothers, with prevalence varying according to geographical region, study population, timing of assessment, and screening instruments used (Adewuya et al., 2005; Thompson & Ajayi, 2016). Nigerian women often experience multiple psychosocial stressors during the postpartum period, including financial hardship, limited partner involvement, household responsibilities, childcare demands, unintended pregnancies, obstetric complications, and inadequate social support (Agbaje et al., 2019; Upadhyay et al., 2017). Cultural norms that encourage women to demonstrate resilience and prioritize family responsibilities above their own wellbeing may further discourage disclosure of depressive symptoms and delay help-seeking behaviours (Oladeji et al., 2019). Furthermore, maternal mental health services remain insufficiently integrated into routine antenatal and postnatal care, resulting in missed opportunities for early identification and timely intervention (WHO, 2022).

Although awareness of postpartum depression has increased in recent years, most Nigerian studies have adopted quantitative cross-sectional designs that primarily estimate prevalence and identify associated risk factors. While these studies provide valuable epidemiological evidence, they offer limited insight into how women themselves experience postpartum depression, interpret their symptoms, negotiate cultural expectations of motherhood, interact with healthcare providers, and develop coping mechanisms within their social environments. Understanding these subjective experiences is essential because mental health is shaped not only by biological factors but also by interpersonal relationships, cultural beliefs, and healthcare experiences (Howard & Khalifeh, 2020).

Qualitative research provides an important opportunity to address these knowledge gaps by exploring women's lived experiences in depth. Through focus group discussions, researchers can gain rich contextual information regarding emotional distress, stigma, family dynamics, healthcare interactions, mother–infant relationships, and coping strategies that may not be adequately captured through standardized questionnaires. Such evidence is particularly valuable in culturally diverse settings like Nigeria, where community norms, extended family structures, and religious beliefs substantially influence maternal experiences and help-seeking behaviours. Insights generated through qualitative inquiry can inform culturally responsive screening approaches, strengthen maternal mental health services, and guide interventions that reflect women's lived realities rather than relying solely on epidemiological estimates.

This study was conducted in 2024 among postpartum mothers attending Life International Hospital, Awka, Anambra State, Southeast Nigeria**,** to explore the lived experiences of postpartum depression and maternal mental health during the first six months after childbirth. Specifically, the study examined women's perceptions of postpartum psychological distress, the effects of these experiences on mother–infant relationships, interactions with family members and healthcare providers, and the coping strategies employed to manage emotional challenges. By generating context-specific qualitative evidence from Southeast Nigeria, this study contributes to the growing body of literature on maternal mental health and provides findings that can inform culturally appropriate screening, psychosocial support, and policy interventions aimed at improving maternal and child health outcomes.

Methods

Study design

This study employed a qualitative descriptive design to explore the lived experiences of postpartum mothers regarding postpartum depression (PPD), maternal mental health, and mother–infant relationships. A qualitative descriptive approach was considered appropriate because it facilitates a comprehensive understanding of participants' experiences using their own words while remaining close to the data without imposing extensive theoretical interpretation. The study adopted a constructivist perspective, recognizing that women's experiences of postpartum mental health are shaped by individual, social, cultural, and healthcare contexts. The study was designed, conducted, and reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) 32-item checklist to enhance methodological transparency and reporting quality

Study setting

The study was conducted between May and August 2024 at a private Hospital, Awka**,** a privately owned secondary healthcare facility located in Awka South Local Government Area of Anambra State, Southeast Nigeria. The hospital provides comprehensive maternal and child health services, including antenatal care, delivery services, postnatal care, immunization, family planning, and neonatal care. It serves women from Awka metropolis and neighbouring urban and rural communities, making it an appropriate setting for exploring diverse postpartum experiences.

Routine postnatal clinics at the hospital provide opportunities for mothers to receive follow-up care during the first six months after childbirth. However, mental health assessment is not routinely integrated into postnatal services, reflecting the broader challenges of maternal mental healthcare delivery in many Nigerian health facilities. Conducting the study within this setting enabled participants to share their experiences in an environment familiar to them while providing insight into healthcare experiences within routine maternal services.

