

Exploring Facebook's Impact on Postpartum Depression Stigma among Survivors in Pakistan

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ABSTRACT

Aim of the Study: The aim of the study was to investigate the relationship between the use of Facebook by survivors of postpartum depression (PPD) in Pakistan with their stigma, emotional support, and help-seeking, and to determine whether the platform relieves or reinforces culturally specific stigma.

Methodology: A phenomenological design using a qualitative approach was used. Through purposive and snowball sampling, 18 women who had approximately less than 5 years of PPD diagnosis, had used Facebook in the last five years, underwent semi-structured interviews and participant-led Facebook walkthroughs. Reflexive thematic analysis (Braun and Clarke, 2006) was utilized and interpreted both inductively and deductively using the Social Support Theory (House, 1981).

Findings: According to the findings by survivors, Facebook was a highly conflicting space. Peer stories provided emotional validation and a common language to many, and the same platform showed them misinformation, idealised images of motherhood, and fear of their families spying on them. Social support and social learning processes were found to be key factors affecting stigma, and the quality and framing of online interaction resulted in either encouraging women to seek help or further forcing them into silence.

Conclusion: The research generated survivor-informed safer, culturally responsive Facebook-based interventions to reduce stigma. The results provide useful guidance to NGOs, clinicians, and policymakers operating in maternal mental health in Pakistan and imply that digital platforms can be useful in supporting recovery when developed with survivors in mind, but not towards them.

Keywords: Postpartum Depression, Perinatal Mental Health, Stigma, Facebook, Social Support, Pakistan.

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1. INTRODUCTION

1.1 Background

Postpartum depression (PPD) is a serious mood disorder in women in the weeks and months after childbirth, which is manifested by low mood that isn't going away, anxiety, irritability, loss of interest, and disrupted maternal-infant attachment (O'Hara and Wisner, 2014). The prevalence is estimated at 10-20 percent in high-income nations, whereas it's significantly greater in low- and middle-income nations, attributable to socioeconomic pressure, poor mental health care, and deep-rooted stigma. The prevalence is between 19 and 41 on record in Pakistan, and in rural environments, it's even higher (Padhani et al., 2024). The clinical and social cost is considerable: children of mothers without treatment have an increased risk of malnutrition, cognitive retardation, and emotional insecurity (Stein et al., 2014). Still, stigma regularly stops survivors to label their suffering or to obtain professional assistance.

1.2 PPD and stigma in Pakistan

Stigma around perinatal mental health can be defined as the mechanisms whereby the affected women are stereotyped, devalued and judged, dis-incentivizing disclosure and treatment. Corrigan et al. (2016) differentiate between three types of stigma: public, self, and structural each of them acquires a specific form in Pakistan because PPD is often denounced as a lack of strong faith, individual failure, or the inability to cope with giving birth instead of a disease (Ali et al., 2025). Honestly, male relatives, husbands, in-laws, and extended family tend to refer troubled women to spiritual solutions, as opposed to psychiatric assistance, which strengthens the silence and isolation.

The extent of the resulting treatment gap is proven by empirical evidence. According to Sajjad et al. (2024), in Punjab, a majority of symptomatic women (more than 90 percent) did not receive any formal care, and stigma was recognized as a key obstacle; the same study by Shahzad et al. (2025) showed that negative attitudes within the immediate support network decreased the probability of seeking help even in the presence of nominal support. The effects on generations are highly documented (Stein et al., 2014). It's in this context that digital platforms are presented as a controversial potential: Facebook groups can provide anonymity and peer support (Yuan et al., 2025), but unmoderated platforms might also spread misinformation that contributes to stigma (Yousef et al., 2020).

Baby Blues (Maternity Blues)

The most frequent and mild type of postpartum mood disorder is the maternity blues, which occurs in an estimated 50-75% of mothers during the first week of childbirth (Tosto et al., 2023). Symptoms mood swings, irritability, fatigue, tearfulness usually disappear in two weeks without treatment (O'Hara and Wisner, 2014). The baby blues is a known risk factor to other more severe disorders such as PPD and postpartum psychosis even though they're short-lived. This phenomenon isn't well understood in Pakistan; emotional changes are usually processed as usual adaptation, postponing the appearance of symptoms or even their growth (Bhatti et al., 2024). Since the culturally idealised motherhood is a time of unremitting happiness and strength, even temporary distress becomes personalised as guilt and shame (Shahzad, 2025).

