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Lived Experiences of Women with Major Depressive Disorder

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Abstract: Culture contributes and influences the identity of people in a way that shapes their identity, beliefs and personality to feel socially integrated with people. Mental health disorders specifically expression of depressive symptoms among women in south Asian culture is misinterpreted and misjudged. To explore how Pakistani women experience and express their depressive symptoms, current study employs Interpretative Phenomenological Analysis (IPA). Semi-structured interviews with 20 women having a diagnosis of depression revealed that cultural stigma enhances emotional repression, economic dependency restricts access to mental health care, and fixed religious beliefs create a contradictory coping strategy. The findings demonstrate that although women with depressive symptoms have spiritual aspect, social support, and internal coping mechanisms to manage resilience, gendered pressures in family dynamics but also cause emotional alienation. These results provide clinical insight into the phenomena of mental health with cultural identity and emphasize the need for faith-integrated therapy, community-based psycho-education, and reasonably priced treatment. The study highlights the urgency of normalizing emotional expression, implementing gender-sensitive treatment techniques, and addressing systemic barriers in mental health through culturally relevant interventions.

Key Words: Depression, Cultural Influence, Depressive Symptoms, Women, Mental Health, Asian Culture

Introduction

People's views of people, their social positions, and their interactions with others are shaped by their culture. A social component of human existence, culture is governed by moral principles and norms. Cultural aspects include things like language, religion, geographical characteristics, social norms, cuisines, arts, and traditional beliefs and practices. Sociologists contend that it is dynamic and changes over time due to both internal and external factors such as migration and globalization (Baldwin et al., 1999).

Cultural differences exist in individual views, understandings, attitudes, behaviors, and practices (Peacock et al. 1981). Different families, organizations, and nations may have different cultural norms. Terms like *"Western culture," "Eastern culture," "American culture," "Asian culture,"* and so forth are commonly used to describe Members of these communities exhibit a wide range of customs, beliefs, and behaviors. Societies vary widely in certain cultural standards (Gopalkrishnan, 2018).

Culturally specific disorders can present as a unique collection of physical or mental symptoms known as *"cultural bound syndromes"* (Gaw, 1993). Culturally specific illnesses can develop as a unique set of mental or physical symptoms, known as culturally bound syndromes (Levine & Gaw, 1995).

Even though it is believed that 29.2% of individuals worldwide may encounter common mental diseases in their lifetime (such as mood, anxiety, and substance use disorders), culture has a big influence on how people experience and think about mental illness as well as how they deal with it. Instead, each illness has culturally specific symptoms.

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According to the American Psychiatric Association (2013), *"all forms of distress are locally shaped"* (p. 758) and the DSM-5.

At its core, culture offers a framework for understanding social reality and one's immediate environment. It offers social positions, hierarchies, and appropriate behaviors that help people feel like they belong. According to Hofstede's Cultural Dimensions Theory, cultural differences like power distance, uncertainty avoidance, and individuality vs. collectivism have a big influence on how society behaves and values its members (Hostede, 2001).

In Pakistani culture, communal cohesion takes precedence over personal goals. The emphasis on extended family ties and group decision-making shows that people value family, community, and societal harmony.

Since physical ailments are more culturally acceptable and more often receive adequate care than mental health issues, somatic symptoms are a common presenting complaint in South Asian cultures among depressed people, particularly women (Chaudhry, 2010).

Freedom of choice is usually subjected to household goals and expectations, and major decisions like education, marriage, schooling, and career are usually impacted by family (Yu et al., 1993).

In Pakistan, families are typically patriarchal and patrilineal, with older men holding sway. Living arrangements in which many generations live together or nearby are known as extended families. Individual rights are subordinated in this system, and choices are usually taken with the good of the entire family in mind. Women are generally assimilated into their husbands' families after marriage, reflecting the patriarchal structure.

A major issue with Pakistani individual's poor mental health is that they believe magic, evil eye, and possession are the sole causes of mental diseases and often seek therapy from a shaman or traditional healer rather than a mental health professional (Gadit et al., 1998).