Participant selection and recruitment

The study population comprised postpartum mothers attending postnatal clinics at Life International Hospital during the study period. Participants were recruited using purposive sampling to ensure inclusion of women with relevant experiences of postpartum emotional or psychological challenges. Purposive sampling enabled the recruitment of participants with varying ages, parity, educational backgrounds, and socioeconomic characteristics, thereby enriching the diversity of perspectives represented in the discussions.

Women were eligible to participate if they:

- were aged 18 years or older;
- were within six months postpartum;
- attended postnatal care services at Life International Hospital during the study period;
- reported experiencing emotional distress, depressive symptoms, or other postpartum mental health challenges during routine clinical interactions or preliminary screening; and
- were willing and able to provide written informed consent.

Women with severe medical illness requiring urgent treatment, diagnosed psychotic disorders, cognitive impairment that limited participation, or inability to communicate in English or Igbo were excluded.

A total of 36 postpartum mothers participated in the study. Recruitment continued until data saturation was achieved, whereby no substantially new concepts or themes emerged from subsequent discussions.

Data collection

Data were collected through four focus group discussions (FGDs) conducted between May and August 2024. Each discussion included eight to ten participants**,** consistent with recommendations for qualitative group interviews. FGDs were chosen because they encourage interaction among participants, stimulate discussion, and facilitate exploration of shared experiences, beliefs, and perceptions regarding postpartum mental health.

A semi-structured interview guide was developed following a review of the literature on postpartum depression and maternal mental health. The guide included open-ended questions exploring women's emotional experiences following childbirth, perceived causes of psychological

distress, effects on infant care and mother–infant relationships, interactions with healthcare providers, family and community support, barriers to seeking professional help, and coping strategies. Probing questions were used to clarify participants' responses and encourage richer descriptions.

The focus group discussions were moderated by the principal investigator, who has training and experience in qualitative health research, assisted by a trained research assistant responsible for note-taking and logistical support. Prior to each session, participants were informed about the study objectives, confidentiality procedures, voluntary participation, and their right to withdraw at any stage without consequences. Written informed consent was obtained before data collection commenced.

Each discussion lasted approximately 60–75 minutes and was conducted in a quiet, private meeting room within the hospital to ensure participant comfort and confidentiality. Discussions were conducted primarily in English, with occasional use of Igbo where participants expressed themselves more comfortably. Igbo responses were translated into English during transcription by bilingual researchers familiar with both languages.

All discussions were digitally audio-recorded with participants' permission. Field notes documenting non-verbal communication, group dynamics, emotional expressions, and contextual observations were recorded immediately after each session to complement the interview transcripts.

Researcher characteristics and reflexivity

The research team comprised academics with backgrounds in public health, health promotion, maternal and child health, and qualitative research. The principal investigator, who moderated the discussions, had previous experience conducting qualitative studies involving maternal health and community-based populations.

Recognizing that researchers' professional backgrounds and prior knowledge may influence data interpretation, reflexivity was maintained throughout the research process. The researchers documented reflexive notes after each focus group discussion, discussed emerging assumptions during analysis meetings, and continuously examined how personal perspectives might influence interpretation. Participants' accounts were prioritized during coding to ensure that themes reflected their experiences rather than researchers' preconceptions.

Data analysis

Audio recordings were transcribed verbatim shortly after each focus group discussion. Transcripts were checked against the original recordings to ensure completeness and accuracy before analysis. Data were analysed using Braun and Clarke's six-phase thematic analysis framework**.** The analysis involved repeated familiarization with the data, generation of initial codes, systematic identification of candidate themes, review and refinement of themes, definition and naming of themes, and preparation of the final report.

Coding was performed manually by two members of the research team independently. Following independent coding, both researchers compared coding frameworks and discussed areas of disagreement until consensus was reached. This process enhanced the credibility and dependability of the findings. Representative quotations were selected to illustrate major themes while preserving participants' anonymity through the use of participant identifiers.

Trustworthiness

The trustworthiness of the study was established using the criteria of credibility, dependability, confirmability, and transferability. Credibility was enhanced through prolonged engagement with participants during focus group discussions, independent coding by two researchers, and regular discussions to reach consensus on emerging themes. Dependability was strengthened by maintaining an audit trail documenting methodological decisions throughout the research process. Confirmability was supported through reflexive journaling and documentation of analytical decisions to minimize researcher bias. Transferability was facilitated by providing detailed descriptions of the study setting, participant characteristics, sampling procedures, and data collection methods to enable readers to assess the applicability of the findings to similar contexts.

