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Lived Experiences of Early Postpartum Mood Changes: A Narrative Phenomenological Study from South India

Saranya T.S

saranya.t.sathish@gmail.com

Head of the Institute, Amity University Bengaluru

Nandana Prajith

Amity University Bengaluru

G Aswin

Amity University Bengaluru

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Abstract

Background:
The early postpartum period is characterized by significant biological, psychological, and social transitions. While postpartum blues are considered common, persistent mood changes may remain unrecognized within routine obstetric care. Understanding women's lived experiences of early postpartum emotional adjustment is essential for improving maternal mental health integration in postnatal services.

Methods:
This qualitative study employed a narrative phenomenological design to explore the lived experiences of women who perceived persistent mood changes within 4–8 weeks after delivery. Five postpartum women were recruited through community networks in South India. In-depth, semi-structured interviews were conducted in participants' households and transcribed verbatim. Descriptive screening using the Edinburgh Postnatal Depression Scale was performed to contextualize symptom range. Data were analyzed using interpretative narrative phenomenological methods to identify shared themes across cases.

Results:
Four superordinate themes emerged: (1) emotional turbulence framed as biological normalcy, (2) fragmented sleep as an amplifier of emotional vulnerability, (3) emotional suppression within familial and cultural expectations, and (4) identity reorganization accompanied by maternal ambivalence. Participants frequently normalized distress as hormonal change and reported limited structured inquiry regarding emotional well-being during postnatal visits. Sleep disruption and sociocultural expectations significantly shaped emotional expression. Ambivalence toward identity transition coexisted with strong maternal attachment.

Conclusion:
Early postpartum mood changes are experienced as complex biopsychosocial processes rather than discrete psychiatric conditions. Emotional distress may remain normalized and underarticulated within clinical settings. Integrating structured emotional screening and culturally sensitive dialogue into routine obstetric care may enhance early identification and support for postpartum women.

Introduction

The postpartum period is widely recognized as a time of profound biological transition, psychological reorganization, and social role adjustment. Although childbirth is frequently framed within cultural narratives of joy, fulfillment, and maternal completion, empirical evidence consistently demonstrates that the early weeks following delivery are also marked by heightened emotional vulnerability (O'Hara & Wisner, 2014). Mood disturbances during this period exist along a continuum ranging from transient "postpartum blues" to clinically significant postpartum depression (PPD) and, in rare cases, postpartum psychosis (Stewart & Vigod, 2016). While postpartum blues affect up to 70–80% of women and typically

resolve within two weeks, postpartum depression is more persistent and impairing, with global prevalence estimates ranging from 10% to 20% (Shorey et al., 2018; Woody et al., 2017). In low- and middle-income countries, prevalence estimates are often higher, with Indian studies reporting rates between 11% and 26%, depending on the population and methodology employed (Upadhyay et al., 2017; Rathod et al., 2018).

Despite increasing epidemiological recognition, postpartum emotional disturbances remain underdetected in routine obstetric practice. In many clinical settings, postnatal consultations prioritize physical recovery—assessment of uterine involution, wound healing, lactation adequacy, contraception planning, and neonatal growth—while structured mental health screening may not be systematically implemented. The result is a substantial gap between prevalence and diagnosis, particularly in sociocultural contexts where emotional distress is normalized as a routine consequence of childbirth (Patel et al., 2002). Within India, where familial expectations and collectivistic norms strongly influence maternal roles, emotional struggles are often reframed as temporary “hormonal mood swings,” thereby minimizing the need for clinical evaluation.

Postpartum depression is characterized by persistent sadness, irritability, anhedonia, feelings of inadequacy, excessive guilt, sleep disturbances beyond infant-related awakenings, and impaired concentration (American Psychiatric Association, 2013). Importantly, maternal depression does not occur in isolation; it has cascading implications for infant attachment, breastfeeding continuity, cognitive development, and long-term emotional regulation in children (Field, 2010; Slomian et al., 2019). Early maternal withdrawal or inconsistent responsiveness has been associated with insecure attachment patterns and developmental vulnerabilities, underscoring the intergenerational impact of untreated maternal mood disorders. Consequently, understanding postpartum emotional experiences is not merely a psychological concern but a public health priority within obstetric and pediatric care systems.