Postpartum Anxiety

Another, often cooccurring aspect of maternal psychological distress is postpartum anxiety, which is characterized by hyper-worry, intrusive thoughts, sleep disturbance, and infant safety or maternal competence fears (O'Hara and Wisner, 2014). In Pakistan, families tend to hide such symptoms as they normalise post-birth emotional disturbance, spiritualise, or deny it, which further delays the acknowledgement and seeking of help (Jamshaid et al., 2023). Treating anxiety as well as depression, is thus a way of seeing the bigger picture of maternal mental health stigma.

1.3 Postpartum Psychosis

The most serious condition of perinatal psychiatry is postpartum psychosis (PPP), which takes place in about 1-2 out of 1000 births (Michalczyk et al., 2023). You know what? it develops quickly in the first week following child birth, and is characterised by hallucinations, delusions, mood swings, and disorganised thoughts. In the absence of timely treatment, the chance of infanticide or committing suicide increases significantly. The recent systematic review evidence supports the idea that genetic and epigenetic vulnerability is a significant contributor (Tsokkou et al., 2024), but social support and cultural framing influence the clinical pathway. PPP has a low awareness among the Pakistani population as a medical condition; psychotic symptoms are commonly explained by supernatural forces like possession or black magic, and families seek medical treatment only after faith healers. Psychotic presentations are also stigmatised by gendered expectations of emotional composure, which further isolate them. PPP is deadly, although very rare, and community awareness and early diagnosis are very important, and foregrounding the applicability of digital platforms to stigma reduction.

1.4 Online Resources and Perinatal Mental Health

The websites, mobile applications, SMS services, and social media have become a wide channel ecosystem where the perinatal health information is created, disseminated, and consumed. Perinatal mental health is defined as psychological wellbeing of the continuum between pregnancy, childbirth, and the first postpartum year and includes both antenatal depression and anxiety, the baby blues, postpartum depression, postpartum anxiety, and postpartum psychosis (O'Hara and Wisner, 2014; Tosto et al., 2023; Syed et al., 2023; Syed et al., 2023a). It's significant to frame the discussion on this complete perinatal arc as opposed to the tighter postnatal window since distress can start during pregnancy and that digital engagement patterns change throughout the perinatal course.

Social media may alleviate isolation and validate experience in women with perinatal mood and anxiety disorders, and offer accessible psychoeducation (Yuan et al., 2025). Let me tell you, the evidence of scoping review shows that members of online peer groups have a lower rate of loneliness, a greater level of hope, and a sense of belonging following exposure to recovery stories (Liblub et al., 2024). The image isn't all that good. Facebook specifically has been connected to the idealised motherhood images that trigger guilt and self-comparisons (Yamashita et al., 2022), and unfiltered content may spread misinformation that reframes perinatal distress as a lack of faith or moral deficiency, postponing professional care (Yousef et al., 2020). Digital platform affordances of perinatal mental health are thus twofold: the very infrastructure needed to expand support throughout the antenatal and postpartum care may cement culturally specific stigma.

1.5 Pakistani Society and Facebook

In Pakistan, Facebook is the most popular social media tool, having more than 43 million users (Statista, 2024). It's a key tool in community mobilisation, health discourse, and advocacy, and NGOs in maternal health started using Facebook groups and pages to connect with women on a large scale (Pulsipher et al., 2026; Hassan & Safdar, 2022; Safdar & Abbasi, 2020; Shabir et al., 2014). The platform can serve as virtual support network to provide emotional support (empathy, acknowledgement), informational support (psychoeducational material and referrals), appraisal support (reframing responses), and instrumental support (service and access to helpline). These dimensions can be directly plotted on the Social Support Theory (House, 1981) that emphasizes the importance of supportive networks in alleviating psychological stress. Groups led by survivors that normalise disclosure and include recovery stories can be particularly consequential.