Ethical considerations

Administrative approval to conduct the study was obtained from the management of Life International Hospital, Awka, before commencement of data collection. All participants received detailed information about the purpose of the study, study procedures, potential benefits and minimal risks, confidentiality measures, and their right to decline participation or withdraw from the study at any time without any consequences for their healthcare. Written informed consent was obtained from all participants before their inclusion in the study.

To protect participants' privacy, no personally identifiable information was collected or included in the transcripts or study reports. Audio recordings, transcripts, and field notes were securely stored on password-protected devices accessible only to the research team. Participants were assigned unique identification codes during transcription and reporting to ensure anonymity and maintain confidentiality throughout the study.

Results

Participant characteristics

A total of 36 postpartum mothers participated in the study. Data were collected between May and August 2024 through four focus group discussions conducted at a private Hospital, Awka, Anambra State, Nigeria**.** All participants were within six months postpartum and represented diverse sociodemographic backgrounds in terms of age, educational attainment, occupation, parity, and marital status (Table 1). Recruitment continued until data saturation was achieved, with no substantially new concepts emerging during the final focus group discussion.

Table 1: Sociodemographic and obstetric characteristics of participants (N = 36)

Characteristic	Category	n (%)
Age (years)	18–24	8 (22.2)
	25–34	20 (55.6)
	≥35	8 (22.2)
Marital status	Married	30 (83.3)
	Single	4 (11.1)
	Divorced/Separated	2 (5.6)
Educational level	Primary	3 (8.3)
	Secondary	12 (33.3)
	Tertiary	21 (58.3)
Occupation	Civil servant	10 (27.8)
	Trader/Business	12 (33.3)
	Self-employed/Artisan	5 (13.9)
	Housewife	4 (11.1)
	Student	3 (8.3)
	Unemployed	2 (5.6)
Parity	Primiparous	14 (38.9)
	Multiparous	22 (61.1)
Months postpartum	≤2 months	12 (33.3)
	3–4 months	15 (41.7)
	5–6 months	9 (25.0)

The thematic analysis generated **two overarching themes** and **seven interrelated subthemes** describing participants' lived experiences of postpartum depression and maternal mental health. These themes reflected women's emotional experiences during the postpartum period and the influence of these experiences on mother–infant relationships and family life (Table 2).

Theme 1: Mental health challenges during the postpartum period

Participants described postpartum depression as a multifaceted experience characterised by emotional distress, persistent anxiety, fear, social withdrawal, and reduced capacity to perform daily activities. Many women explained that their psychological experiences conflicted with societal expectations that motherhood should be a period of happiness and fulfilment.

Emotional distress and depressive symptoms

The dominant experience shared across the focus groups was persistent emotional distress. Mothers described prolonged sadness, unexplained crying, hopelessness, emotional emptiness, guilt, and feelings of worthlessness. Several participants explained that these emotions developed shortly after childbirth and persisted despite having healthy babies and supportive family members.

One participant explained:

"I cried almost every day, but I hid it from my family because they expected me to be happy."

Another participant described the emotional conflict she experienced:

"Sometimes I felt empty, even when my baby was beside me. I wondered if something was wrong with me."

Many women reported feeling guilty because they believed they were failing to experience the happiness traditionally associated with childbirth. These feelings often led to self-blame and emotional isolation.

Anxiety, fear and uncertainty

Alongside depressive symptoms, participants described overwhelming anxiety about caring for their infants. Many constantly worried about their babies' health, feeding patterns, breathing, and overall safety. First-time mothers particularly expressed uncertainty regarding their caregiving abilities.

As one participant stated:

"I was always afraid something would happen to my baby. Even when he was sleeping, I kept checking if he was breathing."

Another participant explained:

"Every small cry made me panic. I thought I was not feeding him well."

Persistent worry resulted in sleep disruption, fatigue, and heightened emotional exhaustion, further worsening participants' psychological wellbeing.