Biological mechanisms underlying postpartum mood changes have been extensively investigated. Childbirth is accompanied by rapid and dramatic hormonal shifts, particularly the abrupt withdrawal of estrogen and progesterone following placental delivery (Bloch et al., 2003). These endocrine fluctuations interact with serotonergic and dopaminergic systems implicated in mood regulation. Alterations in hypothalamic–pituitary–adrenal (HPA) axis functioning, particularly dysregulated cortisol patterns, may further predispose susceptible women to depressive symptomatology (Glynn et al., 2013). Additionally, oxytocin—central to bonding and lactation—has been linked to affective stability, and disruptions in oxytocinergic pathways may influence emotional adaptation in the postpartum phase (Stuebe et al., 2013). However, biological explanations alone do not fully account for the heterogeneity of postpartum experiences. Many women undergo similar hormonal changes without developing depression, suggesting that psychosocial and contextual variables significantly moderate risk.

Sleep deprivation constitutes another critical factor influencing postpartum emotional regulation. New mothers commonly experience fragmented sleep, frequent night awakenings, and circadian rhythm disruption. Sleep disturbance has been robustly associated with impaired prefrontal cortical functioning,

diminished cognitive control, and increased amygdala reactivity, all of which contribute to heightened emotional reactivity (Bei et al., 2015). Chronic sleep loss during the early postpartum period may therefore exacerbate vulnerability to mood disturbances, particularly among women with preexisting stressors or limited social support.

Sociocultural determinants play a central role in shaping postpartum emotional experiences, especially in collectivistic societies such as India. The postpartum period often involves relocation to the maternal home, increased involvement of extended family members, and adherence to traditional confinement practices. While such customs may provide instrumental support, they can also intensify interpersonal tensions, reduce maternal autonomy, and amplify expectations regarding caregiving competence (Chandra et al., 2002). Gender preference for the newborn, particularly in certain sociocultural settings, may further influence maternal emotional adjustment (Patel et al., 2002). Women who perceive dissatisfaction from family members regarding the infant's sex may experience heightened self-blame and distress.

Furthermore, the cultural construction of motherhood as inherently fulfilling can generate internalized pressure to conform to ideals of selfless devotion and constant happiness. When lived experiences diverge from these expectations—manifesting instead as fatigue, irritability, ambivalence, or emotional numbness—women may interpret their feelings as personal failure rather than as understandable responses to physiological and situational stressors. Such internalization may inhibit help-seeking behavior, particularly in contexts where mental health stigma remains prevalent (Rathod et al., 2018).

Screening tools such as the Edinburgh Postnatal Depression Scale have significantly advanced the detection of postpartum depressive symptoms in both research and clinical settings (Cox et al., 1987). The EPDS is widely used in India and internationally due to its brevity, sensitivity, and focus on affective symptoms rather than somatic complaints that may overlap with normal postpartum recovery. Nevertheless, quantitative screening instruments, while indispensable for epidemiological estimation and risk identification, may not fully capture the nuanced, subjective meanings that women attribute to their emotional experiences. Standardized measures quantify symptom severity but do not explore how women interpret mood changes, negotiate identity shifts, or reconcile personal distress with sociocultural expectations.

Qualitative methodologies offer complementary insight into these lived experiences. Phenomenology, grounded in the philosophical traditions of Edmund Husserl and later expanded by scholars such as Heidegger and Ricoeur, emphasizes the exploration of subjective experience as it is consciously perceived and interpreted (Smith et al., 2009). Narrative phenomenology, in particular, foregrounds storytelling as a means through which individuals construct meaning around life transitions. The postpartum period represents a profound existential transformation: women renegotiate bodily autonomy, relational dynamics, temporal rhythms, and self-identity in the context of new maternal responsibilities. Emotional changes cannot be fully understood outside this broader narrative reconstruction of self.

Existing qualitative research on postpartum depression has identified themes such as loss of control, isolation, identity confusion, and perceived inadequacy (Beck, 2002; Hall, 2006). However, much of this literature originates from Western contexts. Cultural norms, healthcare access, familial structures, and gendered expectations differ substantially across settings, limiting the generalizability of findings to Indian populations. Within India, qualitative studies remain comparatively sparse, particularly those examining early postpartum mood changes among women who may not meet full diagnostic criteria for depression but perceive persistent emotional disturbances. This gap is clinically significant because many women experiencing subthreshold symptoms may not seek psychiatric consultation yet continue to experience considerable distress.

The boundary between postpartum blues and postpartum depression is often indistinct in everyday discourse. While postpartum blues typically resolve spontaneously within two weeks, some women describe lingering emotional instability that neither fits the transient profile of blues nor meets formal diagnostic thresholds for major depressive disorder. These ambiguous experiences may be especially vulnerable to dismissal within healthcare settings. Obstetric consultations, constrained by time and focused on physical recovery, may not facilitate open exploration of emotional concerns. Women may hesitate to articulate distress unless directly prompted, and even then may minimize symptoms to avoid appearing “weak” or “ungrateful.”