To evaluate audiences' beliefs and the effectiveness of interventions in enhancing attitudes towards mental health care, it is necessary to deepen our understanding of Pakistani beliefs and values that might be causing stigma around mental health and to create culturally sensitive assessment instruments. This is particularly important for emerging adults (those between the ages of 18 and 29), who are in a pivotal period in their career, social, psychological, and religious/spiritual development.

Viewing mental illness as a characteristic of a person's brain, mind, or personality is one way to comprehend it; this idea forms the basis of the current global disease classifications. These classifications, like the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) classification or the World Health Organization's International Classification of Diseases (ICD) (APA, 2010), are predicated on the idea that all people share a common natural reality and that the symptoms that underlie each diagnosis are comparable everywhere, regardless of location or circumstance (WHO, 1992). Although this idea is presently widely used and recognized as the standard, identifying cultural factors and modifying them to address mental health issues is thought to be an essential part of using this model to different communities among cultures.

Theory and Application

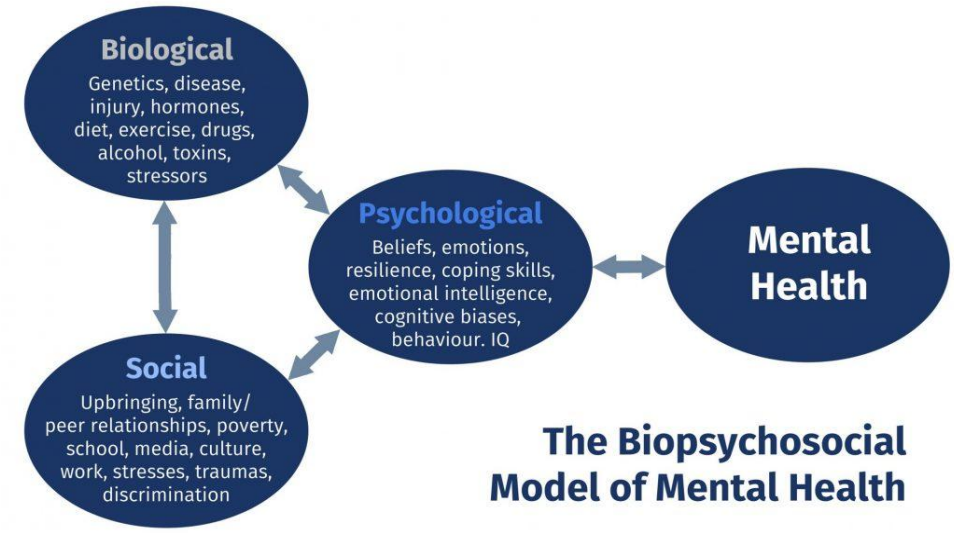
The Bio-psychosocial Model, put forth by George Engel in 1977, is a comprehensive paradigm for understanding health and illness that considers the diverse and complicated connections between biological, social, and psychological elements. It draws attention to the interactions between these factors and how they affect a person's wellbeing. The Bio-psychosocial Model contends that a comprehensive focus on biological processes is insufficient to comprehend health and illness. Instead, it contends that social, psychological, and biological elements interact and influence a person's total health and functioning (Engel, 1977).

The bio-psychosocial model highlights that a variety of biological, psychological, and social factors, such as genetic predispositions, life stresses, and sociocultural contexts, can contribute to depression.

Every aspect of the bio-psychosocial model has a distinct meaning when viewed through the lens of discourse theories of mental illnesses. Patients who experience depression primarily perceive themselves as physical beings who depend on medical knowledge if depression is largely understood within a biological framework. Depression is viewed as an internal dysfunctional (such as developmental or traumatic roots) if a psychological framework takes precedence. Therapy for depression attempts to restore agency by addressing the past and present selves (Cuijpers et al., 2019). Interventions aimed at the micro and macro social worlds, however, also become pertinent if it is perceived, at least in part, as a form of *"social suffering"* (Sik, 2019).