Stigma, silence and delayed disclosure

Participants consistently reported that cultural expectations discouraged discussions about emotional difficulties after childbirth. Many believed that expressing sadness would be interpreted as weakness or ingratitude, leading them to conceal their symptoms from relatives, friends, and even healthcare providers.

One mother explained:

"In our culture, people say you should be strong after childbirth. If you complain, they think you are weak."

Another participant shared:

"I kept quiet because I did not want my family to think I was ungrateful for the baby."

This reluctance to disclose emotional distress delayed recognition of postpartum depression and reduced opportunities for receiving timely professional support.

Functional impairment and social withdrawal

Participants described how psychological distress affected multiple aspects of daily living. Routine household responsibilities became increasingly difficult, and many mothers withdrew from religious, social, and community activities because of emotional exhaustion and fear of being judged.

One participant stated:

"I stopped going to church because I did not want people to see me looking sad."

Another explained:

"Even cooking became a burden. I just wanted to lie down."

These findings demonstrate that postpartum depression extended beyond emotional symptoms to affect women's social participation, family responsibilities, and overall quality of life.

Theme 2: Impact of postpartum depression on the mother–infant relationship

Participants described postpartum depression as having profound effects on their relationships with their infants. Emotional distress frequently reduced maternal confidence, affected caregiving practices, and shaped perceptions of infant behaviour.

Difficulties establishing emotional attachment

Many mothers explained that depressive symptoms interfered with their ability to establish the emotional connection they expected with their infants. Feelings of detachment generated guilt and concerns regarding their adequacy as mothers.

One participant explained:

"I wanted to hold my child, but sometimes I felt disconnected, like I was not the right person to care for him."

Another reflected:

"When my baby cried too much, I felt like I was failing as a mother."

Several participants described these experiences as particularly distressing because they conflicted with cultural expectations that mothers should immediately develop strong emotional bonds with their newborns.

Perceived infant emotional responses

Participants frequently believed that their own emotional state influenced their infants' behaviour. Although these perceptions reflected maternal interpretations, they significantly contributed to feelings of guilt, inadequacy, and emotional distress.

One participant remarked:

"My baby seemed calmer with my mother-in-law than with me. It made me feel useless."

Similarly, another stated:

"I felt that my child could sense my sadness. He cried more when I was around."

Such perceptions reinforced negative self-evaluations and reduced mothers' confidence in their caregiving abilities.

Influence of family relationships

Family relationships emerged as an important contextual factor influencing mothers' experiences. Supportive spouses and relatives provided reassurance, practical assistance, and emotional encouragement, whereas criticism and unrealistic expectations intensified psychological distress.

One participant explained:

"My husband encouraged me, saying I was doing well. That gave me strength."

Conversely, another participant stated:

"My sister told me I was lazy because I could not manage the baby alone. That made me feel worse."

These findings demonstrate the important role of family support in either mitigating or exacerbating postpartum psychological distress.

Cross-cutting findings: Professional support and pathways to recovery

Across all discussions, participants described an ongoing tension between personal emotional struggles and cultural expectations of motherhood. Many women delayed seeking help because they feared stigma or believed their experiences were a normal part of motherhood. However,

those who eventually discussed their symptoms with healthcare professionals described feelings of reassurance, acceptance, and hope.

One participant explained:

"The doctor told me it was normal to feel this way. That helped me accept myself."

Another participant shared:

"When I spoke to the counselor, I realized I was not alone. Other mothers also had similar feelings."

Participants also identified several coping strategies that enabled them to manage psychological distress. Emotional support from spouses and extended family members, religious faith and prayer, listening to music, participation in peer support groups, and personal resilience were frequently described as important sources of comfort. Nevertheless, many participants believed that these strategies could not replace access to professional mental health services and emphasized the need for routine postpartum mental health screening and counselling within maternal healthcare.

