Social Stigmatization, Psychological Distress and Coping Strategies Among Mothers of Only Female Children in Rural Punjab, Pakistan

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Abstract

This research aims to explore the experiences of social stigmatization, psychological distress, and coping strategies among rural Punjabi women who have only female children. The study was conducted within a cultural setting where patriarchy and pronatalism are two complex realities. In such contexts, anyone who deviates from these approved cultural norms may face stigma and distress, and to destigmatize themselves may use coping strategies. A qualitative research design grounded in an interpretive approach was adopted to explore these contextually embedded assumptions. Data were collected through in-depth interviews and focus group discussions carried out with participants residing in the rural setting of Punjab province, including mothers of only daughters and community members. A thematic analysis was conducted to identify key patterns and narratives emerging from participant experiences. The findings reveal that these women face persistent stigmatization, emotional abuse, and social exclusion, particularly from in-laws and other female relatives. They are often blamed for reproductive failure and pressured to seek spiritual or herbal interventions. Despite enduring significant psychological distress such as anxiety, shame, and isolation, many women adopt coping strategies rooted in religious faith, emotional resilience, and avoidance. These insights highlight a critical need for culturally sensitive interventions to protect mothers of only female children from psychological distress and resulting mental health issues.

Keywords: Social Stigmatization, Psychological Distress, Coping Strategies, Non-normative Reproduction

Introduction

In many patriarchal societies, motherhood is not simply a biological role but a status associated with the sex of one's children. While becoming a mother is often described as an empowering transition for women (Pashigian, 2002), the experience can be dramatically different in settings where cultural norms equate a woman's worth with her ability to produce sons. In rural regions of Punjab, Pakistan, the birth of only female children is often perceived not merely as unfortunate but as a reproductive failure (Nene, Coyaji, & Apte, 2005; Rouchou, 2013; Wiersema et al., 2006). These gendered expectations that are rooted in cultural, social, economic, and psychological

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dimensions lead to the devaluation and stigmatization of mothers who fail to bear sons (Nene et al., 2005; Pashigian, 2002; Tabong & Adongo, 2003).

The preference for sons is widely documented across many regions of the world, but it is particularly acute in South and Southeast Asia (Tabong & Adongo, 2003). Sons are viewed as the carriers of the family name, future providers, and protectors of family honor, while daughters are expected to marry out and belong to another family. Consequently, women with only female children find themselves marginalized not only by society at large but often by their immediate family (Wiersema et al., 2006). This marginalization manifests through visible and invisible forms of social stigma. According to Goffman (1963), stigma discredits individuals who deviate from accepted social norms. In this context, women with only daughters are perceived as deviants from the cultural ideal of reproduction, making their "failure" a visible mark of shame (Tabong & Adongo, 2003; Wiersema et al., 2006). In extreme cases, these women are pressured to seek spiritual or medical interventions, or their husbands are urged to remarry to ensure the birth of a son (Donkor & Sandall, 2009; Rouchou, 2013).

This stigma over time becomes a chronic stressor and gives birth to distress. Psychological distress among stigmatized women is well-documented and includes anxiety, depression, low self-esteem, and feelings of helplessness (Hasanpoor-Azghdy, Simbar, & Vedadhir, 2014). While both men and women face psychological consequences of reproductive challenges, research shows that women, especially those in male-dominated societies, bear the larger emotional burden (Zuraida, 2010). They face marital strain, social exclusion, and aggressive questioning from relatives and neighbors (Amiri et al., 2016). Faced with such pressures, stigmatized women often turn to a range of coping strategies, i.e., help-seeking behaviors (active efforts) and ongoing coping methods (passive efforts), to manage their distress (Remennick, 2000; Donkor & Sandall, 2009).

