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The lived experiences of mothers of daughters with mental illness: an interpretative phenomenological analysis

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Abstract

Background

Motherhood is a transformative experience that becomes particularly complex when a daughter develops severe mental illness. In cultural contexts such as Ardabil, Iran, gendered expectations, family honor (āberu), and limited formal support intensify the caregiving burden. Despite extensive quantitative research on caregiver burden, in-depth accounts of how mothers make sense of this experience remain scarce. This study explored the lived experiences of mothers caring for daughters with severe mental illness in Ardabil.

Methods

An interpretative phenomenological analysis (IPA) design was used. Ten mothers with at least two years of caregiving experience were recruited through purposive, criterion-based sampling from welfare centers, psychiatric hospitals, and counseling services. Data were collected via in-depth semi-structured interviews (face-to-face, telephone, or online) lasting 45–90 minutes and analyzed idiographically following Smith, Flowers, and Larkin's framework, moving from personal to group experiential themes. MAXQDA supported data organization. Rigor was enhanced through reflexivity, supervisory review, member checking, and an audit trail. The study adhered to guidelines and received ethical approval.

Results

Three interrelated group experiential themes were constructed: the Palimpsest of Motherhood (shift from intuitive mothering to unsustainable multi-roles, identity fusion, perpetual crisis, and embodied turmoil); Maternal Stigma (illness as maternal failure, self-censorship, defensive strategies, and expansion into familial and phygital domains); and the Labyrinth of Temporality

(ruptured time, invaded present, foreclosed expectation, and mourning of a lost future). These themes formed a self-reinforcing cycle reshaping identity, social positioning, and lived time.

Conclusions

Chronic mother–daughter caregiving rewrites maternal identity, exposes mothers to gendered moral judgement, and disrupts temporal experience. Support should move beyond generic psychoeducation to address somatic strain, maternal self-blame, and culturally specific concerns such as āberu through confidential, mother-centered, and family-oriented interventions. These findings have implications for the design of culturally attuned mental health services that recognize caregivers' own meaning-making and promote family-centered care.

Keywords

Interpretative phenomenological Analysis, Mothers, Mental illness, Daughter, Qualitative research.

1. Background

Motherhood is a transformative experience that reorganizes women's lifeworld across multiple dimensions [1-3]. The mother–daughter relationship is particularly significant because of shared gender, identification, intimacy, and expectations surrounding the daughter's development and future [4]. When a daughter receives a diagnosis of mental illness, mothers, as primary caregivers, are may experience a "psychological tsunami" [5]: a convergence of shock, grief, guilt, anger, and helplessness that begins with the first signs of change and crests at diagnosis. This distress becomes an enduring mode of living alongside loss, reshaping how mothers apprehend the past, inhabit the present, and anticipate the future [4, 6].

Parents of individuals with psychiatric disorders show elevated rates of mood and anxiety disorders and psychotropic medication use [7], underscoring the psychological consequences of prolonged

caregiving [8]. Mental disorders affect over 1.1 billion people worldwide [9], with prevalence in Iran exceeding global estimates and disproportionately affecting women [10, 11]. Psychotic-spectrum and severe mood disorders involve substantial functional impairment, chronic course, and high caregiver dependency, ranking among the costliest psychiatric conditions [12, 13]. Global economic losses attributable to mental illness between 2010 and 2030 approach $16 trillion [14]; in Iran, caregiving burden is compounded by treatment costs and reduced household capacity [15, 16].

In Iran, primary caregiving falls disproportionately on mothers. When the child is a daughter, additional gendered dimensions arise: concern for marriageability, social independence, and accountability for family honour (*āberu*) [8, 11, 17, 18]. Families also experience courtesy stigma, whereby caregivers absorb social judgment and exclusion [19, 20]. Iranian studies link stigma to impaired family functioning and parental social withdrawal [16, 21].