Table 2: Themes and subthemes describing the lived experiences of postpartum depression among postpartum mothers attending Life International Hospital, Awka, Nigeria, 2024

Theme	Subtheme	Description	Representative quotation
Mental health challenges during the postpartum period	Emotional distress and depressive symptoms	Persistent sadness, crying, guilt, hopelessness and emotional exhaustion	"I cried almost every day, but I hid it from my family."
	Anxiety, fear and uncertainty	Constant worry regarding infant wellbeing and maternal competence	"I kept checking if my baby was breathing."
	Stigma, silence and delayed disclosure	Fear of judgment discouraged help-seeking	"People say you should be strong after childbirth."
	Functional impairment and social withdrawal	Reduced participation in household, social and religious activities	"Even cooking became a burden."
Impact of postpartum depression on the mother–infant relationship	Difficulties establishing emotional attachment	Emotional detachment and reduced maternal confidence	"Sometimes I felt disconnected."
	Perceived infant emotional responses	Mothers perceived infant behaviour as reflecting their emotional state	"My baby cried more when I was around."

	Influence of family relationships	Family support alleviated distress, whereas criticism intensified symptoms	"My husband encouraged me, saying I was doing well."
Cross-cutting theme	Professional support, coping and recovery	Counselling, family support, religion, music, peer support and resilience promoted coping	"When I spoke to the counselor, I realized I was not alone."

Summary of findings

The findings demonstrate that postpartum depression affected multiple dimensions of mothers' lives, extending beyond emotional wellbeing to influence daily functioning, maternal confidence, family relationships, and the mother–infant relationship. Participants described persistent sadness, anxiety, stigma, and social withdrawal, which were often reinforced by cultural expectations surrounding motherhood. Difficulties establishing emotional attachment with infants, perceptions of altered infant responses, and varying levels of family support further shaped women's experiences. Although many participants relied on informal coping strategies such as family support, religious faith, music, and peer interactions, they consistently highlighted the value of compassionate professional counselling and the need for routine mental health screening within postnatal care. Collectively, these findings underscore the importance of integrating culturally responsive maternal mental health services into postpartum care in Nigeria.

Discussion

This study explored the lived experiences of postpartum depression among postpartum mothers attending a private Hospital, Awka, Southeast Nigeria**,** in 2024**,** with particular emphasis on maternal mental health challenges and the influence of postpartum depression on the mother–infant relationship. The findings revealed that women experienced persistent emotional distress characterized by sadness, anxiety, guilt, fear, and functional impairment. Participants also described difficulties establishing emotional attachment with their infants, perceived changes in infant behaviour, reluctance to disclose psychological distress because of sociocultural stigma, and the important influence of family support on their recovery. Together, these findings demonstrate that postpartum depression extends beyond individual psychological symptoms to affect family relationships, caregiving practices, and women's engagement with healthcare services.

One of the most prominent findings was the pervasive experience of emotional distress during the postpartum period. Participants described persistent sadness, frequent crying, feelings of hopelessness, guilt, and emotional emptiness that often conflicted with cultural expectations that childbirth should be accompanied by happiness and fulfilment. These findings are consistent with qualitative and quantitative evidence demonstrating that depressed mood, emotional withdrawal, and loss of interest represent the hallmark manifestations of postpartum depression across diverse

cultural settings (Beck et al., 2022; Gowon et al., 2024). However, the present study extends existing evidence by illustrating how Nigerian mothers interpreted these emotional experiences within a sociocultural environment that celebrates motherhood while discouraging acknowledgement of psychological distress. Rather than viewing their symptoms as manifestations of a treatable health condition, many participants interpreted their emotions as personal failure, thereby intensifying feelings of guilt and self-blame.

Anxiety emerged as another central component of mothers' lived experiences. Participants described constant fear regarding infant health, excessive monitoring of infant breathing, concerns about breastfeeding adequacy, and uncertainty about their competence as caregivers. These findings corroborate previous studies showing that postpartum depression frequently coexists with heightened maternal anxiety, creating a cycle in which excessive worry contributes to emotional exhaustion and diminished maternal confidence (Jeličić et al., 2022; Ribeiro Feitosa et al., 2026). Within the present study, anxiety was further amplified by limited opportunities to receive reassurance from healthcare professionals and by cultural expectations that mothers should instinctively possess caregiving skills. These contextual factors may explain why participants frequently interpreted ordinary infant behaviours as evidence of maternal inadequacy.