Women with only female children tend to pursue alternative routes to cope with their problem. Their condition is not one of physical infertility but of a socially constructed deficiency. It is, therefore, interesting to explore whether they consult spiritual healers and herbalists as among infertile women (Greil et al., 2014; Yebei, 2000). Religious faith and spirituality are considered to play a central role in how women with reproductive issues manage their social and emotional suffering (Amjad & Ahmad, 2023). Belief in divine interventions and offering personal prayers is well documented for infertile women but invisible in the case of stigmatized mothers of only daughters (Amjad, 2023; Donkor & Sandall, 2009; Yebei, 2000).

Research studies indicate that infertile women employ a range of psychological strategies i.e., avoiding negative comments, focusing on their other strengths, redefining their situations in a positive light, and seeking emotional support from their husbands, relatives, and friends (Donkor & Sandall, 2009). In addition, some infertile women also engage in more cognitive strategies such as denial, wishful thinking, and attempts to normalize their condition in social settings (Amjad, 2024; Remennick, 2000). Others try to reassert control over their lives by accepting fate and focusing on the future. Emotional resilience, inner strength, and a strong sense of self can be critical to this process. In extreme cases, adoption is also considered a coping strategy. While adoption practices vary widely across cultures, in Southeast Asia, couples typically prefer to adopt from within the family, rather than from foster homes or institutions. There is no such scientific study in the existing literature to highlight the use of such coping methods among stigmatized mothers of only female children. However, academic literature remains scarce on the specific lived experiences of women with only female children in rural Punjab. This study, therefore, seeks to examine the nature of social stigmatization, psychological distress, and coping mechanisms among rural women in Punjab who have only female children.

Review of Literature

Despite extensive research on reproductive health, much of the existing literature predominantly focuses on infertility, either male, female, or both, while largely overlooking the culturally constructed notion of reproductive failure in patriarchal societies, especially in the context of women bearing only female children. In such settings, where the preference for sons is deeply embedded in social and religious norms, the inability to produce sons is viewed as a significant failure of motherhood (Wiersema et al., 2006). Sons are often expected to carry the family name, perform religious rituals, and provide economic and social support, reinforcing their perceived superiority. Consequently, mothers of only daughters might be subjected to various forms of stigmatization and psychological distress, including feelings of guilt, anxiety, and social exclusion (Daar & Merali, 2002).

The literature identifies three broad types of stigmas affecting women with fertility problems, i.e., perceived stigma, experienced stigma, and internalized stigma (Amjad, 2023; Cook & Dickens, 2014). Scholars emphasize that stigma in any form can result in suffering (Tabong & Adongo, 2003). Victims are often subjected to intrusive questioning at social events, where they are asked about their children, gender composition, and steps taken to "fix" their reproductive situation (Rouchou, 2013). They also face judgmental comments, ridicule, and name-calling (Riessman, 2000). The blame often comes from close family members, especially the mother-in-law, who accuses them of reproductive failure (Wiersema et al., 2006). Although abandonment is rare, the constant fear of it adds to women's psychological burden (Shahnooshi & Karimi, 2010).

The situation worsens in rural areas, among less-educated and economically dependent women who lack the resources or social status (Amjad, 2024). Interestingly, the most frequent stigmatizer are other women, i.e., mother-in-law, female relatives, and community women, while men play a relatively subdued role in direct stigmatization (Riessman, 2000). In public and private spaces alike, these women encounter various forms of social shaming that reinforce their outsider status and deepen their distress (Wiersema et al., 2006). The literature strongly suggests that reproductive failure, especially in the form of bearing only daughters, is a socially constructed issue rather than a biological one. Yet, its impact on women's lives is profoundly real and deeply damaging.

Women experience significant psychological distress, including depression, anxiety, feelings of worthlessness, and chronic emotional pain. The shame associated with reproductive failure often results in withdrawal from social life, reluctance to participate in community events, and the internalization of inferiority. Many women choose to suffer in silence, fearing judgment or ridicule. The emotional burden is compounded when the stigma comes from within the family, particularly in-laws and spouses, creating an environment of persistent emotional insecurity. Research has shown that stigmatized women tend to self-isolate, limit their social interactions, and develop low self-esteem (Donkor & Sandall, 2009; Tabong & Adongo, 2003).