Prolonged caregiving reorganizes caregivers' roles and self-understanding, making caregiving constitutive of identity [22, 23], consistent with maternal identity as an ongoing achievement [24]. The World Health Organization (WHO) Mental Health Action Plan 2013–2030 notes that families manage complex demands with minimal formal support and calls for extending "no health without mental health" to caregivers [25]. Iranian evidence shows that sustained exposure to a child's difficulties erodes mothers' psychological capital and generates internal conflict, worsened by gaps in social support [10, 16]. Clinical guidance therefore advocates family-centered care grounded in understanding of caregivers' lived experience [26].

Although Iranian qualitative studies have examined mothers of children with autism or disability [10, 16], in-depth idiographic accounts of mothers caring for a daughter with severe psychiatric illness remain scarce, especially in traditional settings such as Ardabil. In these contexts, gendered

expectations around motherhood, marriage, and reputation shape interpretation of the daughter's illness. Much of the existing mental health research has focused on patients' experiences [27], yet psychotic and mood-related suffering unfolds within a relational field, making caregivers' experience equally important.

Interpretative Phenomenological Analysis (IPA) was chosen for its phenomenological, hermeneutic, and idiographic commitments [27]. Knowledge of how mothers construct meaning from caregiving for a daughter with severe mental illness and how gender and cultural context shape this meaning-making remains limited in Ardabil. This study therefore explored how mothers of daughters with severe mental illness experience and make sense of their lives and identities within the sociocultural context of Ardabil, Iran.

2. Methods

2.1. Study design

This qualitative study employed Interpretative Phenomenological Analysis (IPA), following the methodological framework of Smith, Flowers, and Larkin [27], to explore how mothers of daughters living with severe mental illness experienced and made sense of this experience within the sociocultural context of Ardabil, Iran. IPA was selected for its focus on lived experience and meaning-making, along with its idiographic commitment to detailed analysis of individual cases before examining patterns across cases [27]. The approach is grounded in phenomenology, hermeneutics, and idiography. It incorporates a double hermeneutic, whereby participants make sense of their experiences, and the researcher seeks to make sense of this meaning-making [27]. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (supplementary file 1) [28].

2.2. Setting and participants

The study was conducted in Ardabil, Iran, in 2026. Participants were mothers of daughters diagnosed with a psychiatric disorder, with priority given to psychotic-spectrum and mood disorders because of the potentially complex and sustained caregiving demands associated with these conditions. Purposive, criterion-based sampling was used to recruit a relatively homogeneous group with respect to the phenomenon under investigation, consistent with IPA's idiographic orientation [27].

Eligible participants were required to: (i) be the biological mother of a daughter with a psychiatrist-confirmed psychiatric diagnosis; (ii) have at least two years of caregiving experience following the onset of the daughter's disorder; (iii) reside in Ardabil; and (iv) be willing and able to describe their experiences in Persian or Azerbaijani Turkish. Psychotic-spectrum disorders (e.g., schizophrenia) and mood disorders (e.g., bipolar I disorder or major depressive disorder with psychotic features) were prioritized. Mothers were excluded if they had an acute psychiatric condition themselves, if continued participation was judged likely to cause substantial psychological distress, or if their daughter did not have a documented psychiatric diagnosis.

Potentially eligible mothers were identified through three referral pathways in Ardabil: welfare centers, hospitals with psychiatric wards, and counseling/psychological service centers. Professionals familiar with the relevant clinical records identified mothers who appeared to meet the eligibility criteria and facilitated initial contact. Following preliminary agreement to participate, the researcher contacted each mother directly, explained the study, answered questions, and arranged the interview according to the participant's preferences and circumstances. All mothers who were referred, met the eligibility criteria, and were approached agreed to participate—the final sample comprised 10 mothers.

