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Exploring Psycho-social Dimensions of Infertility: A Qualitative Study of Challenges and Coping Mechanisms among Urban Women

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Abstract:

Infertility remains one of the most overlooked reproductive health concerns, disrupting the natural reproductive processes of both men and women due to medical, physiological or environmental causes. The inability to conceive often generates multidimensional challenges that extend beyond the biological realm. This qualitative study aimed to explore the psychosocial difficulties and coping mechanisms of women experiencing infertility. Using a snowball sampling approach, ten women with primary infertility residing in metropolitan Lahore were recruited. After obtaining informed consent, semi-structured interviews were conducted, audio-recorded and subsequently transcribed verbatim. Thematic analysis revealed four overarching themes: (1) the psychosocial challenges of infertility, (2) infertility as a lifelong crisis, (3) the significance of support systems and (4) coping strategies. The findings highlight infertility as a complex biomedical and psychosocial condition that adversely influences women's physical well-being, emotional health, financial stability and spousal relationships. Regardless of socioeconomic status or medical etiology, participants described infertility as an enduring life crisis. Familial and spousal networks emerged as the most consistent sources of moral, emotional and financial support. Participants also employed diverse problem-focused and emotion-focused coping mechanisms including medical, traditional, spiritual and social strategies.

Keywords: Infertility, primary infertility, psychosocial challenges, support systems, coping strategies, emotional health

INTRODUCTION

Sexual reproduction is one of the most fundamental biological processes, serving as a cornerstone of human continuity and societal development. Fertility, defined as a natural capability to conceive and bear offspring has been considered as a defining aspect of human identity, family formation and social stability throughout history. Conversely, infertility the inability to achieve conception

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despite regular, unprotected intercourse represents a significant disruption of this natural process. It not only affects the physical dimension of reproduction but also deeply influences the psychosocial, emotional and cultural well-being of individuals and families (Mascarenhas et al., 2012).

Globally, infertility has emerged as one of the most challenging yet neglected reproductive health concerns. Despite its profound consequences, it often receives limited attention within public health discourse, particularly in developing and low-resource contexts. The World Health Organization (WHO) recognizes infertility as a disease of the reproductive system, defined by the failure to achieve pregnancy after 12 to 24 months of regular, unprotected sexual intercourse (Hochschild et al., 2009). Although medical and physiological causes are evident, the social stigma, psychological distress and economic burden associated with infertility transform it into a multidimensional issue extending far beyond biomedical boundaries.

Globally, it is estimated that approximately 80% of couples achieve conception naturally, while the remaining 20% experience varying degrees of infertility (Saif et al., 2021). Infertility affects both men and women and is triggered by a combination of biological, environmental, genetic and lifestyle factors (Begum & Hassan, 2014). Additionally, external contributors such as stress, obesity, environmental toxins, smoking and substance use exacerbate reproductive challenges across genders.

According to WHO estimates, the prevalence of infertility in developed countries comprises approximately 8% of cases attributed to male factors, 37% to female factors and 35% to combined causes. In developing countries, however, infertility affects between 60 and 168 million individuals, with roughly one in every ten couples experiencing either primary or secondary infertility. Notably, the incidence of primary infertility remains higher at 21.9%, compared to 3.5% for secondary infertility (Saif et al., 2021). These statistics reflect not only underlying biological causes but also the social and cultural meanings attached to fertility across different regions and societies.

In developed world, infertility is increasingly associated with delayed marriages, postponed pregnancies and lifestyle factors such as stress, poor diet or substance use. Assisted reproductive technologies (ARTs) such as in vitro fertilization (IVF), intrauterine insemination (IUI), surrogacy and cryopreservation are widely available and socially accepted in these contexts (Greil et al., 1988). Conversely, infertility in developing countries often translates into a social and emotional crisis shaped by limited healthcare infrastructure, economic barriers and entrenched patriarchal norms. Factors such as malnutrition, untreated infections and lack of reproductive health education exacerbate infertility rates (Begum & Hassan, 2014). Within these contexts, infertility is often viewed not merely as a medical condition but as a moral or social failure, an interpretation that dis-proportionality burdens women.