The findings also highlight the powerful influence of stigma on maternal mental health. Many participants concealed their emotional struggles because they feared being perceived as weak, spiritually deficient, or ungrateful for childbirth. This finding aligns with emerging qualitative evidence from Nigeria demonstrating that sociocultural beliefs continue to discourage discussion of perinatal mental illness and contribute to delayed help-seeking (Oladeji et al., 2019; Omale et al., 2026; Ohenhen et al., 2026). Beyond limiting access to professional support, the present findings suggest that stigma also reinforces internalized guilt, social withdrawal, and emotional isolation. Consequently, postpartum depression remains largely hidden despite its significant impact on maternal wellbeing. Addressing stigma should therefore be considered a critical component of maternal mental health interventions in Nigeria.

Functional impairment represented another important finding. Participants described reduced motivation to perform household responsibilities, withdrawal from religious and social activities, and difficulty maintaining routine daily functioning. These experiences demonstrate that postpartum depression affects women's ability to participate fully in family and community life, extending its consequences beyond psychological wellbeing alone. Similar findings have been reported in previous African studies, where untreated perinatal depression contributed to reduced social participation and diminished quality of life (Falana, 2026). The findings reinforce the need for early identification and management of postpartum depression before functional limitations become more severe.

Consistent with previous international research, postpartum depression substantially affected the mother–infant relationship. Participants frequently described emotional detachment from their infants, reduced confidence in caregiving, and concerns regarding their ability to establish meaningful emotional bonds. These findings support evidence demonstrating that maternal depression adversely affects mother–infant attachment and early caregiving interactions (Stein et al., 2014; Vanwalleghem et al., 2023; Ribeiro Feitosa et al., 2026). An important contribution of the present study is the observation that mothers often interpreted normal infant crying and

behavioural responses as reflections of their own perceived inadequacy. This reciprocal interpretation appeared to reinforce negative self-perceptions, creating a self-sustaining cycle in which maternal distress and perceived infant responses intensified one another.

Family relationships emerged as both protective and detrimental influences on maternal mental health. Participants consistently described emotional encouragement, practical assistance, and reassurance from supportive spouses and relatives as important sources of resilience during the postpartum period. Conversely, criticism, unrealistic expectations, and dismissive attitudes from family members intensified emotional distress and reduced maternal confidence. These findings are consistent with previous evidence identifying inadequate social support and poor family relationships as major determinants of postpartum depression (Nor Idham et al., 2026; Tadanki et al., 2026). Given the central role of the extended family within many Nigerian households, interventions designed to improve maternal mental health should actively engage spouses, mothers-in-law, and other family members to foster supportive caregiving environments.

The findings can be interpreted within the framework of Attachment Theory and the Biopsychosocial Model**.** Attachment Theory proposes that maternal psychological wellbeing influences the development of secure emotional bonds between mothers and infants. Participants' descriptions of emotional detachment, reduced caregiving confidence, and concerns regarding infant responsiveness reflect disruptions in early attachment processes associated with depressive symptoms (Vanwalleghem et al., 2023). At the same time, the Biopsychosocial Model provides a comprehensive explanation for the multidimensional nature of postpartum depression observed in this study. Biological changes associated with childbirth, psychological responses such as sadness and anxiety, and broader social influences including stigma, family relationships, and healthcare experiences interacted to shape women's lived experiences. This multidimensional perspective supports growing evidence that postpartum depression cannot be effectively addressed through biomedical treatment alone but requires integrated psychosocial interventions (Howard & Khalifeh, 2020; Nor Idham et al., 2026).

The findings have important implications for maternal healthcare policy and practice in Nigeria. Routine screening for postpartum depression should be incorporated into postnatal care services to facilitate early identification and referral of affected women. Healthcare providers should receive training to recognize common manifestations of maternal psychological distress and to provide culturally appropriate psychosocial support. Given the influence of family relationships on maternal wellbeing, family-centred counselling interventions should accompany individual psychological care. Community-based mental health education programmes that challenge misconceptions about postpartum depression and reduce stigma may further encourage early disclosure and help-seeking among postpartum women. Collectively, these strategies would contribute to strengthening the integration of maternal mental healthcare within existing maternal and child health services.