Understanding how women narrate their postpartum emotional journeys can illuminate the subtle processes through which distress becomes normalized, silenced, or reframed. Narrative inquiry enables exploration of temporal sequencing—how women describe the onset, progression, and fluctuation of mood changes—and relational dynamics, including interactions with spouses, mothers-in-law, and healthcare providers. Such insights have practical implications for obstetricians and gynecologists, who are often the primary healthcare contact during the perinatal period. By appreciating the subjective dimensions of emotional adjustment, clinicians may become better equipped to initiate sensitive conversations and integrate mental health screening into routine care.

In the Indian healthcare context, where mental health resources may be unevenly distributed and stigma persists, obstetricians occupy a pivotal role in early detection. Integrating qualitative evidence into obstetric practice supports the movement toward holistic maternal care that encompasses both physical and psychological well-being. Journals such as The Journal of Obstetrics and Gynecology of India increasingly emphasize the importance of maternal mental health within obstetric discourse, recognizing that perinatal outcomes extend beyond biomedical parameters.

The present study adopts a narrative phenomenological approach to explore the lived experiences of women who perceived persistent mood changes during the early postpartum period. Rather than seeking to estimate prevalence or quantify symptom severity, this inquiry aims to understand how women interpret emotional shifts, attribute causality, negotiate social expectations, and construct meaning around their transition to motherhood. By focusing on women’s narratives within the first six

weeks after delivery, the study situates emotional experiences within the immediate context of hormonal changes, sleep disruption, and evolving familial roles.

Through in-depth interviews, this research seeks to illuminate the experiential textures that often remain unarticulated in quantitative surveys. It aims to identify recurring narrative patterns, emotional metaphors, and relational themes that characterize early postpartum mood changes. The findings are intended to inform obstetric practice by highlighting areas where clinical conversations may be expanded, screening protocols strengthened, and psychosocial support integrated. Ultimately, understanding postpartum emotional experiences from the perspective of women themselves is essential for developing compassionate, culturally sensitive, and clinically responsive maternal healthcare systems.

Methodology

Study Design

This study employed a qualitative design grounded in narrative phenomenology to explore the lived experiences of women who perceived persistent mood changes during the early postpartum period. Narrative phenomenology emphasizes the interpretation of subjective experience as constructed through personal storytelling and meaning-making processes (Smith et al., 2009). This approach was chosen to capture the depth, temporal unfolding, and contextual embeddedness of postpartum emotional experiences rather than to quantify symptom severity.

The study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines to ensure methodological rigor and transparency (Tong et al., 2007).

Study Setting

The study was conducted in a community-based setting in South India. Participants were recruited through informal community networks and referrals from local healthcare providers. All interviews were conducted in the participants' households to facilitate comfort, privacy, and contextual immersion within their lived environments. Conducting interviews in the home setting allowed for a deeper understanding of the sociocultural and familial dynamics influencing postpartum emotional experiences.

Interviews were scheduled at times convenient to participants, typically when infants were resting, to minimize interruptions and ensure focused engagement. A private space within the home was identified for each interview to maintain confidentiality. The household setting provided valuable contextual insight into caregiving arrangements, family involvement, and environmental stressors that may shape postpartum mood experiences.

Participants and Sampling

Inclusion Criteria

- Women aged 20–35 years
- Within 4–8 weeks postpartum
- Self-perceived persistent mood changes following delivery
- Able to provide informed consent
- Fluent in Malayalam or English

Exclusion Criteria

- History of major psychiatric disorder diagnosed prior to pregnancy
- Postpartum psychosis or severe psychiatric emergency
- Significant obstetric complications requiring intensive medical management

Purposive sampling was employed to recruit participants who could provide rich, experiential accounts of postpartum emotional changes. A total of five women were included in the study. The sample size was determined based on the principles of phenomenological inquiry, which prioritize depth and richness of narrative over numerical representation (Creswell & Poth, 2018). Data saturation was considered achieved when no substantially new thematic insights emerged from successive interviews.

Screening and Contextual Assessment

To contextualize emotional experiences, participants completed the Edinburgh Postnatal Depression Scale. The EPDS was used descriptively to indicate the range of depressive symptoms within the sample and not for diagnostic categorization. Scores were reported in aggregate to preserve confidentiality. Women scoring in the moderate to high range were provided with referral information for psychological consultation.