Figure 1

The Bio-Psychosocial Model of Mental Health



Pakistan is likely considered a collectivistic society (Hofstede, 2017), with a high emphasis on family and links in decision-making. However, these identities are not so easy. There is a proceeding (and often violent) conflict among the devout between those who demand purportedly individualistic Westernization and those who seek historic Islamic law (Farhat- Holzman, 2012), Collectivistic movements like women's education and marital equality are still observed by others. Pakistan is home to many different ethnic groups, dialects, and customs; therefore, these experiences would probably differ by region and at the nexus of socioeconomic groups and generations. And lastly, the views of Pakistanis towards mental health and its treatment reflect the country's strong adherence to Islamic values and collectivism. In certain instances, Pakistan's high stigma around mental health and low rates of help-seeking may be caused by a preference for religious and spiritual (as opposed to Western) conceptualizations of mental illness, as well as the previously mentioned roles of intergenerational trauma and collectivism that developed after the country's formation.

Here, this high prevalence is caused by several factors, including economic dependency, domestic abuse, gender inequality, and restricted access to mental health care (Mirza et al., 2022). Furthermore, Pakistan's stigma around mental health frequently keeps women from getting professional assistance, which results in untreated or protracted depressive episodes (Garcia-Toro & Aguirre, 2007).

The Current Study

To date no exploratory qualitative study has been done to investigate the true personal experience of women experiencing these symptoms in a specific culture. The prevalence and clinical manifestations of depression have been extensively studied worldwide, but little qualitative research has been done on how cultural and gender-specific norms influence women's subjective experiences and expressions of depressive symptoms in South Asian contexts, especially in Pakistan (Choudhry & Bokharey, 2013). The real, complex, and culturally rooted experiences of women navigating

depression within patriarchal and collectivist frameworks are largely ignored in favor of quantitative measurements in most current research.

Because individualism and collectivism are highly correlated, often act as confounding factors, and are likely to intersect, the authors argued that more nuanced research is necessary to better understand how individualistic, cultural, and collectivistic beliefs and values influence psychological outcomes across all groups. Examining cultural norms and attitudes regarding mental illness is crucial, according to (Çiftçi et al., 2013). These results highlight the urgent need for gender-specific approaches to diagnosing and treating depression. Depression is more common in women than in males because women are more prone to internalize their emotions (Nolen- Hoeksema, 2012).

Many factors, such as biological, psychological, and social variations, hormonal fluctuations, gender-specific stressors, and societal expectations regarding caring responsibilities and emotional reactions, have been implicated in this gender distinctness. Families in Pakistan are usually patriarchal and patrilineal, with older men wielding influence. Extended family living arrangements, in which numerous generations reside together or close by, are common. In this system, family obligations and duties take precedence over individual rights, and decisions are typically made to benefit the entire family. When women marry, they often move into their husband's family and are incorporated into that home, mirroring the patriarchal system.

Method

Setting

The study was conducted in Pakistani cities at psychiatric hospitals, community centers, and mental health clinics. Women having a clinical diagnosis of depression or those who tested positive for depressed symptoms were made available in these situations to share their experience. There are more resources available, such as the DSM-5, participant information, and consent form. Because doing so would violate confidentiality, the actual data cannot be made publicly available.

Participants

Using purposive sampling, 20 women aged 25–45 years with a DSM-5 diagnosis of depressive disorder were selected. Participants spoke English or Urdu fluently. Women who have serious mental health conditions were not included. Participation was private and voluntary, and informed consent was acquired. A variety of ethnic groups were represented in the sample, reflecting the diversity of the region where the data were gathered.

Procedure

Participants were gathered when they were in inpatient wards or during their outpatient consultations with psychiatrists or psychologists. To find out if a potential participant met the eligibility requirements. Participants were refused entry if they did not fit into the criteria. The participant information sheet and consent form were given to eligible participants, who then offered their informed consent if they wanted to participate. The researcher then set up a time to visit with the person at a convenient place, such as their home or the clinic, either inpatient or outpatient. Enough time was allotted for participants to interview and discuss their experiences. Personal experiences of depression, gender roles, coping mechanisms, emotional expression, and expectations from family and society were all examined in semi-structured interviews. Consistency between sessions was guaranteed using an interview guide. To ensure comfort and anonymity, interviews were held in private locations, lasted 45 to 60 minutes, and were audio recorded with consent.