Review of existing literature indicated a number of coping strategies adopted by the women facing reproductive stigma, i.e., resistant thinking, reinterpreting their situation, strategic avoidance, staying away from gatherings or relatives, speaking out and acting up to avoid hurtful comments (Riessman, 2000; Wiersema et al., 2006). While naming the husband is rare due to patriarchal constraints, some women subtly shift blame (Rouchou, 2013). Adoption and fostering, usually within extended family, offer a way to meet societal expectations, though formal adoption is often frowned upon (Amiri et al., 2016). Psychological strategies include denial of the problem and wishful thinking about future resolution, talking to trusted others, fate acceptance and social support (Donkor & Sandall, 2009).

Overall, the provided literature indicates that any label or characteristic which discredits women's social position and lowers their status works as stigma. Stigma, as proposed by scholars, is always hurting and discrediting. The overwhelming nature of the stigma is painful and negative; therefore, it gives birth to psychological distress, i.e., anxiety, depression, feelings of shame and guilt, isolation and deprivation. The studies also indicate that victims use many different help-seeking behaviors and coping methods to destigmatize themselves. However, the studies included in the review are published mainly on infertility among women (Amjad and Ahmad, 2023), and none of the direct study was identified from the literature to explore the experiences of mothers with only female children. Therefore, in the present study, a review of the literature is provided to understand the context of social stigmatization, psychological distress and coping strategies rather than critically examining studies published on a broader study topic.

Methodology

Research Approach and Philosophical Foundations

The present study employed a qualitative research approach, rooted in the philosophical underpinnings of the interpretive paradigm. Interpretivism focuses on understanding the subjective realities and lived experiences of individuals within specific sociocultural contexts. This philosophical stance aligned well with the study's focus on exploring the experiences of women with only female children in a patriarchal and pronatalist rural setting. A qualitative design allowed the researcher to capture the depth and complexity of stigmatization, psychological distress, and coping mechanisms that could not be effectively quantified. Through these lenses, knowledge was co-constructed between the participants and the researcher, allowing for rich, nuanced insights.

Study Setting

The study was conducted in the rural areas of District Hafizabad in Punjab, Pakistan. This district was selected purposively because of its strong adherence to patriarchal and pronatalist cultural norms. In this region, the preference for sons is deeply embedded in the social fabric, and women who give birth only to daughters often face discrimination, emotional neglect, and stigmatization. This setting provided the researcher with a context where the issues under study were culturally relevant and widely observed. The district is primarily agrarian, with limited educational and healthcare resources, especially for women. The prevalence of traditional gender roles and community-based honor codes further amplified the significance of sons, making the experiences of these women more pronounced and worthy of study.

Recruitment of the Participants

Participants were recruited through purposive sampling, which allowed the researcher to select individuals who had firsthand experience with the research topic. The study included 82 participants, consisting of 42 women with only female children (in-depth interviews) and 40 community members for conducting focus group discussions, including both men and women. Specific inclusion criteria were established, i.e., women participants had to be residents of rural areas of District Hafizabad, have given birth to at least three daughters, and have no sons. The community members included elderly men and women, locally influential people, and neighbors who could provide insights into societal attitudes and community behaviors. The purposive selection ensured that each participant brought valuable and relevant perspectives to the research.

Data Collection

The study utilized a semi-structured interview guide and a discussion guide as the primary tools for data collection. These guides were designed to explore key dimensions of participants' lived experiences, including stigmatization, psychological distress, and coping strategies. The guides were divided into sections, starting with basic demographic information, followed by open-ended questions that encouraged narrative responses. The tools were first developed in English and then translated into Urdu, the national language, to ensure clarity and understanding for both participants and field researchers. The use of guides allowed us to probe deeper based on participants' responses, thereby uncovering insights that might not emerge in a rigidly structured format. In addition to individual interviews, the guides were flexible enough to accommodate hypothetical scenarios and allow the use of fictional characters, which helped participants discuss sensitive issues indirectly. Mock interviews were conducted during the training of female research assistants to ensure the guide's usability and effectiveness.