Challenges remain, however. Survivors are also concerned that their relatives will keep track of their activity, restricting their openness, and fake news on the Internet can only strengthen but not decrease stigma (Yousef et al., 2020). These tensions are related to Sustainable Development Goal 3 (Good Health and Well-Being), which is a promise to healthy lives and wellbeing throughout the life course: reducing

PPD stigma and enhancing access to proper information and timely care are part of healthier mothers, babies and families (United Nations, 2025; United Nations Statistics Division, 2016).

1.6 Problem Statement

Although the prevalence of PPD is reported between 19 and 41% (Padhani et al., 2024), it is under-acknowledged and immensely stigmatised among Pakistani women. Families and communities often redefine PPD as common stress, poor faith, and personal weakness, discouraging disclosure and limiting access to formal care (Ali et al., 2025; Sajjad et al., 2024). Facebook, which boasts more than 43 million Pakistani users (Statista, 2024), provides an informal platform where survivors will be able to share their stories and feel peer-validated, and past experience indicates that online peer support can help lessen stigma levels and promote help-seeking (Liblub et al., 2024). But Facebook can also be associated with risks of exposure to information about privacy, misinformation, and the idealised images of motherhood that can exacerbate shame (Yamashita et al., 2022; Ittefaq et al., 2020). There's limited research on how Facebook influences PPD stigma by Pakistani survivors, which constrains the creation of culturally responsive, digitally aware anti-stigma interventions. The current research fills that gap.

1.7 Study Objectives

- To explore how PPD survivors in Pakistan understand Facebook's impact on their experience of stigma.
- To identify the forms of social support and social learning that survivors received through Facebook.
- To develop survivor-informed recommendations for Facebook-based anti-stigma interventions.

2. LITERATURE REVIEW

2.1 PPD in Pakistan

Despite being a known maternal mental health issue in the world, PPD has been under-recognised and under-treated in Pakistan. The 19-41 percent prevalence rates in Pakistani mothers (Padhani et al., 2024) are significantly higher than the global average of 10-20 percent, also due to socioeconomic stress, a lack of mental health services, low literacy, and restricting gender norms (Sajjad et al., 2024). PPD is further burdened by stigma: husbands, in-laws, extended family tend to view it as lack of faith or personal failure instead of an illness (Ali et al., 2025), and survivors internalise these labels, feeling guilty, shameful, and unwilling to seek assistance (Shahzad et al., 2024).

2.2 The Gap in Treatment and Care Access.

The majority of Pakistani women with PPD lack formal mental health care. According to Sajjad et al. (2024), a significant treatment gap was reported, with stigma and cost and the lack of female providers being the most prevalent barriers; most women resort to spiritual healers or informal services, which postpones the clinical intervention. The effects are intergenerational, as the untreated maternal depression is associated with malnutrition, cognitive delay, and emotional insecurity among children (Stein et al., 2014). Stigma therefore does not just serve as a social prejudice but as a structural impediment to equitable maternal mental health treatment.

The digital platforms, on the other hand, have provided new avenues of communicating maternal health. In a scoping review, Liblub et al. (2024) discovered that online peer spaces confirmed the experiences of women, created hope in recovery stories, and alleviated stigma through empathy and belonging. These advantages are accompanied by actual dangers: Yamashita et al., (2022) indicate that idealised motherhood images on Facebook may enhance shame and self-doubt, whereas unproven health assertions can postpone the proper treatment (Yousef et al., 2020). In Pakistan, where Facebook has about 43 million users (Statista, 2024) and is already used to advocate maternal mental health (Pulsipher et al.,

2026), the platform could potentially act as a virtual support network which includes the four dimensions of the Social Support Theory emotional, informational, appraisal, and instrumental (House, 1981). But, the threat of family monitoring and spread of stigmatising misinformation makes this a prospective a challenge, which warrants a survivor-centred qualitative investigation.

2.3 Survivor-Centred Perspectives

The focus of Pakistani PPD studies has been on prevalence, risk factors, and family perceptions (Ali et al., 2025; Padhani et al., 2024), but relatively little has been done on survivor stories. In a phenomenological study in Lahore, Ayub et al. (2025) found that the survivors described their experiences as isolation, stigma, and lack of validation. Jamshaid et al. (2023) discovered that perceived social support was linked to a lower depressive symptomatology as the perceived social support increased, which highlights the importance of community affirmation. there's, however, a marked gap: little survivor-centered Pakistani research on the particular role of Facebook in the process of constituting or challenging PPD stigma exists. The international experience with online peer support (Yuan et al., 2025; Liblub et al., 2024) can't be directly transferred to the context where confidentiality issues, patriarchal family structure, and cultural stigma limit open interaction. The current research aimed at filling this gap.