Recruitment continued until 10 in-depth interviews had been completed. Consistent with the study's recruitment procedure, the final three interviews were also considered in relation to the emerging data; no substantially new patterns relevant to the research question were identified, supporting the adequacy of the sample for the intended idiographic analysis. [27]

2.3. Data collection

Data were collected through one-to-one, in-depth, semi-structured interviews. The interview guide (supplementary file 2) followed IPA principles and served as a flexible framework rather than a fixed questionnaire [27]. Interviews began with a broad, open question inviting participants to describe their experience in their own words: “When did you first realize that your daughter was not like before? Can you tell me how you remember those early days, the first signs, the process of diagnosis, and how this affected you?”

Subsequent questions were adapted to each participant's account. They explored the recognition of changes in the daughter, diagnosis and treatment, everyday caregiving, hospitalization, family relationships, maternal identity and role, responses from others, and the mother's understanding of her own experience. Prompts such as "Could you tell me more about that?" and probes such as "When you use this word, what does it mean for you?" encouraged elaboration and exploration of personally meaningful experiences.

Three interviews were conducted face-to-face, three by telephone, and four through synchronous online voice calls, according to participants' preferences and circumstances. The three face-to-face interviews were conducted in private rooms in quiet settings agreed upon with the participants. Only the researcher and participant were present. Telephone and online interviews were conducted at times and in settings selected by participants to facilitate privacy and minimize interruptions. Each interview lasted approximately 45–90 min. All interviews were audio-recorded with

participants' consent. Following each interview, the researcher recorded reflective notes concerning the context of the interview, emotional responses, and initial impressions. Recordings were transcribed verbatim, with relevant paralinguistic features, including prolonged pauses, crying, laughter, and notable changes in tone, documented where appropriate. Transcripts were anonymized before analysis. No repeat interviews were conducted.

2.4. Data analysis

Data analysis followed the IPA framework described by Smith et al. [27]. The first author conducted the analysis primarily and proceeded idiographically, fully analyzing each case before moving to the next.

For each transcript, the researcher first listened repeatedly to the corresponding audio recording and read the transcript several times to become familiar with the participant's account. Exploratory notes were then developed at descriptive, linguistic, and conceptual levels, focusing respectively on the content of the account, the participant's use of language, and possible underlying meanings. These notes were developed into concise experiential statements capturing significant aspects of each participant's account [27, 29]. We then examined relationships among experiential statements, including convergence, divergence, similarity, and difference. Related statements were clustered into personal experiential themes (PETs) and subthemes, and emerging interpretations were repeatedly checked against the original transcript to remain grounded in the participant's account. This process was completed independently for each participant before moving to the next case, preserving IPA's idiographic commitment. After analyzing all 10 cases, PETs were compared across participants to identify group experiential themes (GETs), while retaining meaningful similarities and differences between individual accounts [27].

MAXQDA version 2024.4.1 was used to organize transcripts, exploratory notes, coding, and thematic structures and to maintain an auditable record of the analytic process. The software served as an organizational tool; the researcher remained responsible for interpretation and theme development.

2.5. Quality, rigor, and reflexivity

The first author, a female final-year Master's student in Clinical Psychology, conducted the interviews and primary analysis and received training in qualitative interviewing from her academic supervisor. She had no prior formal clinical employment experience. The researcher maintained reflexive notes on personal assumptions, emotional responses, and emerging interpretations throughout data collection and analysis. Consistent with IPA's interpretative orientation, reflexivity was treated as an ongoing process of examining the researcher's influence on interpretation rather than an attempt to eliminate prior assumptions [27].

Methodological quality was considered in relation to the criteria of Lincoln and Guba [30] and Yardley's principles for qualitative research [31], including sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance. The researcher engaged extensively with the recordings and transcripts through repeated listening, reading, and iterative analysis. The two academic supervisors reviewed aspects of the coding and thematic structure throughout the analytic process and critically discussed alternative interpretations. In addition, three participating mothers were presented with the preliminary themes and invited to comment on whether the interpretations reflected their experiences; their feedback informed refinement of the thematic structure. We maintained an audit trail from the original recordings and transcripts through exploratory notes, coding, and the final thematic structure. Detailed contextual information and

participant quotations supported transparency and allowed readers to assess the relevance of the findings to comparable contexts [30, 31].