Researcher's Positionality and Reflexivity

The researcher's positionality was central to the design and implementation of this study. Being a male resident of rural Hafizabad, the researcher had firsthand exposure to the cultural and social dynamics under investigation. This insider status offered both advantages and challenges. While it allowed the researcher to access the field more easily and understand the participants' contexts intimately, it also posed the risk of introducing personal biases. To manage this, reflexivity was adopted as a core methodological tool. The researcher remained critically self-aware of how his background, beliefs, and assumptions might influence data collection and interpretation. Recognizing the cultural sensitivity of the topic and the potential discomfort female participants might experience speaking to a male researcher, two female research assistants were recruited and trained to conduct interviews with women. These assistants were sociology graduates from the same district and were familiar with the local dialect and norms. Their involvement ensured a more comfortable and open environment for female participants, while also contributing to a more balanced and unbiased analysis through collaborative coding and theme identification. This reflexive strategy enhanced the credibility and ethical integrity of the research while maintaining respect for cultural boundaries.

Strategies to Enter the Research Site

Entering the research site and establishing trust with participants required careful planning and sensitivity to local cultural dynamics. The researcher relied on personal networks and community gatekeepers to initiate contact. Gatekeepers, such as local elders, teachers, or health workers, helped build trust and legitimacy for the study. However, gatekeepers were not involved in selecting participants to avoid introducing bias or undue influence. Rapport building was treated as an ongoing process that started with the first interaction and continued throughout the fieldwork. The researcher and the field team approached community members respectfully and transparently, explaining the study's purpose, scope, and confidentiality measures. Female research assistants played a vital role in easing access to female participants by ensuring cultural appropriateness and fostering comfort during interviews.

Ethical Considerations

Ethical integrity was maintained throughout the research process. Informed consent was obtained from all participants, both verbally and in writing, after explaining the study's aims, methods, and

potential risks. Participants were assured that their involvement was voluntary and that they could withdraw at any time without consequences. They also had the right to skip any question they found too personal or distressing. The researcher and field team created a comfortable, respectful environment by using culturally sensitive language and methods. Hypothetical characters and storytelling techniques were offered to participants as alternative ways to discuss sensitive experiences. All interviews were conducted in private spaces selected by the participants to ensure confidentiality and comfort. Special care was taken to protect participants' identities; names were anonymized, and data were securely stored in password-protected files and locked storage. Audio recordings were kept confidential and used strictly for transcription purposes.

Data Analysis

The data analysis followed an inductive, thematic approach that allowed patterns to emerge directly from the participants' narratives. After data collection, audio recordings and field notes were transcribed verbatim in English. These transcripts were cross-checked by the researcher and female research assistants to ensure accuracy and avoid misinterpretation. Thematic analysis was conducted in several stages. Initially, the researcher immersed himself in the data by reading each transcript multiple times to gain familiarity. The text was then broken down into meaningful units, such as sentences or paragraphs, which were manually coded. These codes represented significant concepts, emotions, or events discussed by participants. Codes with similar meanings were grouped into broader categories, and from these categories, overarching themes were derived. Both common and emergent themes were identified. The analysis remained flexible, allowing for revision of codes and themes as new insights emerged. Female research assistants contributed to the coding process, ensuring triangulation and minimizing researcher bias. The entire process was documented systematically, enhancing the transparency and rigor of the analysis. This method provided a rich, nuanced understanding of the experiences of stigmatization, psychological distress, and coping among women with only female children.