Strengths and limitations

This study provides in-depth qualitative evidence regarding the lived experiences of postpartum depression among women in Southeast Nigeria, a setting where qualitative maternal mental health research remains limited. The use of focus group discussions enabled participants to describe their emotional experiences, family relationships, and healthcare interactions in their own words, providing rich contextual information that complements existing quantitative evidence. Reporting the study in accordance with the COREQ guideline further enhances the transparency and credibility of the findings.

Nevertheless, several limitations should be considered when interpreting the findings. The study was conducted at a single healthcare facility in Southeast Nigeria, which may limit the transferability of the findings to other regions or healthcare settings. Participants were recruited purposively from women attending postnatal care services and may not represent mothers who do not access formal healthcare or those experiencing more severe mental illness. Furthermore, the focus group format may have influenced participants' willingness to disclose highly sensitive experiences despite efforts to create a supportive and confidential environment. Future studies should consider multicentre qualitative research and longitudinal designs to examine how maternal mental health experiences evolve throughout the postpartum period.

Implications for future research

Future research should explore postpartum depression across multiple geopolitical regions of Nigeria to better understand regional, cultural, and socioeconomic variations in maternal mental health experiences. Longitudinal qualitative studies would provide valuable insight into how psychological wellbeing, mother–infant relationships, and coping strategies change over time. Further research should also evaluate culturally appropriate psychosocial interventions, family-centred support programmes, and the integration of routine mental health screening into antenatal and postnatal care services to determine their effectiveness in improving maternal and infant outcomes.

Conclusion

The findings demonstrate that postpartum depression is characterised by interconnected experiences of emotional distress, anxiety, stigma, functional impairment, and challenges in establishing and maintaining the mother–infant relationship. These experiences were shaped not only by individual psychological responses but also by sociocultural expectations surrounding motherhood, family relationships, and healthcare experiences.

The study highlights that many women experienced psychological distress in silence because of fear of stigma and negative judgement, thereby delaying disclosure and access to appropriate support. Family members emerged as influential determinants of maternal wellbeing, with supportive relationships promoting resilience and confidence, whereas criticism and lack of understanding intensified emotional distress. These findings reinforce the importance of

recognising postpartum depression as a multidimensional maternal health issue requiring integrated psychological, social, and family-centred approaches.

The findings have important implications for maternal healthcare in Nigeria. Routine screening for postpartum depression should be incorporated into postnatal care services to facilitate early identification and timely referral of affected women. Healthcare providers should be equipped to deliver culturally appropriate psychosocial support, while community-based awareness programmes should aim to reduce stigma surrounding maternal mental health and encourage help-seeking. Family-centred interventions that actively involve spouses and other significant relatives may further strengthen maternal recovery and improve early mother–infant relationships.

This study contributes context-specific qualitative evidence to the growing body of literature on maternal mental health in sub-Saharan Africa. By amplifying the voices of postpartum mothers in Southeast Nigeria, it provides evidence to inform culturally responsive clinical practice, maternal health policy, and future research aimed at improving maternal and infant wellbeing.

Recommendations

Based on the findings of this study, strengthening maternal mental healthcare should become an integral component of routine maternal and child health services in Nigeria. The following recommendations are proposed:

- **Integrate routine screening for postpartum depression** into antenatal and postnatal care services using validated screening tools to facilitate early identification, timely referral, and appropriate management of maternal mental health conditions.
- **Strengthen the capacity of healthcare providers** through continuous training on the recognition, assessment, counselling, referral, and management of postpartum depression, with emphasis on culturally sensitive and woman-centred care.
- **Develop community-based mental health awareness programmes** to improve public understanding of postpartum depression, reduce stigma associated with maternal mental illness, and encourage early help-seeking among postpartum women and their families.
- **Promote family-centred maternal mental health interventions** by actively engaging spouses, partners, mothers-in-law, and other significant family members in education and psychosocial support programmes to enhance emotional support and reduce negative attitudes towards affected women.
- **Support multicentre and longitudinal qualitative and mixed-methods research** across diverse regions of Nigeria to further explore sociocultural influences on postpartum mental health and evaluate the effectiveness of culturally appropriate interventions for improving maternal and infant outcomes.

These recommendations have the potential to strengthen maternal mental healthcare delivery, improve the early detection and management of postpartum depression, and contribute to better health and psychosocial outcomes for mothers, infants, and families in Nigeria.

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