2.6. Ethical considerations

The Research Ethics Committee of Islamic Azad University, Ardabil Branch, approved the study (approval number IR.IAU.ARDABIL.REC.1405.25). Before participation, mothers were informed about the study aims, procedures, voluntary nature of participation, confidentiality, and audio recording. We obtained written and oral informed consent from all participants. Participants were told they could decline any question or withdraw at any time without consequence. Interview timing and format were arranged according to their preferences. Given the sensitive nature of the topic, we paid particular attention to participants' emotional responses. When participants expressed statements reflecting hopelessness or a wish to die, the interview was paused or discontinued when necessary. Information about available psychological support services was provide (123 and 1480), and their psychological wellbeing was followed up 24–48 h later if significant distress had emerged. The team removed all identifying information from transcripts and study documents. The research team stored audio recordings and transcripts on a password-protected device accessible only to the team. The analysis and reporting used participant codes rather than names.

3. Results

This study included ten mothers of daughters living with severe mental illness in Ardabil, Iran (Table 1). Participants were aged 42–54 years (mean 49) and their daughters 20–33 years (mean 26). Educational levels ranged from basic literacy to master’s degree; half were homemakers. Six mothers were married, three widowed, and one separated. Daughters’ diagnoses included bipolar disorder (n = 4), schizophrenia (n = 2), major depressive disorder (n = 2), depression with anxiety

(n = 1), and bipolar disorder with mild intellectual disability (n = 1). Eight daughters had a history of psychiatric hospitalization and five had a history of suicide attempts.

Table 1. Demographic and Clinical Characteristics of Participants

ID	Mother's age	Education	Occupation	Marital status	Daughter's age	Daughter's diagnosis	Age at diagnosis	Suicide attempt	Psychiatric hospitalization
M1	45–50	Master's degree	Accountant	Married	20–25	Bipolar disorder	17	Yes	Yes
M2	40–45	High school diploma	Homemaker	Married	20–25	Major depressive disorder	13	No	No
M3	45–50	High school diploma	Homemaker	Married	20–25	Major depressive disorder	20	Yes	Yes
M4	50–55	High school diploma	Tailor	Separated	25–30	Schizophrenia	20	No	Yes
M5	50–55	Bachelor's degree	Schoolteacher	Widowed	30–35	Schizophrenia	23	Yes	Yes
M6	50–55	Adult literacy program	Homemaker	Widowed	30–35	Bipolar disorder	13	No	Yes
M7	45–50	Middle school	Former hairdresser	Widowed	20–25	Bipolar disorder + ADHD	16	No	Yes
M8	45–50	Bachelor's degree	Engineer	Married	25–30	Bipolar disorder	17	Yes	Yes
M9	50–55	Master's degree	Homemaker	Married	25–30	MDD with anxiety	16	Yes	Yes
M10	50–55	High school diploma	Homemaker	Married	25–30	Bipolar disorder + mild ID	7	No	Yes

Note. ADHD = attention-deficit/hyperactivity disorder; ID = intellectual disability; MDD = major depressive disorder; Ages are presented as ranges to protect participant anonymity.

Three group experiential themes (GETs) were constructed from the analysis, each elaborated through four subthemes (Table 2): the Palimpsest of Motherhood, Maternal Stigma, and the Labyrinth of Temporality. Together, these themes describe how the onset of a daughter's psychiatric illness reorganized participants' sense of self, their position within their social world, and their relationship to time.