Findings

The setting of the study was found to be highly patriarchal, in which male family members headed the majority of the households, and patrilocality was the most common pattern of residence. Married couples lived with the husbands' parents in joint family systems, and the wives' relatives were found to visit their daughters only occasionally. Experiences of the research participants confirmed that traditional gender roles persisted in the household, where women were expected to care for children and the home. Furthermore, husbands were found responsible for earning and bearing the family's financial burden. These contextual factors confirmed that the present study was highly cultural in terms of patriarchy and pronatalism. The findings indicated that marriage, a socio-religious bond, aims to produce children, especially sons. Hence, mothers' lives were influenced by their ability to produce children, especially sons. One of the research participants during the focus group discussion narrated;

> *The ultimate goal of marriage is to produce children. Marriage is incomplete without children. Daughters are blessings, and sons are also a favor of Allah. Mothers need to take care of their children, and fathers are to take responsibility for the household.*

The study also found that social stigmatization of the mothers of only female children was a highly cultural phenomenon. The research participants further narrated that the contextual characteristics of the overall rural Punjabi community influenced it.

Stigma of Non-Normative Reproduction

It was found in the study that reproduction was not understood purely in biological terms; instead, it was interpreted through a socio-cultural lens where the birth of sons elevated a woman's status, and the repeated birth of daughters signaled misfortune, reproductive failure, and shame in rural Punjabi culture. Furthermore, folk wisdom, steeped in patriarchal ideology, consistently blamed women for producing daughters while absolving men of any biological or moral responsibility. The findings confirmed the gender nature of reproduction, in which the responsibility of producing children was placed on mothers rather than both parents. It was found that misfortune, fertility, and the blame for daughters were intergenerationally assigned to women. One mother who was in her late thirties described:

> *After the third continuous birth of a daughter, I was also very disappointed. It was an environment of great disappointment and sorrow for my in-laws. Even some relatives were suggesting my husband to remarry. It was no less than a bomb to hear this all. It seems I am faulty and responsible for my inability to produce sons. My husband often uses to say that his uncle remarried and he is father of two sons.*

These findings highlight that the lack of sons invites communal sympathy for the husband, while the mother is stigmatized and discarded. Religious scholars and lady health visitors criticized these narratives in focus group discussions, calling such practices harmful and misinformed. Nevertheless, cultural traditions and ignorance overrode such voices. The study confirmed that the stigmatization of mothers for non-normative reproduction is deeply gendered and systemic. The findings further revealed the multifaceted stigmatization experienced by mothers of only female children in patriarchal Punjabi society. Participants i.e., women with only female children, reported persistent social questioning and labels, i.e., nemani, keeri, panad, na-khasmi, acchot and badbakhat,, often at inappropriate times. They faced inappropriate questions about their reproductive history and lack of sons by friends, family members and relatives. This was accompanied by unwanted comments, gossip, and indirect ridicule, particularly from in-laws, friends, and community members. One of the research participants reported:

> *I was attending a ceremony at my aunt's house, and a woman was telling her friend that I had four daughters and no son. She was a little bit away, yet they were loud enough to make me listen clearly. I also faced many such comments from my sister-in-law, even in my presence. Their comments are taunts and irritate me. Once I heard one of our relatives saying," She does not know why I was so happy and proud. My relatives do not want me to be happy and smiling. If I do not have a son, it is my fate that they want me to be sad and shabby.*

It was noted that the stigma extended into direct ridicule and verbal abuse, often from close family members. A more severe consequence was abandonment, as reported by participants. Several women were temporarily or permanently abandoned, and some divorced by their husbands, who sought male heirs through remarriage. Focus group discussions supported these accounts, highlighting cultural beliefs that legitimize second marriages when a wife bears no sons. Despite this, a strong religious discourse emerged in participants' narratives. Many mothers viewed the birth of daughters as the will of Allah, emphasizing that divine will governs reproduction. One such mother claimed:

> *It is the will of Almighty Allah whether the baby will be a boy or a girl. It is a divine system which is beyond humans' control. It is the destiny of humans which is under the powerful control of Allah Almighty. It is the will of my Lord; Allah is the wisest and never burdens*

anyone beyond their tolerance. If I am the mother of five children, it is the will of Allah. Perhaps, sons were not in my best interest; therefore, He never blessed me with a baby boy.