3. THEORETICAL FRAMEWORK

3.1 Social Support Theory

Social Support Theory (SST) is a theory developed by House (1981), which highlights the role of supportive relationships in safeguarding the physical and mental health through the moderation of exposure and response to stress. House has found four major types of support, namely: emotional (caring, trust, empathy); informational (advice, guidance, knowledge helpful in navigating a situation); appraisal (feedback that helps reassess and reframe one circumstances); and instrumental (tangible assistance in the form of goods or services). The supportive networks increase self-esteem, facilitate connectedness, and buffer acute and chronic stressors; without these, individuals become more vulnerable to stigmatization, isolation, and poor health conditions. In the particular case of PPD, SST explains the importance of validation, practical guidance, and reframing as concerns the survivors.

3.2 Application to PPD Survivors and Facebook

Support is given emotionally as peers can provide empathy and mutual understanding in response to feelings of isolation and shame (you aren't alone). When the content is credible, informational support is delivered via posts, group discussions, and shared resources about PPD symptoms, treatment, helplines, and services, which contributes to mental health literacy. The support with appraisal addresses the threat of self-blame directly by reclassifying distress as a medical condition to be treated as opposed to maternal failure. Less common on the internet, instrumental support involves referrals to clinics, counselling services, telehealth and emergency contacts as a means of transferring online interaction into offline care. Facebook has the potential to provide semi-anonymous access to the forms of support that are otherwise hard to get in the Pakistani context, where stigma prevents any open family discussion (Shahzad et al., 2024).

3.3 Relevance to Pakistan

SST was especially good as far as this study is concerned, in that it allowed a program to be followed to trace the supportive pathways by which Facebook could alleviate stigma validation, practical advice, constructive reframing and the negative pathways by which dismissive messages, stigma-laden advice and misinformation could enhance stigma. The theory recognises that not all support is helpful. Online communities can serve as an alternative source of validation and advice, and also replicate the same dismissive reactions survivors get offline, in patriarchal families where the women have little emotional or informational support to rely on in PPD. This is a two-lenses necessary in examining the controversial role of Facebook in PPD stigma.

4. METHODOLOGY

4.1 Research Design

A qualitative, phenomenological design was selected, oriented towards the lived experience of PPD survivors. The use of phenomenology was suitable since the research focused on the subjective perceptions, feelings, and interpretations of stigma and online communication parts that hadn't been adequately measured using quantitative methods (Braun and Clarke, 2006).

4.2 Sampling and Participants

Snowball referrals were used in addition to purposive sampling. Inclusion criteria were: women aged 18 to 45 years, having had a diagnosis of PPD in the last five years, and using or used Facebook; women admitted to hospital with severe psychiatric illness were excluded. The recruitment was done using mental health clinics, maternal health NGOs and online support groups in urban and peri-urban Pakistan. The thematic saturation was reached in a final sample of 18 participants which was in line with the qualitative research standards. Demographic characteristics are summarised in Table 1.

Table 1: Demographic characteristics of participants ($N = 18$)

Characteristic	Category	n	%
Age group	18–25 years	4	22%
	26–35 years	11	61%
	36–45 years	3	17%
Residence	Urban	12	67%
	Peri-urban	6	33%
Education	Secondary	5	28%
	Undergraduate	9	50%
	Postgraduate	4	22%
Family structure	Joint family	13	72%
	Nuclear family	5	28%
Time since PPD diagnosis	< 1 year	6	33%
	1–3 years	8	44%
	3–5 years	4	22%
Facebook use frequency	Daily	15	83%
	Weekly	3	17%

Note. Percentages rounded to the nearest whole number.

4.3 Data Collection

There were two complementary approaches. Semi-structured interviews (4560 minutes) were used to record lived experiences, perceptions of stigma, and memories of Facebook use. Participant-directed Facebook walkthroughs allowed each participant to freely move through certain groups, pages, or posts that they had explored or avoided during their PPD, and explain how these experiences influenced their attitude toward their illness and its stigma. Interviews were either in Urdu or English depending on the participant preference and were audio-taped with informed consent.