Data Collection Procedure

Interview Approach

Data were collected through in-depth, semi-structured narrative interviews. Participants were encouraged to describe their emotional journey beginning from childbirth to the time of interview. The guiding prompt was:

Can you walk me through your emotional experiences from the time you delivered your baby until now?

Follow-up probes explored:

1. Onset and progression of mood changes
2. Sleep patterns and fatigue
3. Breastfeeding experiences
4. Family and partner support
5. Feelings of guilt, inadequacy, or overwhelm
6. Interactions with healthcare providers
7. Help-seeking behavior

Each interview lasted between 45 and 75 minutes. Interviews were audio-recorded with consent and transcribed verbatim. Where interviews were conducted in Malayalam, transcripts were translated into English and back-translated to ensure semantic accuracy.

Researcher Reflexivity

The researcher is trained in psychology and qualitative research methods, and has conducted all interviews. Reflexive journaling was maintained throughout the study to document personal assumptions, emotional responses, and interpretative decisions. This process enhanced transparency and minimized researcher bias. Given the sensitive nature of postpartum experiences, efforts were made to establish rapport and create a non-judgmental space for disclosure.

Data Analysis

Data were analyzed using narrative phenomenological analysis inspired by interpretative phenomenological analysis (IPA) principles (Smith et al., 2009).

Step 1: Immersion

Transcripts were read multiple times to gain holistic understanding. Initial notes captured emotional tone, metaphors, and significant statements.

Step 2: Identification of Meaning Units

Significant statements reflecting emotional shifts, identity negotiation, relational tensions, and help-seeking experiences were highlighted. These were grouped into preliminary meaning units.

Step 3: Narrative Reconstruction

Each participant's story was reconstructed chronologically to understand the trajectory of emotional experience across the postpartum period.

Step 4: Thematic Development

Cross-case analysis was conducted to identify shared experiential themes. Themes were refined through iterative comparison, ensuring that they were grounded in participant narratives. Representative verbatim quotations were selected to illustrate each theme.

Trustworthiness and Rigor

To enhance credibility and rigor, the following strategies were employed:

- **Member Checking**: Participants were provided with summaries of their narratives for confirmation of accuracy.
- **Peer Debriefing**: Two independent qualitative researchers reviewed coding and thematic interpretations.
- **Audit Trail**: Detailed documentation of analytic decisions was maintained.
- **Reflexivity Journal**: Ongoing reflection on positionality and interpretive processes.

Transferability was supported through thick description of context and participant characteristics. Dependability was ensured through systematic documentation of data analysis procedures.

Ethical Considerations

Ethical approval

was obtained from the Institutional Ethics Committee of Amity Institute of Behavioural Health and Allied Sciences. Written informed consent was secured prior to participation. Participants were informed of their right to withdraw at any stage without affecting their medical care. Confidentiality was maintained through anonymization of transcripts and use of pseudonyms in reporting findings.

Given the potential sensitivity of emotional disclosures, participants exhibiting elevated EPDS scores or expressing significant distress were provided with referral information for mental health services. Immediate support resources were made available if required.

Positionality Statement

The researcher acknowledges that her background in psychology may influence interpretive engagement with participants' narratives. Conscious bracketing of pre-existing assumptions regarding postpartum depression was practiced to remain attentive to participants' lived meanings rather than imposing diagnostic frameworks.

Results

Five postpartum women between 4 and 8 weeks after delivery participated in the study. Participants ranged in age from 23 to 32 years. All described persistent mood changes following childbirth. Although none had received formal psychiatric consultation, EPDS screening indicated mild to moderate depressive symptom ranges. Participant characteristics (in pseudo names) are presented in Table 1.

Table 1
Participant Characteristics

Participant (Pseudonym)	Age (Years)	Parity	Mode of Delivery	Weeks Postpartum	EPDS Range	Living Arrangement
P1 – Ananya	26	Primiparous	LSCS	6	Mild	Joint family
P2 – Meera	29	Primiparous	Vaginal	5	Moderate	Joint family
P3 – Kavya	23	Primiparous	LSCS	4	Mild	Nuclear family
P4 – Divya	32	Multiparous	Vaginal	8	Moderate	Joint family
P5 – Nisha	28	Primiparous	LSCS	7	Mild	Nuclear family

Narrative phenomenological analysis generated four superordinate themes that reflect the layered emotional realities of early postpartum life.