Study further confirmed that religious teachings, particularly those from Islamic traditions, were invoked to affirm the value and blessing of daughters. This religious counter-narrative stood in stark contrast to the prevailing social stigmatization, highlighting a tension between cultural practices and spiritual beliefs.

Experiences of psychological distress

Data indicated that in rural Punjabi culture, women who bore only daughters faced significant psychological distress due to societal expectations of normative reproduction, which prioritizes the birth of sons too. These women endured distressing experiences, including verbal insults, rejection, and being labelled as inadequate. Despite their efforts, they were held accountable for their "non-normative" reproduction, resulting in feelings of guilt, pain, and humiliation, exacerbated by deeply rooted cultural beliefs and gendered family expectations. One of the participants reported:

After repeated births of the daughters, I feel that I am the cheapest and invaluable in my family. Many times, I felt that they did not consider me worthy of taking my opinion. I am not acceptable, and even my mother-in-law cannot tolerate my existence in her home. She cursed me by saying; You are the first to produce daughters in family.

The study highlights that psychological distress linked to non-normative reproduction is deeply gendered, with mothers being overwhelmingly blamed for having only daughters. Distress stemmed from family members, especially mothers-in-law, sisters-in-law, and co-wives, through verbal abuse, social exclusion, and favoritism. Though some husbands and fathers-in-law also contributed to the stigma, women were the primary perpetrators. One of the mothers with four daughters who was in her late forties reported:

My father-in-law is more abusive than my mother-in-law. He said many times, Look, girl, I need a successor for my son in either case. I did not make you my daughter-in-law to produce only daughters. I cannot bear my lands distributed among my relatives, they are my competitors, not supporters. It was his order which forced me to produce five daughters. At the end, he selected a girl for my husband and without informing me, my husband married a second time. When I came to know, I was broken and cried for many days and nights.

The distress experienced by these mothers included depression, anxiety, helplessness, and even suicidal thoughts as reported by the participants. The stigma acted as both an acute and chronic stressor, limiting mothers' social acceptance, status, and emotional well-being. Participants, i.e., women with only female children, perceived failure to produce sons led to profound psychological suffering and social marginalization.

Coping Strategies

The mothers of only female children were also found using multiple coping strategies, i.e., help-seeking behaviors and coping methods, to destigmatize themselves and to overcome psychological distress. During in-depth interviews, women with only female children reported the use of traditional folk strategies to produce sons, i.e., planning pregnancy on odd moon nights, by midwives, etc. In addition, many of these mothers practiced spells, magic and charms as suggested by different religious scholars and spiritual healers. One of the mothers of only female children who visited a magician reported:

> *My mother-in-law and I visited him. He was living in an abandoned place near a graveyard. He asked me to repeat two verses after being naked at the intersection of two streets. After three continuous births of daughters, I visited him again, and he asked me to visit the graveyard at 12 AM. I performed his suggested magic for forty-two days, but I was unable to produce a baby boy.*

A mother of only daughters who was in her mid-forties claimed:

> *My mother-in-law forced me to visit a peer who was living in a nearby village. He was very famous for helping mothers produce sons. He asked me to visit him every Sunday for about seven weeks. First of all, he gave me many amulets. I was asked to soak those amulets in water and take a shower with that water. He strictly ordered me to visit him as soon as the menses start. In the third week during my menses, I visited him. He asked me to remember a verse and visit any house where a newborn baby boy was born. I was to sit there to repeat those verses in my heart for about seven minutes.*