4.4 Data Analysis

The six-phase procedure of reflexive thematic analysis outlined by Braun and Clarke (2006) familiarisation, initial coding, theme generation, theme review, theme definition, and reporting was used to analyse the transcripts. The coding was inductive as participants gave their narrations and deductive as it was through the four dimensions of the Social Support Theory. Five main themes were narrowed down by repeated examination; the results are presented with pseudonymised identifiers (M-1 to M-18) to ensure anonymity but anticipate the voice of the survivors.

4.5 Ethical Considerations

All participants signed an informed consent. The confidentiality, right to withdraw and provision of referral information to any participants who were distressed during data collection was sensitive to PPD. The process of analysis involved deleting identifiable information before analysis and giving the participants the chance to comment on their transcripts and get a copy of the transcript.

5. FINDINGS

Five themes were generated during analysis summarised in Table 2 and visualised in Figure 1. All themes are approached with direct quotations of the participants to maintain the voice of survivors, presented with direct participant quotations to preserve survivor voice.

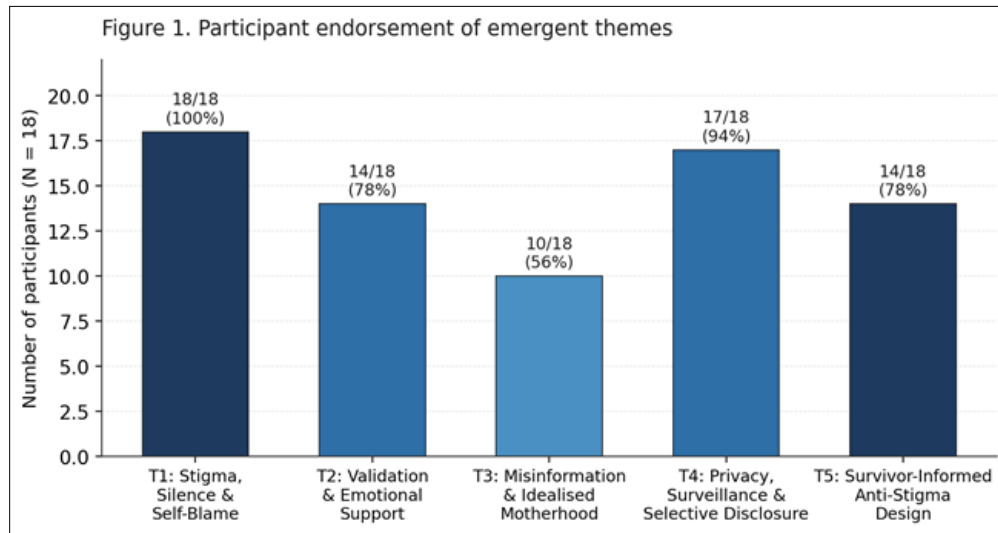


Figure 1: Participant endorsement of emergent themes (N = 18).

Table 2: Summary of themes, participant endorsement, theoretical mapping, and objective linkage

Theme	n (%)	Core content	SST dimension(s)	Objective served
T1. Stigma, silence & self-blame	18 (100%)	Fear of judgement; internalised shame; distress as personal failure.	Absence / failure of support	Objective 1
T2. Validation & emotional support	14 (78%)	Peer stories normalising PPD; shared vocabulary; reduced isolation.	Emotional; Appraisal	Objectives 1, 2
T3. Misinformation & idealised motherhood	10 (56%)	Unrealistic imagery and moralising content intensifying self-comparison.	Negative informational; distorted appraisal	Objective 1
T4. Privacy, surveillance & selective disclosure	17 (94%)	Fear of family monitoring; lurking; use of pseudonymous accounts.	Structural constraint on support access	Objective 1
T5. Survivor-informed anti-stigma design	14 (78%)	Requests for moderated groups, credible psychoeducation, referrals.	Informational; Instrumental	Objectives 2, 3

Note. SST = Social Support Theory (House, 1981). Percentages are rounded.