Table 2. Group Experiential Themes and Subthemes

Theme	Subtheme
Palimpsest of Motherhood	From a single maternal role to unsustainable multiplicity
	From an autonomous self to a fused identity
	From conventional mothering to survival amid perpetual crisis
	From ease to embodied and psychosomatic turmoil
Maternal Stigma	Reflected stigma: the daughter's illness as maternal failure
	Living with stigma: self-censorship and fear of disclosure
	Confronting stigma: concealment, defensive isolation, and choosing the lesser shame
	Expanding stigma: familial and phygital stigma
Labyrinth of Temporality	Ruptured time: a bifurcated existence before and after the crisis
	Invaded time: a present saturated with catastrophic futures
	Foreclosed time: acquired non-expectation as a survival strategy
	Suspended time: mourning a lost future

3.1 The Palimpsest of Motherhood

A palimpsest is a manuscript whose original text has been scraped away so the surface can be reused, yet the earlier writing remains faintly visible beneath the new script. This image captures what happened to participants' sense of their own role. An earlier text—an intuitive, nurturing

motherhood oriented toward a daughter's growth and eventual independence—was forced into erasure under the cumulative weight of chronic crisis. In its place, a functional, institutional, and permanently vigilant form of caregiving was written, though traces of the earlier text persisted as guilt, longing, and comparison with a former self.

3.1.1. From a single maternal role to unsustainable multiplicity

Across the sample, mothering shifted from a single, largely intuitive bond into a set of discrete functional roles performed simultaneously and without relief. M1 described this fragmentation in her professional vocabulary: "*It's really hard. I'm supposed to be a doctor one moment, a police officer the next, a disciplinarian after that, a bank manager after that. I can't play all these roles at once,"* adding that returning home meant becoming "a counselor, a psychiatrist" before she could rest. M8 contrasted this with clinical professions: *"A doctor or a nurse can watch a hundred patients die and still go home to an ordinary life once the shift ends. My shift never ends."* For M4, mothering had reduced to bare maintenance: *"Right now, being a mother means keeping her alive and getting through one more day." Several mothers also described becoming a buffer between their daughter and a critical spouse or extended family—a role M1 called being "a shield."*

3.1.2. From an autonomous self to a fused identity

For most participants, the boundary between mother and daughter gradually dissolved. M9 stated this fusion without qualification*: "My entire being has become this child."* M6 described it more viscerally: *"When she's doing well, I feel like the world is mine… when she's upset, I'm upset… it felt like both of us aged at once."* This blurring extended into daily routine; M10 once addressed her healthy daughter by her ill daughter's name, explaining, *"what difference does it make, in my heart I was already talking to her."* M4 summarized the totalizing character of this identification: *"Once you become a mother, you are always a mother."*

3.1.3. From conventional mothering to survival amid perpetual crisis

Several mothers described an unchosen shift from fostering growth to averting catastrophe. M9 summarized this reversal: *"I used to think I had to teach my daughter to fly. Now all I try to do is stop her from throwing herself off the roof."* M8 captured permanent emergency care: *"It's like my whole life turned into an emergency room… I had to stay on constant standby."* For M7, vigilance took concrete form—locking the front door and hiding the key, then checking it upon return. M3 described the accompanying erosion of trust: *"I felt like I didn't recognize my own child anymore, and I was afraid of her… but you love your child like breathing."*

3.1.4. From ease to embodied and psychosomatic turmoil

Traces of the earlier self-persisted in the body. Several mothers reported chronic physical symptoms linked to caregiving strain. M10 described: *"My own body took a hit… the stress gave me intestinal problems, an ulcer. I feel like my skin is peeling off me."* M8 offered a comparable account: "*My muscles just tighten… breathing becomes difficult… it's like the light behind my eyes dims."* M1 used the image of physical weight: "*There's a hundred-kilo stone that's always on my shoulder, or on my chest."* Guilt also persisted; M1 reasoned, *"if the numbers don't balance, the result is wrong… I blame myself."*

3.2. Maternal Stigma

Mothers consistently described their social world less as a source of support than as a site of continuous surveillance and judgment. This experience unfolded across four related patterns: its reflection back into the mother as personal failure, the chronic self-censorship required to live with it, the active strategies mothers used to confront it, and its extension beyond the mother into wider family and online life.