Theme 1: Emotional Turbulence Framed as Biological Normalcy

Participants described the early postpartum period as emotionally intense, unstable, and unpredictable. Crying episodes emerged suddenly, often without identifiable triggers. Irritability, heightened sensitivity, and emotional overwhelm were recurrent experiences. However, these fluctuations were consistently contextualized—both by participants and by family members—as “just hormones.”

Rather than being recognized as distress signals, emotional experiences were reframed as inevitable biological consequences of childbirth. This framing created a paradox: while normalization reduced immediate alarm, it simultaneously invalidated deeper emotional struggles.

One participant stated:

I would cry even if the baby was sleeping peacefully. I didn’t know why. But everyone kept saying it’s because of hormones. So I thought maybe I should not make it a big issue.

Another described:

There were moments I felt empty… not sad exactly, but not happy either. Still, I told myself this is part of becoming a mother.

This theme reflects a process of **self-silencing through biological rationalization**. Emotional distress was absorbed into a cultural narrative that childbirth inevitably disrupts mood. The ambiguity between transient postpartum blues and more persistent emotional dysregulation remained unresolved in participants’ narratives.

Importantly, none of the women reported structured inquiry regarding emotional well-being during postnatal consultations. This absence reinforced the interpretation that emotional turbulence was expected and did not require clinical attention.

Theme 2: Fragmented Sleep as an Amplifier of Emotional Vulnerability

Sleep disruption was not described as a mere inconvenience but as a destabilizing force shaping daily emotional functioning. Participants narrated nights marked by repeated awakenings, anticipatory vigilance, and difficulty returning to sleep even during infant rest periods.

One mother explained:

Even when the baby slept, I couldn't sleep deeply. I was always alert, like something might happen.

Another reflected:

After many nights of broken sleep, small things started bothering me more than usual. I would react strongly and later regret it.

Participants linked sleep deprivation to irritability, tearfulness, reduced patience, and cognitive fog. Emotional reactivity was often described as disproportionate to triggers. Several women noted that daytime recovery sleep was limited due to household responsibilities, visitors, or caregiving expectations.

The narratives suggest that sleep fragmentation functioned as an **amplifier of existing vulnerability**, intensifying mood fluctuations and diminishing emotional regulation capacity. Fatigue was experienced both physically and psychologically, blurring the boundary between bodily exhaustion and emotional distress.

This theme highlights the interconnectedness of physiological disruption and affective instability in early postpartum adjustment.

Theme 3: Emotional Suppression Within Familial and Cultural Expectations

Participants described strong familial involvement in the postpartum period, particularly within joint family systems. While instrumental support—such as assistance with household tasks or infant care—was available, emotional validation was often limited.

The cultural script of joyful motherhood exerted subtle but powerful pressure. Participants expressed reluctance to voice distress for fear of appearing ungrateful or inadequate.

One participant shared:

Everyone was celebrating the baby. I felt if I said I was struggling, they would think I am not appreciating what I have.

Another stated:

If I cried, they said I am weak. So after some time, I stopped showing it.

Within some narratives, indirect comments—such as remarks about the infant's gender—contributed to internalized self-doubt.

Someone said next time it should be a boy. That comment stayed with me longer than I expected.

This theme reveals how postpartum emotional experience is embedded within relational and sociocultural structures. Distress was not only internally regulated but socially mediated. Emotional vulnerability was often concealed to maintain harmony and uphold expectations of maternal competence.

The absence of structured mental health dialogue within obstetric care further reinforced this silence. Participants did not recall being asked directly about emotional well-being during follow-up visits.

Theme 4: Identity Reorganization and Maternal Ambivalence

The transition to motherhood was described as transformative yet destabilizing. Participants articulated a profound shift in identity, routine, autonomy, and self-perception.

While affection and commitment toward the infant were consistently expressed, participants also described feelings of loss—particularly loss of independence, professional identity, and prior routines.

One participant stated:

Before delivery, I was working, going out, meeting friends. Now everything revolves around feeding and sleeping. I sometimes miss who I was.

Another shared:

I love my baby deeply. But sometimes I question if I am doing things correctly. I compare myself to other mothers.

Ambivalence was not framed as rejection of motherhood but as coexistence of joy and vulnerability. Participants navigated tension between societal expectations of effortless bonding and the lived reality of adjustment struggles.

Breastfeeding challenges, infant crying, and social comparison intensified self-doubt. The postpartum body was also described as unfamiliar, contributing to altered self-image.

This theme reflects a broader process of **identity renegotiation**, wherein emotional instability was intertwined with existential transition.