Theme 1: Stigma, Silence and Self-Blame

The 18 mothers all talked about PPD being silencing, fear-driven, and bound to blame oneself. Some were afraid of being called weak, ungrateful or incompetent in case they expressed their distress. One of them remembered that she would cry in the washroom alone since when once she told her that she wasn't okay she was told that a mother should be thankful, not depressed (M-3). There was internalisation of stigma: the participants habitually explained their suffering as a personal failure. One mother explained that she thought other women must be better at it and something is wrong with me (M-11). These stories show that even those survivors who don't receive formal care are silenced by stigma.

Theme 2: Facebook as a Place of Authentication and Emotional Support

Fourteen mothers referred to Facebook groups and pages as low-threshold place of validation, reassurance, and a feeling of shared experience. Reading the stories of other women lessened solitude and provided words to express their own misery. The truth is, one of the participants (m-6) told about the first instance when she was reading other mothers who were saying exactly what she was feeling and realised that this had a name and she wasn't the only one. Emotional value was more important to many: comment threads, peer encouragement, anonymity provided little relief that isn't available in real life. A different one (M-14) even said that when I wasn't posting, reading positive comments made me feel less broken. This theme aligns one-to-many on the emotional and appraisal dimensions of SST.

Theme 3: Torture and Perfect Motherhood

Ten moms said that Facebook was also a source of recreated stigma, mostly via misinformation and unrealistic motherhood pictures. Respondents mentioned feeds of smiling, perfectly polished mothers, who seem to be doing the same job effortlessly, and messages of moralising framing depression as a sign of weakness or lack of faith. Everywhere I saw, mothers were smiling, cooking, feeding, looking perfect and I started to believe that there was something wrong with me, said one participant (M-12). Shame and delayed help-seeking were particularly exacerbated by misinformation. Some of the posts made it seem that I just needed to be more powerful or religious and that's why I concealed my symptoms even further (M-9). Online stigma was thus an interpersonal and an embedded platform discourse situation.

Theme 4: Privacy, Surveillance and Selective Disclosures

Seventeen mothers talked about a persistent conflict between the desire to be supported and the fear of being seen. Although Facebook provided semi-anonymous access to peer groups, some were afraid that their parents, spouses, or in-laws would check their activity, capture screenshots, or ask why they were online. One participant (M-7) said that when he or she joined groups he did not use his or her real profile, as he feared that a relative might see it and inform his or her family. Most so engaged in selective disclosure lurking without commenting, with second accounts, or in closed groups. Another (M-12), explained that I needed some help but I also needed to defend myself, so I was highly controlled online. Perceived safety of visibility filtered Facebook supportive affordances.

Theme 5: Survivor-Informed Digital Anti-Stigma

Fourteen mothers claimed that Facebook could be safer and more helpful when the design process will be driven by the needs of survivors. Participants appreciated mediation groups, plausible psychoeducation, language that was culturally sensitive, and defined access to professional care. Some of the mothers observed that in case there was a group with doctors and mothers speaking in a respectful tone, more women would have believed it and sought assistance (M-5). In addition to motivational messages, participants highlighted the privacy protection, the ability to participate anonymously and make referrals that can be acted upon. Another (M-13) said: Women need a space to ask questions without shame and receive actual assistance, not mere condemnation. Survivor-informed, modulated, and linked directly to offline services, this theme implies that effective digital anti-stigma work needs to be effective.

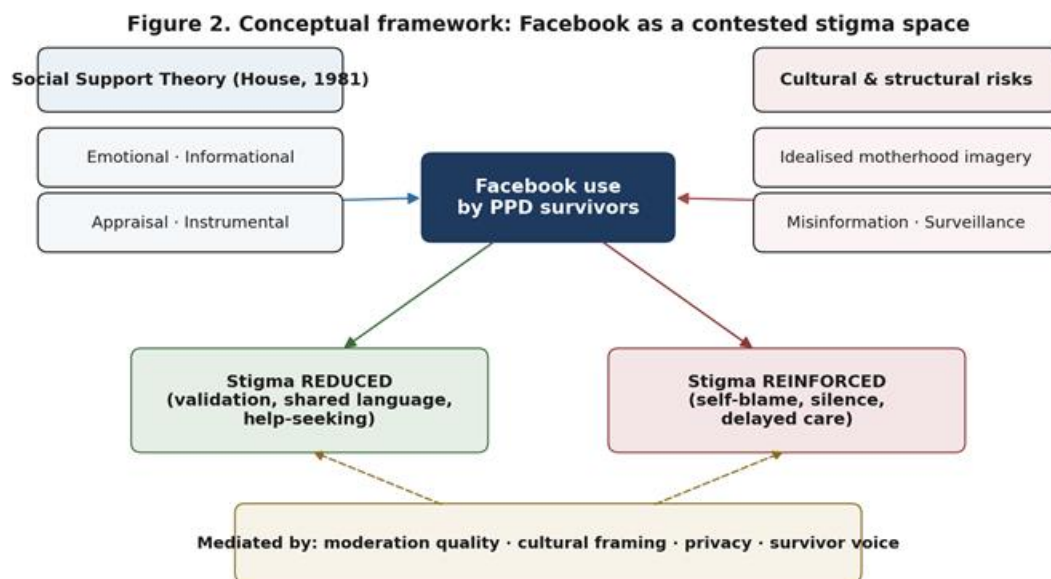
5.1 Themes in the Themes of fulfilment of Research Objectives