3.2.1. Reflected stigma: the daughter's illness as maternal failure

Others frequently read a daughter's illness as evidence of maternal failure. M2 named this mechanism: *"They don't say she lacks willpower—they say, what did her mother teach her?"* M1 reported near-identical accusations from her husband*: "he keeps coming back to it, that I'm the reason for all of this."* M9 generalized the surveillance: *"I don't even call them family anymore, I call them inspectors… every time I go out, I'm afraid of who's going to see me and start talking."*

3.2.2. Living with stigma: self-censorship and fear of disclosure

Self-censorship became a near-universal strategy. M1 described travelling to Tehran rather than being seen taking her daughter to a local psychiatrist, calling herself *"the biggest liar in Ardabil" who performs "a show every single day.*" She added: *"It's like living with a bomb that could go off any moment."* M2 used a visual metaphor: *"it's like I've set up a storefront that looks nice from outside, but I know it's empty inside."*

3.2.3. Confronting stigma: concealment, defensive isolation, and choosing the lesser shame

Responses varied. M5 adopted a defensive boundary: "*I drew a line around all of them… I've grown thick skin… Let them say whatever they want."* Several mothers whose daughters had been hospitalized described the decision through a calculus of comparative shame. M6 explained: *"I feel at ease knowing she's there… someone might kidnap her off the street… there, at least she gets a meal and stays alive."* M7 offered a similar justification centered on neighbors*: "if I keep her home… eventually the whole street will be talking."*

3.2.4. Expanding stigma: familial and phygital stigma

Stigma spread beyond the household. M3 reported that relatives generalized the illness into a hereditary flaw*: "they say madness runs in your family."* The same surveillance migrated online; M1 described hostile responses even from users who identified as progressive, and searching for

other mothers only to find further silence, experienced as *"one more source of pain."* M8 avoided posting any photograph of herself, reasoning that any image would be read as evidence of a hidden difficult life.

3.3. The Labyrinth of Temporality

For these mothers, the temporal structure of everyday life was itself disrupted. Four related patterns describe this altered relationship to time: a rupture between a before and an after; a present invaded by imagined future disaster; a foreclosure of expectation as a coping strategy; and an ongoing, unresolved mourning for a future that will not arrive.

3.3.1. Ruptured time: a bifurcated existence before and after the crisis

Mothers frequently narrated their lives as split into two periods, returning repeatedly to the past in search of explanation. M1, despite a biological view of illness, still returned to self-blame*: "I know it's an illness, but I still constantly blame myself… and I can't even locate what it was."* M8 described ongoing rumination fed by her husband's recriminations, listing competing hypotheses. Years of unresolved searching also eroded trust in the health system; M7 recalled being told for years that her daughter merely had a low IQ.

3.3.2. Invaded time: a present saturated with catastrophic futures

For some mothers, the future became a field of continuous anticipated threat. M1 listed possible disasters and noted that even neutral events, such as her salary arriving, had become tinged with dread*: "what good is money if my daughter isn't well?"* She closed with an image of total impasse: *"I can't die, and I can't stay with my daughter either; I can't lose my mind, and I can't stay sane."* M3 feared for her own physical safety after a threat of violence. M10 described a permanent alert state: *"I'm in a state of stress every moment, worrying she'll slip away."*

3.3.3. Foreclosed time: acquired non-expectation as a survival strategy

Other mothers responded by consciously extinguishing expectation. M5 described this stance calmly: *"I've let go of all of it for my daughter, marriage, the future, a career… Every day, as long as no new disaster comes, is enough."* M8 reframed her standard of comparison with therapeutic help: *"I stopped comparing myself to other people… now I only compare myself to who I was last week."* M4 expressed a wish to become invisible: *"the biggest favor anyone could do for me is simply not to see me."*