Women were also visiting quacks' clinics and medical stores to take bio-medical treatment for producing sons. Many mothers also visited hakeems, who, with the help of herbs, were supposed to help them produce sons. This herbal treatment was found to be less costly, and hakeems were readily available in rural areas, making them one of the most visited agents by such mothers. It is pertinent to mention the role of spiritual healing and guidance which such mothers received in the form of holy verses, saying prayers, promising and sacrificing, visiting peers and shrines. One such mother reported:

> *I visited a peer who lives in our city. He handed over a dozen amulets and divided them into three categories. The first four were to dip in water and drink water before going to bed and after waking up in the morning. The second category was of those amulets which were to be hung around the neck, and the third category of amulets were to be placed at the entrances and exits of the house. The respected peer told us that I was under the spell of black magic and was advised to follow his instructions very carefully.*

The present study further revealed that mothers of only daughters in a rural Punjabi society also coped with stigma through various strategies, including emotional sharing, spiritual acceptance, and symbolic acts like adopting a male child from relatives. Many participants concealed their emotions, avoided social gatherings, or sought comfort in religion, framing their situation as destiny or divine will. One such mother claimed:

> *It is my fate that I am a mother of only daughters. Whenever my mother-in-law or someone else teases me, I pray to Allah to help me overcome the pain. It is the Will of Almighty Allah. He has His best plans. Suppose I am unable to produce sons. It is in our best interests. It is our test and I do not have any regret or complaint.*

Some participants, i.e. women with only daughters, blamed their husbands, citing biological facts to shift accountability, while others passed the stigma as usual by invoking religious narratives. Although similar to coping strategies reported among infertile women (e.g., spiritual coping, denial), these practices are uniquely shaped by gendered expectations and cultural context.

Discussion

This study examined the lived experiences of rural Punjabi women who bear only female children, within a cultural milieu shaped by strong patriarchal and pronatalist norms. The findings reveal a deeply entrenched belief system that places an overwhelming value on sons, viewing them as carriers of lineage, providers of social security, and upholders of religious and familial legacy. Within this framework, the inability to bear sons is constructed not only as a reproductive

inadequacy but as a social failure of the woman. These findings strongly align with prior scholarship that views reproductive stigma, particularly in patriarchal societies, as a socially constructed phenomenon rather than a purely biological one (Riessman, 2000; Wiersema et al., 2006).

In the present study, women were stigmatized through both overt and subtle forms of social discrimination. They were labelled with derogatory terms, ridiculed in both private and public spaces, and subjected to questioning and gossip, particularly from other women, such as mothers-in-law and female community members. This finding echoes the literature, which suggests that stigma is often perpetuated more intensely by women than men in patriarchal cultures, due to internalized gender roles and expectations (Donkor & Sandall, 2009; Riessman, 2000). The cultural belief is that a woman's reproductive capacity, specifically her ability to produce sons, defines her worth. It was found to be central to the experiences of stigma in the present study. As reported by Sharma et al. (2024), the sociocultural lens through which reproduction is interpreted leads to the woman being held solely responsible for the gender of the child, despite scientific evidence attributing this to male chromosomes. The present study's findings are consistent with those of Sharma et al. (2014).

Stigma, as reported in the present study, was not limited to name-calling or verbal abuse but extended to abandonment, emotional isolation, and second marriages initiated by husbands. These outcomes demonstrate how reproductive stigma translates into tangible social consequences. While similar patterns have been noted in previous studies on infertility (Tabong & Adongo, 2003; Rouchou, 2013), this study contributes to the literature by focusing on a distinct group, i.e., mothers of only daughters, whose experiences have received limited direct attention.

A significant insight from the data is the intersection of religious belief and cultural practice. While societal norms often devalue daughters, many participants resisted internalizing this stigma by invoking religious narratives that emphasized divine will and the spiritual value of daughters. This spiritual framing served as both a coping mechanism and a form of resistance to the dominant cultural discourse. These claims supported the findings by Sternke and Abrahamson (2015). They claimed that religious coping offers a means of psychological resilience in stigmatizing situations, particularly for women constrained by limited social and emotional outlets.