The five themes cover all the three research objectives, and each objective is achieved by particular themes that work in conjunction (see also Table 2).

Objective 1: The role of Facebook in the experience of stigma in survivors is achieved by Themes 1, 2, 3, and 4 combined, which chart the process of stigma experience within and around the platform. Theme 1 supports the offline stigma that survivors create around their Facebook use and explains why the platform is such a desirable escape. Theme 2 demonstrates that peer narratives and emotional validation lessen the stigma by normalising PPD and offering common words. Theme 3 reports the reverse process: the idealised images and misinformation intensify self-blame and strengthen stigma. Theme 4 shows that even supportive affordances are mediated by surveillance and privacy risk such that the stigma effect of Facebook isn't just a matter of content but a matter of conditions of visibility in which survivors can use it.

Objective 2: The discovery of social support and social learning forms received through Facebook is achieved mostly through Themes 2 and 5, against the SST framework. Theme 2 records emotional and appraisal support: peers confirmed distress, redefined PPD as a remediable condition, and role-modeled recovery, exemplifying social learning through common stories. Theme 5 builds this in to informational and instrumental support, with participants talking of the importance of credible psychoeducation and referral information, and explicitly making clear what kind of support they needed, yet did not get. What's interesting is combined the two themes outline what sst dimensions Facebook provides and its weakest areas.

Objective 3: Theme 5 realises the development of survivor-informed recommendations to be applied to Facebook-based anti-stigma interventions, which Themes 3 and 4 provide the design constraints that it needs to respond to. Actually, the positive content of the recommendations is constituted by the calls of the participants to participate in moderated groups, culturally sensitive psychoeducation, anonymity of participation, and direct referral channels. Themes 3 and 4 define the issues those recommendations must address: the issue of misinformation and idealised imagery (Theme 3) predetermines the necessity of moderation and content standards whereas the issue of surveillance and threats to privacy (Theme 4) predetermines the necessity of anonymity protection and safety-by-design. Figure 2 conceptualizes these relationships by demonstrating how the concept of dual potential of Facebook is mediated by quality of moderation, cultural framing, privacy and centrality of survivor voice.



6. DISCUSSION

The results show that the PPD stigma of Pakistani survivors was conditioned by the offline social pressure in addition to the communicative conditions of the online platforms. Theme 1 proved that the experience of stigma was that of external judgement and self-blaming self-silencing, which aligns with the public-self-structural typology of stigma developed by Corrigan et al. (2016). These responses help to explain why not all women received formal care at an early stage when maternal distress is commonly minimised or moralised (Ali et al., 2025; Sajjad et al., 2024).

Theme 2 brought out the opposing role of Facebook. To most mothers the platform offered an important source of emotional validation and peer support; just the mere finding of similar accounts minimized perceived deviance and loneliness. This conforms to the emotional and appraisal parts of Social Support Theory (House, 1981), and to previous findings that online peer spaces normalise depressive experience and provide less stigmatising language of interpretation (Yuan et al., 2025; Liblub et al., 2024).