3.3.4. Suspended time: mourning a lost future

Underlying these patterns was unresolved grief for a future that would never arrive. M1 offered the most resonant image*: "it's like I'm carrying my daughter's corpse alone, and I'll never reach her grave to bury it."* M3 enumerated the loss as a litany of absent pleasures*: "Food? No. Shopping? No… Getting married? No. She doesn't enjoy anything anymore."* Several mothers described a further, more difficult layer—privately wishing for their daughter's death before their own so she would not be left unprotected. M1 admitted this thought with guilt: *"sometimes I think, I wish she would die first… then I feel disgusted with myself."* M10 voiced a similar prayer: *"God… take her before me… I don't want her left waiting."*

4. Discussion

This study explored how mothers of daughters with severe mental illness in Ardabil, Iran, made sense of their caregiving experience through an interpretative phenomenological lens. Three group experiential themes were constructed: the Palimpsest of Motherhood, Maternal Stigma, and the Labyrinth of Temporality. Rather than discrete difficulties, these themes capture interlocking transformations in identity, social positioning, and lived time. Consistent with IPA, interpretation involved a double hermeneutic: mothers made sense of their experiences, and the researcher sought

to make sense of that meaning-making [27]. The findings therefore offer an interpretation of how chronic mother–daughter caregiving reshaped participants' sense of self and world.

The Palimpsest of Motherhood extends accounts of maternal identity development, including Mercer's framework [24], by suggesting that maternal identity under chronic psychiatric caregiving may remain perpetually under revision rather than reaching a stable endpoint. Mothers described accumulating institutional roles (nurse, psychiatrist, security guard, financial manager) that echo McAuliffe et al.'s [5] findings among parents of adults with schizophrenia. However, whereas older parents in that study rarely framed their experience as "burden," the present, younger mothers repeatedly described burden, failure, and an endless "shift." This contrast may reflect differences in caregiving stage, with these mothers experiencing ongoing crisis more acutely. The palimpsest metaphor moves beyond conventional caregiver-burden models [32, 33], which conceptualize burden as accumulated strain. Here, each new demand overwrote but did not erase earlier maternal identities, leaving previous versions of the self-embedded within an increasingly complex caregiving identity. The dissolution of mother–daughter boundaries also diverged from Armitage et al.'s [34] finding of reduced closeness; rather than distancing, mothers described fusion. This may reflect the severity of psychotic-spectrum and mood disorders alongside cultural expectations of maternal responsibility and enmeshment [15]. Somatic experiences—gastrointestinal symptoms, chest pressure, disrupted sleep—further indicate that strain was embodied, with physical suffering intertwined with the meaning of mothering itself.

Maternal Stigma shows that the social consequences of illness were experienced through a distinctly gendered moral lens. Consistent with courtesy-stigma theory [19, 20], mothers were evaluated through their daughters' illness. However, stigma functioned as a specifically maternal indictment, interpreted by relatives, spouses, and community members as evidence of maternal

inadequacy. This builds on Akbari et al.'s [35] documentation of stigma in Iranian families by highlighting a gendered allocation of responsibility: mothers, more than fathers, became the primary social bearers of the daughter's illness. From a Goffmanian perspective, this constitutes a relational form of "spoiled identity" [19], in which the diagnosis contaminated the mother's social identity through the mother–daughter bond. Anticipated stigma [20] generated concealment and self-censorship consistent with Martin et al.'s [36] work on parental shame, but here these responses involved sustained management of information, relationships, and self-presentation. Responses were not uniform: some mothers practiced active self-censorship, others established firmer boundaries, illustrating IPA's idiographic variation.

Contrary to Enkoyee et al.'s [37] account of resilience through peer contact, mothers more often avoided peers and sometimes used hospitalization partly to protect family reputation. The cultural salience of āberu (social honour) thus shapes stigma management in ways insufficiently captured by resilience models from other contexts. Stigma also extended into social-media environments, indicating that affiliate stigma now operates across physical and digital ("phygital") domains not yet fully represented in existing frameworks.