Cross-Theme Integration

Across narratives, postpartum mood changes did not emerge as isolated psychological symptoms but as interwoven experiences shaped by biological transitions, sleep disruption, relational dynamics, and sociocultural expectations. Emotional turbulence, initially framed as hormonally driven and therefore "normal," interacted with cumulative sleep deprivation to heighten irritability, tearfulness, and emotional reactivity. However, these internal experiences were simultaneously mediated by external relational contexts. Within family systems that emphasized maternal joy and resilience, participants often minimized or suppressed expressions of vulnerability, reinforcing ambiguity about the legitimacy of their distress.

The coexistence of affection for the infant and self-doubt about maternal competence further complicated emotional interpretation. Participants described deep attachment alongside feelings of inadequacy, fatigue, and loss of prior identity. This ambivalence was not experienced as rejection of motherhood but as part of an ongoing identity reorganization. Yet, without structured inquiry during postnatal healthcare encounters, these layered emotional states remained unarticulated within clinical spaces. The absence of direct questions regarding psychological well-being contributed to the normalization of distress and delayed consideration of professional support.

Taken together, the findings suggest that early postpartum mood changes are best understood as a biopsychosocial phenomenon, wherein physiological vulnerability, disrupted sleep architecture, cultural narratives of idealized motherhood, and shifting identity converge. Emotional distress was rarely labeled as "depression" by participants; rather, it was experienced as persistent yet socially contained turbulence within the broader transition to motherhood. This integration underscores the importance of proactive emotional screening within obstetric care, particularly during the early postnatal period when ambiguity regarding symptom severity is most pronounced.

Narrative phenomenological analysis involved iterative reading, coding, and cross-case comparison of participant transcripts. Through this process, recurring experiential patterns were identified and organized into four superordinate themes. These themes reflect shared structures of meaning across participants while preserving individual narrative depth. The thematic organization captures both the subjective emotional states described by participants and the contextual influences shaping those experiences.

An overview of the superordinate themes and their corresponding subthemes is presented in Table 2.

Table 2
Superordinate Themes and Subthemes

Superordinate Theme	Subthemes	Interpretive Insight
Emotional Turbulence Framed as Biological Normalcy	Crying, irritability, internal unrest	Distress minimized through hormonal explanation
Fragmented Sleep as Amplifier	Night vigilance, exhaustion, irritability	Sleep loss intensifies emotional reactivity
Emotional Suppression in Cultural Context	Pressure to appear joyful, lack of validation	Sociocultural mediation of vulnerability
Identity Reorganization	Loss of former self, maternal ambivalence	Transitional identity instability

As illustrated in Table 2, the themes collectively reflect a multidimensional experience of early postpartum emotional adjustment. While each theme represents a distinct experiential domain, they are deeply interconnected. Emotional turbulence was frequently rationalized through biological explanations, sleep disruption intensified affective instability, familial expectations mediated emotional expression, and identity reorganization shaped self-perception.

The thematic structure demonstrates that postpartum mood changes were not experienced as discrete symptoms but as evolving processes embedded within daily caregiving routines, relational environments, and sociocultural narratives of motherhood. The following sections elaborate each theme in detail, supported by verbatim excerpts from participant narratives.

To preserve the authenticity of participants' lived experiences, representative verbatim excerpts are presented alongside each identified theme. These excerpts were selected for their conceptual richness and clarity in illustrating the emotional meanings described by participants. While individual narratives varied in tone and intensity, the quotations reflect shared experiential patterns that informed thematic development.

Table 3 presents illustrative excerpts corresponding to each superordinate theme.

Table 3
Representative Verbatim Excerpts

Theme	Illustrative Quote
Emotional Turbulence	"I didn't know why I was crying, but they said it's just hormones."
Sleep Disruption	"My body was tired, but my mind wouldn't rest."
Emotional Suppression	"I stopped talking about how I felt."
Identity Transition	"I love my baby, but I don't feel like my old self."

As reflected in Table 3, participants' narratives reveal the layered complexity of early postpartum emotional adjustment. The quotations highlight how distress was often framed as hormonally inevitable, how sleep disruption amplified emotional reactivity, how sociocultural expectations constrained open expression of vulnerability, and how identity shifts generated ambivalence alongside maternal attachment.

Importantly, the excerpts demonstrate that participants did not explicitly label their experiences as depression; rather, they articulated emotional turbulence within the broader context of caregiving demands and relational expectations. These narrative expressions underscore the need for sensitive, structured inquiry into emotional well-being during postnatal care, as experiential distress may remain unspoken unless actively explored.