Thematically, Theme 3 revealed that Facebook wasn't only conducive, but also stigmatizing. Negative self-comparison was encouraged by exposure to idealised images of motherhood and moralising information and reiterated previous research on social comparison and health misinformation (Yamashita et al., 2022; Ittefaq et al., 2020). The power of Facebook is thus not necessarily supportive or harmful; it's predetermined by the stories, tips, and standards that prevail in any digital space.

Theme 4 was an addition that brought about a dimension that could easily be overlooked in international literature. Access to online support was conditioned by privacy concerns, family surveillance, and reputational risk. Even online communication can be a source of exposure in patriarchal, tightly controlled homes. The selective-disclosure tactics that participants reported imply that online presence is negotiated, as opposed to freely exercised access, does not necessarily result in usability.

Theme 5 flipped the analysis to response. Recommendations provided by participants indicate that anti-stigma efforts on Facebook are most likely to be most effective when survivor-led, professionally mediated, culturally sensitive, and explicitly connected to offline care pathways. This has direct implications on NGOs, clinicians, and maternal health advocates in Pakistan: it defines the platform-level characteristics that are most likely to minimize harm and provide support. Collectively, the themes paint a picture of Facebook as a two-sided social space: one that reduces stigma by providing legitimacy, shared experience, and support and one that increases stigma by exerting influence over idealisation, misinformation, and fear of disclosure. Culture, privacy, credibility, and the quality of social support mediates the digital media-stigma relationship.

7. CONCLUSION

This paper has explored the importance of Facebook in the development of the perception of PPD in survivors in Pakistan and the picture that has been returned isn't homogenously rosy or homogenously negative. Survivors were ambivalent about Facebook. They wanted peer approval, vocabulary to express their pain, and emotional support, and most of them found these but they also came across romanticised visuals, untested advice, and the fear of being checked on by their loved ones that silently perpetuated the stigma they already bore in the real world. Facebook had become both safe haven and prison, traversed with both cautious and often secretive tactics.

This study makes a threefold contribution to the literature. To begin with, it focuses the voices of survivors on a prevalence-dominated, family-based research field, which fills a gap in the literature on maternal mental health in Pakistan. Second, it applies the Social Support Theory to the digital field characterized by patriarchal family systems, demonstrating that emotional and appraisal support may have a strong impact but are limited by privacy issues and surveillance risk. Third, it disrupted the dichotomy of social media as being either helpful or harmful to mental health through showing that the same platform can be both at one time during a session depending on what is experienced, and in what circumstances it's experienced.

The implication is pragmatic. With regard to NGOs and maternal health organisations, the study recommends that Facebook-based interventions need to be survivor-centered instead of targeted at survivors, moderated, credible, and direct access to professional care, instead of inspirational messaging. To clinicians, the results highlight that online information about PPD is the initial experience of many women and thus digital literacy and management of misinformation are valid issues of standard maternal mental health care. As a policymaker, the findings inform the need to consider digital platforms as a component of mental health infrastructure, especially in the context of stigma discouraging a visit to the clinic. To platform designers and community moderators, the results demonstrate privacy rights, anonymity, and language sensitivity that does not moralise distress.

There are a number of limitations to be considered. Being a qualitative study with a given urban and peri-urban sample of Pakistan, findings can't be statistically generalised. Facebook memory was based on the recollection of participants, which might have led to retrospective bias, and the analysis of Facebook contents wasn't performed directly. Future studies might involve the integration of survivor interviews with content analysis of Pakistani maternal mental health groups to track the spread of misinformation and support at a platform level. Comparisons across regions or platforms of Pakistani people such as WhatsApp and Tik Tok would further hone the insights into the impact of various digital spaces on stigma. Designs that monitor Facebook use and help-seeking over the postpartum year, family member studies (husbands and mothers-in-law in particular), and intervention trials of moderated survivor-led groups versus ordinary online conditions would give the evidence base required to determine what really lowers stigma in practice.

Primarily, this paper suggests that the PPD stigma in Pakistan can't be comprehended without focusing on the digital space, and that the digital space can't be comprehended without paying much attention to survivors. Facebook isn't a white sheet of paper. it's an embodied space where mothers desire to be acknowledged, where they face judgement and negotiate silently to what extent they can safely expose themselves. it's possible and necessary to make that environment safer, more truthful and more in touch with the reality of what real care is, and the beginning of that process is the experience of the women who have already gone through it.

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Conflict of Interest

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