Infertility represents a profound psychosocial challenge that undermines both individual identity and social standing. Across cultures, parenthood, are deeply embedded within gender roles and cultural expectations, often determining social respectability, marital stability and emotional fulfillment. While both men and women experience distress due to infertility, women disproportionately face stigma, blame and exclusion (Begum & Hassan, 2014). They often endure feelings of guilt, depression, fear, isolation and hopelessness, coupled with pressure from family and community to conceive children shortly after marriage.

In collectivist societies, where family reputation and lineage carry immense importance, infertility can lead to marital discord, domestic violence and in some cases polygamy. In contrast, men's infertility is less visible due to cultural taboos surrounding masculinity and reproductive potency. This gendered silence reinforces the patriarchal narrative that places the burden of childbearing solely on women, thereby absolving men of accountability and intensifying women's marginalization and emotional trauma (Naz & Batool, 2017).

Religion and cultural belief systems play a significant role in shaping perceptions of infertility and individual's responses to it. Within Islamic doctrine, marriage and procreation are sacred duties, forming half of one's faith. The Qur'an and Hadith affirm that fertility and childbearing ultimately depend on the will of Allah, citing examples of the miraculous conceptions of Prophets Ibrahim (Abraham) and Zakariyyah (Zechariah) as reminders of divine power and mercy (Rabia, 2013).

Islamic jurisprudence encourages medical interventions for infertility within ethical boundaries. Assisted reproductive technologies such as IVF are permissible under Islamic law, provided that the gametes used belong to the married couple and no third-party involvement such as donor sperm, eggs or surrogacy is included (Al-Bar & Chamsi-Pasha, 2015). Surrogacy and gamete donation, on the other hand, are strictly prohibited due to concerns of lineage confusion and violation of marital sanctity. Adoption, however, is viewed as a virtuous act, particularly for caring for orphans, though Islamic jurisprudence emphasizes guardianship rather than legal parentage.

These religious interpretations offer moral clarity and psychological reassurance to many Muslim women facing infertility. Many find comfort in faith, prayer and acceptance of divine will, framing infertility not as punishment but as a test of endurance and spiritual strength.

Pakistan, as a patriarchal and agrarian society, attaches deep cultural significance to fertility and lineage. Manhood is symbolically linked to fatherhood, while womanhood is primarily defined by motherhood. A women's ability to bear children especially sons is perceived as both a duty and a privilege for women, ensuring social stability, inheritance continuity and familial honor (Naz & Batool, 2017). Consequently, infertility is often equated with personal failure, weakness, moral deficiency or divine disfavor.

Empirical estimates suggest that approximately 22% of Pakistani couples face infertility, including 4% with primary infertility and 18% with secondary infertility (Naz & Batool, 2017). In many cases, the blame disproportionately falls on women, even when male infertility is medically confirmed. Due to notions of masculinity and shame, men frequently avoid diagnosis or treatment, leaving women to bear the social and psychological consequences alone.

Within joint-family systems, infertile women often experience domestic conflict, emotional abuse or exclusion from social events such as weddings and baby showers. In extreme cases, infertility results in marital instability, polygamy, or divorce. Women are often subjected to derogatory labels such as "barren" or "accursed," further alienating them from their communities. Many resort to traditional healing practices, spiritual healers or excessive hormonal medication in hopes of conceiving, often with harmful side effects (Ali et al., 2011).

Moreover, infertility is frequently interpreted through the lens of superstition attributed to black magic, the evil eye or divine punishment rather than seen as a medical condition requiring clinical intervention. This perception not only delays treatment but also deepens women's psychological

suffering. Limited awareness of reproductive health, inadequate healthcare facilities and high costs of fertility treatments further hinder effective management. Despite advancements in medical science, infertility remains a deeply stigmatized and taboo subject in Pakistan, seldom discussed openly due to cultural modesty and rigid gendered social restrictions.

The psychosocial burden of infertility manifests through emotional distress, self-blame and social withdrawal. Studies from South Asia indicate that infertile women often experience anxiety, depression and lowered self-esteem, leading to strained marital relations and diminished quality of life (Begum & Hassan, 2014). The emotional toll is compounded by the societal expectation that women must conceive soon after marriage, framing infertility as a moral or personal inadequacy rather than a medical condition.

This gendered stigmatization perpetuates a cycle of silence and internalized shame. Many women refrain from seeking medical assistance due to fear of social judgment, lack of spousal support and anticipated blame from extended family members. Others adopt passive coping strategies such as isolation, religious faith or acceptance of fate, while a smaller proportion pursue alternative or biomedical solutions largely contingent upon financial resources and family approval (Naz & Batool, 2017).