Data Analysis

Interpretative Phenomenological Analysis (IPA) was used to analyze the transcriptions of the interviews. To identify significant themes pertaining to gender norms, emotional coping, and cultural stigma, the transcripts were examined recursively. To comprehend how society shapes the physical manifestations of depression symptoms, both common and distinct experiences were investigated.

Results

Table 1

Main Themes and Sub-Themes

Superordinate Themes	Master Themes	Emergent Themes
Depression Under the Auspices of Lived Experience: Unraveling Sociocultural Influences	Cultural & Social Stigma	Pressure on women to meet societal expectations, no right for women to speak up, notion of emotional strength, fear of judgement, label of house wrecker, women's emotional needs labeled as oversensitivity & drama, restricted emotional expression.
	Supportive & Endeavour Interpersonal connections	Reliance on family support, burnout from gender roles, distorted self-esteem and confidence, Relationship Strain from mood shifts.
	Religion as a Paradox in Coping	Prayer as an emotional refuge, guilt & hopelessness from unanswered prayers, depression as spiritual test or punishment, religious practices provide sense of solace, religious practices creating pressure, prayer as a sense of relief, faith as a pillar of resilience, conflicted response to religious guidance
	Economic Struggles & Accessibility	Economic Dependency on men limiting the treatment access, economic challenges dispensing emotional strain & hopelessness, neglected care due to high costs, treatment,
	Inner Turbulence & Emotional Resilience	Emotional struggles (irritability, sadness, self-doubt) aimed at gender based societal pressure, challenges influenced by traditional gender specific responsibilities,

Five superordinate themes were developed from the participant's interviews and narratives that perfectly illustrates the experience and expression of their depressive symptoms.

Culture and Social Stigma

Culture and Social Stigma include the experiences of the participants demonstrated how social stigma prevents women from expressing their emotional difficulties, which results in their isolation and lack of assistance. Cultural norms discouraged candid conversations about mental health by emphasizing the need for women to look emotionally robust. Participants experienced pressure to live up to social norms that characterized emotional displays as *"drama"* or *"oversensitivity."*

Men must serve as the major protectors of women's vulnerabilities in these cultural contexts since women are considered as the primary carers and bearers of family honor. As a result, only women who conform to these cultural standards are valued in society.

Participants 7 reported feelings of burnout and relational strain:
"There are days when I feel angry or exhausted, and it affects my relationships. I feel like I'm failing as a wife, a mother, and a daughter, and it destroys my confidence"

This is consistent with the mental health self-stigma model (Corrigan & Rao, 2012), which describes how people internalize unfavorable social perceptions and become reluctant to seek help. According to the emotion suppression theory (Gross & John, 2003), social pressure to repress feelings might exacerbate psychological suffering and depressive symptoms.

This stigma poses serious obstacles to therapy engagement in clinical psychology. Clinically tailored interventions that acknowledge emotional distress in a culturally acceptable setting are necessary because women who experience cultural guilt about depression may be reluctant to fully engage in therapy.

Supportive and Endeavor Interpersonal Connections

Supportive and Endeavor Interpersonal Connections indicate Family interactions were characterized by the participants as a source of both comfort and anxiety. Some women experienced emotional neglect from their partners, which led to feelings of loneliness and self-doubt, while others turned to family members, particularly mothers, for Solace and peace.

One participant shared:
"My mother understands, but my husband tells me to stop overthinking. He thinks depression is just being dramatic." (Interview 12).

This is incarnated with attachment theory (Bowlby, 1988), which postulates that people in distress look for safe attachments to control their emotions. However, emotional security is disrupted, and feelings of helplessness are reinforced when family members minimize or reject symptoms (Mikulincer & Shaver, 2016).

According to a psychiatric viewpoint, tense interpersonal relationships exacerbate depression by causing self-doubt and confidence to decline. For clients to negotiate emotional support and seek validation in healthier ways, therapy interventions must address these relational patterns.