Summary

The expanded thematic analysis demonstrates that early postpartum mood changes are complex, layered, and frequently normalized within familial and healthcare contexts. Emotional vulnerability coexisted with maternal attachment and caregiving engagement. The absence of structured emotional screening during postnatal care contributed to ambiguity regarding help-seeking and symptom recognition.

Discussion

The present narrative phenomenological study explored the lived experiences of women who perceived persistent mood changes during the early postpartum period. The findings reveal that postpartum emotional changes were experienced not as discrete psychiatric symptoms but as layered, evolving experiences shaped by biological transitions, sleep disruption, sociocultural expectations, and identity renegotiation. The discussion below directly interprets each identified theme in relation to existing literature and obstetric practice.

Emotional Turbulence Framed as Biological Normalcy

Participants consistently described crying spells, irritability, and emotional heaviness that were attributed to "hormonal changes." This normalization reduced immediate alarm but simultaneously contributed to ambiguity regarding the seriousness of distress. The framing of emotional instability as a biological inevitability echoes existing literature suggesting that postpartum hormonal withdrawal—particularly abrupt declines in estrogen and progesterone—may contribute to mood reactivity (Bloch et al., 2003).

However, while endocrine shifts provide a physiological context, the present findings highlight how biological explanations can function socially to silence distress. When emotional changes are interpreted exclusively as transient hormonal phenomena, women may delay acknowledgment of persistent symptoms. This aligns with research indicating that postpartum depression is often

underrecognized in routine obstetric settings, particularly when symptoms are minimized as “normal adjustment” (O’Hara & Wisner, 2014).

Importantly, none of the participants reported structured inquiry into emotional well-being during postnatal visits. Although validated screening instruments such as the Edinburgh Postnatal Depression Scale are widely recommended (Cox et al., 1987), their implementation remains inconsistent. The absence of formal screening reinforces the normalization of distress observed in this study.

Fragmented Sleep as an Amplifier of Emotional Vulnerability

Sleep disruption emerged as a central experiential factor intensifying emotional instability. Participants described hypervigilance, difficulty returning to sleep, and cumulative fatigue that heightened irritability and emotional reactivity. Rather than functioning as an isolated symptom, sleep fragmentation appeared to amplify existing vulnerability.

This finding aligns with evidence linking postpartum sleep disturbance to increased depressive symptom severity (Goyal et al., 2009). Sleep deprivation is known to impair emotional regulation and increase sensitivity to stress (Bei et al., 2015). In the present study, participants described disproportionate emotional responses followed by guilt, suggesting a cyclical interaction between fatigue and self-criticism.

Importantly, daytime rest was often constrained by caregiving expectations and household responsibilities, particularly within joint family contexts. This suggests that sleep disruption in the postpartum period is embedded within social structures and not solely determined by infant feeding patterns. Clinically, routine obstetric consultations rarely include detailed assessment of sleep quality beyond infant care guidance. The findings indicate that addressing maternal sleep may represent an accessible intervention point within postnatal care.

Emotional Suppression Within Cultural and Familial Contexts

Participants described strong instrumental support from family members but limited emotional validation. The expectation that motherhood should be joyful contributed to suppression of distress. Emotional vulnerability was sometimes interpreted as weakness or ingratitude.

These findings are consistent with Indian research highlighting the influence of stigma and gendered expectations on postpartum mental health disclosure (Patel et al., 2002; Rathod et al., 2018). In collectivistic contexts, maintaining relational harmony may take precedence over individual emotional expression. As reflected in participants’ narratives, distress was often internalized rather than openly discussed.

Subtle comments regarding infant gender, though not overtly hostile, were experienced as emotionally salient. Such sociocultural pressures may compound self-doubt and emotional strain. Importantly, participants did not report being asked directly about their emotional state during medical follow-ups. Without structured inquiry, women navigating cultural expectations may be unlikely to initiate mental health discussions.

These findings underscore that postpartum emotional experiences are relationally mediated. Obstetric care that focuses exclusively on biomedical recovery may overlook these contextual dynamics.

Identity Reorganization and Maternal Ambivalence

The transition to motherhood was experienced as both meaningful and destabilizing. Participants expressed deep attachment to their infants alongside longing for aspects of their previous identity. This coexistence of affection and self-doubt reflects the complex process of identity reorganization during early motherhood.