Psychological distress among these women was profound and multifaceted, including depression, anxiety, feelings of worthlessness, and even suicidal ideation. These experiences were primarily rooted in systemic blame and exclusion within the family. The emotional pain reported by participants, particularly in being viewed as inadequate or as failures by their in-laws, aligns with Cook and Dickens' (2014) categorization of internalized stigma, where external blame is absorbed into the woman's self-concept. Furthermore, the presence of gendered violence in the form of verbal insults, emotional neglect, and abandonment illustrates how reproductive stigma intersects with broader forms of gender-based oppression (Islam, Chaudhary, & Aziz, 2022).

Coping strategies employed by the women were both culturally embedded and individually adaptive. Participants reported seeking help from spiritual healers, using amulets, charms, and traditional beliefs to "correct" their reproductive outcome. These behaviors indicate the strong influence of folk wisdom and supernatural interpretations of fertility, which persist in rural contexts with limited access to formal education and healthcare (Amiri et al., 2016). Additionally, women also employed psychological and emotional strategies such as denial, reinterpretation of events, withdrawal from social settings, and acceptance of fate. These findings are consistent with previous literature that identifies similar coping mechanisms among infertile women (Donkor &

Sandall, 2009; Sormunen et al., 2018), suggesting that stigma, regardless of its reproductive cause, produces common patterns of psychological response.

However, the current study reveals some coping strategies that are particularly distinctive to mothers of only female children. For instance, symbolic acts like attempting to adopt a male child from extended family members or shifting blame subtly towards the husband by referencing scientific facts highlight a gendered adaptation to cultural expectations. Moreover, the deliberate framing of daughters as blessings and trials from Allah presents a dual strategy of emotional survival and spiritual resistance. These findings illuminate how women can reinterpret religious and cultural scripts to regain agency, even within oppressive environments (Ahoya, 2021).

The study also contributes to theory-building around stigma in reproductive health. It supports the conceptual triad of perceived, experienced, and internalized stigma (Cook & Dickens, 2014), while adding cultural specificity to these categories. For example, "perceived stigma" was observed in women's fear of public ridicule and self-censorship at gatherings; "experienced stigma" manifested in direct verbal abuse and exclusion; and "internalized stigma" appeared in their feelings of shame and devaluation. Importantly, these layers of stigma were embedded in a patriarchal structure that systemically privileges sons and marginalizes daughters.

This study also highlights the profound emotional, social, and spiritual toll of bearing only daughters in a cultural context where son preference dominates. It draws attention to the interplay of stigma, distress, and culturally contextual coping strategies, and demonstrates how patriarchal norms, family dynamics, and spiritual beliefs coalesce to shape women's reproductive experiences. Future research should explore intervention strategies to challenge these cultural norms and psychologically support affected women. Additionally, policy frameworks must recognize the harmful impact of son preference and address the social institutions that perpetuate reproductive stigma while incorporating efforts from all stakeholders. There is also a dire need for collaborative efforts among researchers and policymakers.

Conclusion

This study reveals the deep-rooted stigma and psychological distress experienced by women in rural Punjab who give birth only to daughters. In a society where reproductive success is measured by the ability to produce sons, these women face systemic discrimination and emotional instability. The findings underscore that stigmatization is not only external but also internalized, contributing to long-term psychological distress. However, the study also shows the use of coping mechanisms among these mothers of only daughters, including spiritual healing, reliance on religious faith, and selective avoidance. Many women reinterpret their experiences through culturally appropriate narratives that offer emotional relief and social justification. The absence of targeted support structures and the persistence of harmful cultural ideologies call for urgent policy and community-based interventions. By shedding light on this overlooked population, the research contributes to a broader understanding of gendered stigmatization and the need for inclusive health and social policies in patriarchal societies.

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