Religion as Paradox in Coping

Religion as Paradox in Coping depicts that a major but contradictory feature in the lives of the participants was religion, which provided both solace and conflict in managing symptoms of depression. When spiritual problems remained unresolved, participants felt guilty and despairing even if prayer and religious activities gave them a sense of calm and fortitude.

One participant shared:
"My religious beliefs give me comfort and support in prayer. I think that Allah will help me, but ometimes worse. Praying is my escape when I feel hopeless, but when nothing changes, I feel like I'm being punished for not being good enough in my faith" (Interview 4).

This paradox aligns with religious coping theory (Pargament, 1997), which makes a distinction between negative religious coping (perceiving hardship as divine retribution) and positive religious coping (looking for strength through religion). Clinically responsive therapy techniques that incorporate faith into mental health treatment without encouraging guilt are necessary because research indicates that religious guilt might exacerbate depressive symptoms.

According to Pearce et al. (2018), faith-based therapy, such as Spiritually Integrated Cognitive Behavioral Therapy, can assist women in redefining their religious challenges in a way that fosters healing instead of self-blame.

In a patriarchal system, men are viewed as the breadwinners and active members of the political and economic spheres of society, while women are mainly limited to taking care of family matters, such as cooking, cleaning, childrearing, sewing, creating strong bonds with family members by planning family gatherings, and helping out in some areas of farming. Because they are unpaid laborers who make minimal contributions to economic maintenance, women are considered irrelevant in decision-making. This makes it very difficult for professional women, especially mothers, to balance their roles.

Economic Struggle and Accessibility

Economic Struggle and Accessibility reflects the financial difficulties had a big impact on participants' capacity to get mental health care. Access to professional care is restricted because to financial dependence on male family members and the high expense of therapy.

Due to the high cost of therapy and financial reliance on male family members, access to professional care is limited. Participants overlook their mental and physical health in favor of household responsibilities. Another factor contributing to long-term mental distress was economic stress and financial strains:

Indeed, a person's financial situation has a significant impact on the signs, manifestations, and management of this condition. I wouldn't have needed to rely on my parents or husband for medical care if I had the funds. My depression symptoms have gotten worse, and my depression has increased because of this dependency. Depression cannot be avoided. It seems like there is no way out of the mounting financial issues (Interview 8).

The results show that people who are struggling financially feel even more hopeless, which feeds the cycle of neglect and makes mental health problems worse. These findings demonstrate the necessity for affordable, easily available mental health care tailored to the needs of low-income women.

These findings suggest that complex gender roles and societal expectations are closely linked to participants' emotional challenges, which are typified by melancholy, self-doubt, and wrath. According to the participants, they repressed their feelings in order to conform to social norms, which harmed their self-esteem and led to untreated health problems. *"I constantly doubt myself,"* the participant said. *"I feel like I can never be good enough,"* is an example of how social pressure feeds a vicious cycle of emotional pain and self-criticism. This is aligned with Bourdieu's (1984) symbolic violence theory, which holds that people internalize social norms and hold themselves accountable for structural problems.

Discussions

In accordance with earlier studies on South Asian countries, the results show that sociocultural norms significantly impair women's ability to openly express depressive symptoms. Participants emphasized how women's problems are suppressed, and feelings of shame and loneliness are increased because society expects them to be emotionally tough and strong. This is consistent with (Taj, 2016), who emphasized how mental health issues are often stigmatized in South Asian cultures as personal defects rather than legitimate issues.

Women internalize social guilt and prefer emotional seclusion as a means of avoiding criticism, as seen by the statement, "*being stigmatized by society for having depression led to many difficulties. I made the decision to keep quiet and not express my emotions to anyone outside of my immediate family to manage. I am aware that society will never accept my illness and will only discuss me in ways that make me feel worse rather than helping me. A person gets broken from the inside out by having to live with such a condition in this society, which is a humiliating experience.*" This is in line with the stigma hypothesis put forth by Goffman (1963), which maintains that people conceal their struggles to avoid being labelled as "*deviant*" or "*weak*."