Qualitative literature similarly describes motherhood as a period of identity reconstruction involving shifts in autonomy, routine, and self-perception (Beck, 2002; Hall, 2006). The present findings extend this understanding within an Indian sociocultural setting, where maternal roles may be strongly defined by family norms.

Importantly, ambivalence did not equate to impaired bonding. Rather, it reflected adjustment to new responsibilities and expectations. The participants' narratives challenge binary categorizations of "happy" versus "depressed" motherhood and instead reveal a nuanced continuum of emotional adaptation.

In clinical practice, recognizing identity-related vulnerability may prevent misinterpretation of ambivalence as pathology while still acknowledging emotional strain. Psychoeducation regarding normal transitional challenges may reduce self-blame and promote resilience.

Integrated Interpretation of Themes

Taken together, the themes suggest that early postpartum mood changes are best conceptualized as a biopsychosocial process. Biological shifts initiated emotional vulnerability; sleep disruption amplified instability; sociocultural expectations shaped emotional expression; and identity reorganization influenced self-perception. These domains interacted dynamically rather than operating independently.

Participants did not self-identify as depressed, yet described persistent emotional turbulence that extended beyond transient postpartum blues. The absence of structured emotional assessment within postnatal care contributed to ambiguity regarding symptom severity. This gap between lived experience and clinical inquiry highlights an opportunity for obstetric practice to integrate mental health screening more systematically.

Clinical Implications

The findings of this study underscore the need for greater integration of maternal mental health within routine obstetric care during the early postpartum period. Participants described persistent emotional turbulence that was frequently normalized as hormonal adjustment and seldom explored within postnatal consultations. Given that none of the women recalled being directly asked about their emotional well-being, incorporating structured psychological screening into standard follow-up visits may enhance early identification of distress. The routine use of validated instruments such as the Edinburgh Postnatal Depression Scale can provide a systematic framework for assessment while normalizing discussion of emotional health.

Beyond formal screening, obstetricians may consider incorporating direct yet empathetic inquiry regarding sleep quality, emotional fluctuations, perceived family support, and adjustment to maternal identity. The present findings indicate that sleep disruption significantly amplifies emotional instability; therefore, counseling regarding shared caregiving responsibilities and realistic sleep expectations may serve as a preventive intervention. Additionally, psychoeducation about the common yet complex emotional transitions associated with early motherhood may reduce self-blame and validate women's experiences of ambivalence.

Given the influence of sociocultural expectations on emotional disclosure, clinicians practicing in collectivistic contexts should recognize that women may hesitate to spontaneously report distress. Creating a confidential and non-judgmental space for discussion during postnatal visits may facilitate more open communication. Integrating mental health dialogue into routine obstetric care not only addresses individual well-being but may also strengthen maternal–infant outcomes by promoting early support and timely referral when necessary.

Limitations

The study's small sample size limits generalizability; however, the goal of phenomenological inquiry is depth rather than representativeness. The findings reflect experiences within a specific sociocultural and geographic context. Future research may incorporate longitudinal designs to explore how early postpartum emotional turbulence evolves over time.

Conclusion

This study demonstrates that early postpartum mood changes are experienced as complex, relationally embedded phenomena rather than discrete clinical entities. Emotional turbulence is often normalized, amplified by sleep deprivation, mediated by cultural expectations, and intertwined with identity reorganization. Integrating structured emotional screening and culturally sensitive dialogue within obstetric care may enhance early recognition and support for women navigating this vulnerable transition.

Declarations

Ethical Approval

The study was conducted in accordance with the ethical standards of the institutional research committee and the principles of the Declaration of Helsinki. Ethical approval was obtained from the Institutional Ethics Committee of Amity Institute of Behavioural Health and Allied Sciences, Amity University Bengaluru.

Informed Consent

Written informed consent was obtained from all participants prior to data collection. Participants were informed about the purpose of the study, voluntary nature of participation, confidentiality measures, and their right to withdraw at any stage without any impact on their medical care.

Consent for Publication

Participants provided consent for the use of anonymized narrative excerpts in academic publication. All identifying information has been removed to ensure confidentiality.

Availability of Data and Materials

The qualitative datasets generated and analyzed during the current study are not publicly available due to the sensitive nature of the interviews and confidentiality agreements but may be made available from the corresponding author upon reasonable request and subject to ethical approval.

Conflict of Interest

The author declares that there are no conflicts of interest related to this study.

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Author Contributions

The author S.T.S conceptualized, designed, supervised and validated the study, N.P and A.G conducted the interviews, performed data analysis, interpreted the findings, and prepared the manuscript.

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Clinical Trial Number

NA

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