The Labyrinth of Temporality reframes caregiving distress as a disturbance of lived time rather than solely of mood or coping [38, 39]. Mothers repeatedly returned to the past seeking causal explanations, echoing retrospective self-blame noted by Armitage et al. [34] and McAuliffe et al. [5], while also reinterpreting earlier events through the present crisis. In phenomenological terms, lived time forms an interconnected horizon of past, present, and future [39]. Anticipated relapse, hospitalization, harm, or abandonment after the mother's death entered the present as ongoing possibility, consistent with research on unpredictability as a chronic stressor [40]. Some mothers responded by narrowing expectations to short-term stability. The findings also resonate with

ambiguous loss [41], in which the loved one remains physically present while the anticipated future is lost, and with anticipatory or "future" grief for unrealized possibilities. Limited family-centered mental health support in Iran [26, 42] may intensify this experience by leaving mothers to manage future crises largely alone.

Taken together, the three themes form a self-reinforcing process: continual revision of maternal identity heightens vulnerability to social judgement; anticipated judgement encourages concealment and vigilance; and this vigilance further reshapes experience of time, expectation, and hope. The findings therefore move beyond quantitative burden frameworks toward an account of how chronic psychiatric caregiving alters a mother's sense of self, social identity, and temporal horizon. Clinically, support should extend beyond generic psychoeducation to address somatic strain, maternal blame, and confidential peer- or family-centered help, culturally adapted to local understandings of *āberu*, maternal responsibility, and gendered caregiving. At the same time, IPA's interpretative and context-bound nature means these findings should be read as situated accounts of meaning rather than universal representations; this scope should be considered alongside the methodological limitations discussed below.

4.1. Limitations

Consistent with IPA's idiographic focus, the sample of ten mothers from Ardabil enabled in-depth analysis but limits statistical generalizability; transferability depends on contextual resonance. Recruitment through clinical services and prioritization of severe diagnoses may exclude different caregiving experiences. Translation from Persian/Azerbaijani Turkish into English involved interpretive decisions that may have attenuated certain nuances. Although reflexivity, supervisory review, and member-checking were employed, the double hermeneutic remains an active

interpretative process. The cross-sectional design captures a single point in the caregiving trajectory; longitudinal work could examine how these themes evolve.

5. Conclusions

This IPA study revealed that mothers of daughters with severe mental illness in Ardabil experience interlocking transformations in identity (Palimpsest of Motherhood), social positioning (Maternal Stigma), and lived time (Labyrinth of Temporality). Chronic caregiving does not merely add burden; it rewrites maternal identity, exposes mothers to gendered moral judgement, and disrupts temporal experience. Clinically, support should move beyond generic psychoeducation to address somatic strain, maternal self-blame, and the cultural management of āberu through confidential, mother-centered, and family-oriented interventions. The findings offer a situated account of meaning-making that can inform culturally attuned practice and future longitudinal research.

List of abbreviations

ADHD: Attention/Hyperactivity Disorder

COREQ: Consolidated Criteria for Reporting Qualitative Research

GETs: Group Experiential Themes

ID: Intellectual Disability

IPA: Interpretative Phenomenological Analysis

MDD: Major Depressive Disorder

PETs: Personal Experiential Themes

WHO: World Health Organization

Declarations:

Ethics approval and consent to participate

The Research Ethics Committee of Islamic Azad University, Ardabil Branch, approved the study (approval number IR.IAU.ARDABIL.REC.1405.25). We obtained informed consent from all participants after explaining the study's aims, their right to withdraw at any time without consequences, and their option to choose a suitable method, time, and location for interviews upon request.

Consent for publication

Not applicable.

Availability of data and materials

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Competing interests

The author(s) declared no potential conflicts of interest concerning this article's research, authorship, and publication.

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AI usage declaration

During the preparation of this work, the author(s) utilized OpenAI's ChatGPT to enhance the language and structure of the manuscript. Following the use of this tool/service, the author(s) reviewed and edited the content as necessary and take full responsibility for the publication's content.

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