Their emotional needs are frequently framed around *"oversensitivity,"* making it harder to ask for help. Likewise, the gender norms in collectivist cultures may foster emotion suppression by women resulting in poor mental health outcomes (Garcia-Toro & Aguirre, 2007). The findings highlight the importance of culturally relevant initiatives that reduce stigma and create safe spaces for open conversations.

Family ties are a double-edged experience that can provide emotional solace but also growing feelings of relational strain and fatigue, participants said. Women reported feeling overwhelmed by their gendered responsibilities and their desire for family assistance. This puzzle is indeed in line with the discoveries of (Luna et al. 2019), highlighting that the balance of family responsibilities can contribute to emotional exhaustion for women taking on multiple responsibilities.

"Yes, I faced pressure to hide my depression symptoms. However, if I consider societal or in-law perspectives, yes, there was pressure to hide my condition from them." said one participant, underscoring the notion that women should put the needs of others before their own. Because women's strength is seen as essential to preserving a harmonious home, society expects them to be strong in all situations. *"But this expectation feels oppressive to me. Being a person, I have strong emotions. There are moments when I wish I was independent so that my health wouldn't affect other people. Do I not have the right to communicate the emotional pain I'm experiencing? However, society denies me this independence, which is killing me from the inside out."* Said another participant. Gilligan's (1982) ethics of care paradigm, which maintains that women are socialized to get self-worth from giving care, puts this data in context.

It was shown that participants' religious views and practices both contributed to their resilience and caused internal conflict. Even though faith and prayer offered comfort and relief, participants also experienced guilt and hopelessness when spiritual coping was unable to alleviate their emotional challenges. According to research by Koenig et al. (2012), religion can have a paradoxical effect on mental health, providing solace while also inciting self-blame in people who feel their faith is insufficient. This contradiction is in line with their findings. The participant's statement, "m*y beliefs provide me consolation and encouragement when I pray. I believe that Allah will help me, but occasionally I also wonder whether my dua is not being heard, which would worsen my situation.*" This exhibits how undelivered spiritual expectations can accelerate emotional pain in the individuals. This is corresponding to Pargament's (1997) notion of religious coping, which distinguishes between good religious coping (like finding comfort in prayer) and negative religious coping (like feeling abandoned or scolded).

Financial constraints were identified as a major barrier to obtaining mental health care, which is consistent with study done in low-income countries by Rahman et al. (2008). Participants' financial dependence on male family members also limited their freedom to pursue therapy. *"How can I think about seeing a doctor when we don't even have enough for basic needs?"* asked one participant. This financial burden not only restricts access to professional help but also exacerbates persistent stress and sad feelings. The findings validate those of Patel et al. (2010), who suggested that poverty and mental health issues are closely related, with financial difficulties and economic constrains aggravating psychological suffering in individuals.

Limitation and Future Directions

- To start, although the study's sample size of 20 women generated rich, detailed data, it may not be fully representative of the region's larger cohort of Pakistani women with depression. Women from economically disadvantaged or remote communities who may face additional barriers to mental health care access may not have been represented under the non-probability purposive sampling design, which compromises the generalizability of the findings to those who were able and willing to travel to the study sites. Any biases that might influence self-reported data, like social desirability or hesitance to address sensitive issues, also become more likely.
- Moreover, this study does not consider the potential influence of socioeconomic factors as well as the differences experienced by individuals in urban and rural settings regarding mental health conditions.
- The lack of financial means is among the most important barriers to accessing mental health care. Interventions considering clients' financial situation are essential as financial support programs have been associated with improved accessibility and adherence to treatment (Roy-Byrne et al., 2009).

Future research can explore subculture comparison of experiences in depression and the effects of gender norms and stigma associated with mental health with respect to emotional expressiveness in different South Asian subcultures. Studies focused on the intervention and effect of religiously infused cognitive behavioral therapy (CBT) in collectivist societies. Explore how online therapy and other digital mental health solutions can help the patients access treatment

despite financial and social barriers. Engagement of the community in the design of mental health services ensures that the services align with the unique socioeconomic and cultural context of the target community. At present, this forms a calibrated and widely acceptable mechanism for effective mental health services (Kohrt et al., 2018).

Research suggests that culturally tailored counselling services can reduce symptoms of anxiety and depression in South Asian communities. Indeed, a recent randomized clinical study shows that these so-called culturally sensitive and faith-integrated therapies improve mental health outcomes (Maddock et al., 2020).

This piece contributes to the global conversation around mental health by linking qualitative research with culturally appropriate interventions and high promotion of inclusive, gender-based psychological care in non-Western cultures.

Clinical Implications

Culturally Embedded Symptom Representation

It will provide insight into the tabulation of the symptoms of depression in Pakistani cultural contexts as compared to their details in Western diagnostic manuals – such as DSM-5 and ICD-10. Language and cultural differences mean that symptoms can be described very differently in Urdu in a variety of different ways and that can lead to either an incorrect or under diagnosis or just make expressing depression more difficult. Illness can also be described as idioms of anguish such as dil bhari ho jana (heavy heart) or sar dard (headache) which may cover for underlying sadness (Karasz et al., 2007). This underscores the importance of culturally competent language as a first step to embedding cultural and linguistic factors into diagnostic protocols to improve sensitivity and specificity.

Enhanced Case Identification in Clinical Settings

Shedding light on how depression is expressed in local women is important for mental health professionals and health care professionals so that they will not miss depressive symptoms that may be ignored or misunderstood. It is particularly important in contexts where symptoms predominantly manifest as somatic complaints and where emotional pain may not be able to be verbalized due to stigma (Chaudhry et al., 2010). Screening tools that are sensitive to culture and compatible with local symptom and expression definition and presentation can lead to improved early detection.

Increased ratio of Depression

The authors declare there is no conflict of interest with respect to the study or its findings. The authors did not receive any research or article funding. The study contributes to the growing body of evidence that depressive disorders are immensely common in Pakistani women, with an increasing trend, often due to structural injustices, economic dependency and gendered expectations (Albert, 2015). Policymakers and mental health professionals can thus better promote and allocate resources for gender-responsive mental health practices.

NGO's & Community Based Support Groups

Partnerships with peer support groups, community-based mental health services, and NGO awareness campaigns are vital to reduce cost and sociocultural barriers. These initiatives have been shown to improve care accessibility and acceptance in settings with scarce resources (Rahman et al., 2008; Javed et al., 2021). When local organizations and mental health professionals work together; women can be empowered, mental health literacy can be raised, and stigma can be decreased.

Key Challenges

- There were many challenges whilst designing and implementing this study. One major challenge was identifying participants willing to discuss openly their experiences and difficulties in acknowledging their depressive symptoms, due to the significant stigma around the topic and the fear of judgment from others (Willis et al., 2020).
- Moreover, since direct reference to mental illness has been linked to stigma (Shafiq, 2020), it was important to balance clinical language with vernacular terms when developing the interview guide to enable the content to be culturally stakeholder-driven.

- Other constraints were logistical, including how to protect anonymity in conservative family settings and secure private venues for interviews. Finally, an important analytical issue was to assess participants' nuanced feelings surrounding translation without losing cultural significance (Choudhry & Bokharey, 2013).

Conclusion

This study shows that women use depression to speak from the place of losing their value through the lens of society through their roles and the relations. Many people experienced emotional repression and self-doubt, internalizing cultural norms, particularly those concerning strength, sacrifice and silence. But if women did use support in the home to manage the strain from support, those same systems had also helped build resilience. These findings suggest that the cultural and contextual background of lived experience should be considered alongside symptom counts in determining clinical psychological profiles (Noreen et al., 2021; Abdullah & Brown, 2011).

This is one of the first studies to investigate how cultural, familial, economic, and religious influences shape the lived experiences and expression of depression symptoms in Pakistani women through Interpretative Phenomenological Analysis (IPA). Through elaborate narratives, this research sheds refined light on emotional pain as multifaceted in sociocultural constrained setting. The results show that women's psychological unease is deeply dependent upon gendered roles, faith-affiliated coping strategies and social predilections rather than being addressed as a strictly clinical or scientific matter.

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