The persistence of patriarchal structures limits women's agency to make reproductive decisions, perpetuating dependence on husbands and families. Consequently, even when infertility stems from male factors, cultural norms dictate that women shoulder the blame and bear the emotional consequences. This gendered imbalance reflects the intersection of reproductive health, power dynamics and social inequality within Pakistani society.

Despite the pervasive stigma, many women develop resilience through various coping strategies and social support systems. Family members particularly mothers, sisters and sympathetic spouses often serve as vital sources of emotional and moral strength. Social networks, religious communities and close friendships provide spaces of empathy and shared experience.

Coping strategies among infertile women are diverse, encompassing both problem-focused and emotion-focused approaches. Some pursue medical solutions such as assisted reproductive technologies (IUI, IVF), while others turn to spiritual practices, prayer or traditional remedies. Social withdrawal and isolation are also commonly employed, as women attempt to avoid judgment or emotional pain. For some women, financial independence and career engagement emerge as alternative pathways to self-worth and social recognition. More recently, digital media platforms offer new avenues for emotional support, allowing women to connect with others experiencing similar struggles.

These adaptive mechanisms, while varied, highlight the need for structured psychosocial interventions, awareness programs and inclusive healthcare services that acknowledge infertility as both a medical and social concern. Strengthening support systems could significantly enhance women's emotional well-being and reduce the psychological toll associated with infertility. By focusing on primary infertile women in the urban setting of Lahore, this study seeks to fill a critical gap in gender-sensitive research on reproductive health in Pakistan. It aims to generate nuanced understanding of how infertility is experienced, negotiated and managed in patriarchal cultural

contexts, thereby informing both policy and practice in the fields of gender studies and health psychology.

Given the multidimensional impact of infertility, this study aims to explore its psychosocial implications and coping frameworks among urban women in Pakistan. The specific objectives include; to examine women's self-perceptions and beliefs regarding infertility. To identify the psychosocial consequences experienced by infertile women. To investigate the coping strategies and support systems utilized by women to manage infertility-related stress and stigma. The study focuses on the following research question: How do women experiencing infertility in Lahore perceive and cope with the biological and psychosocial challenges shaped by social learning and patriarchal cultural norms?

LITERATURE REVIEW

The existing body of literature consistently documents the complex and multi-dimensional impact of infertility on individuals and couples. Across cultural and geographical contexts, recurring themes include stigma, psychosocial distress, gendered blame, limited access to infertility treatments and the reliance on informal coping strategies (Ali, et. al., 2011; Behboodi-Moghadam, 2017; Naz & Batool, 2017). Although study settings vary considerably from Iran and Nepal to Nigeria, Mali, Brazil, India and the United States many core patterns remain consistent. Women experience greater social exclusion and emotional suffering compared to men; families and spouses act as critical but variable sources of support; and coping resources include biomedical intervention, traditional remedies, faith and spirituality and social isolation (Bista, 2015; Casu et al., 2018; Eleje et al., 2019; Tripathy et al., 2020).

Prevalence, Psychosocial Burden and Gendered Differences

Epidemiological and psychosocial research continues to underline the scale of infertility's burden particularly among women. A recent large-scale meta-analysis found a pooled odds ratio of 1.63 (95% CI 1.24-2.13) for psychological distress among infertile women compared to their fertile counterparts highlighting that infertility places a substantial mental health burden on women globally. Another systematic review of infertility stigma found that social support, living environment, educational level, occupation and fertility awareness emerged as major influencing factors of the stigma experienced by women.

The gender-specific analyses further reinforce these disparities. A systematic review and meta-analysis comparing the psychological status between infertile women and men found significant differences such as women consistently reported higher levels of anxiety, depression, stress and lower self-efficacy across diverse geographical settings. These findings reaffirm that although infertility is a shared biological condition, its psychological and social consequences are disproportionately borne by women, a pattern particularly reflected in patriarchal contexts where motherhood plays a central societal role.

Stigma, Identity and Social Exclusion

The notion of infertility as a stigmatized condition emerges repeatedly in qualitative and quantitative work. Research conducted in Pakistan has explored the social stigma of infertility and its consequences, finding that infertile women experienced stress, depression, marital conflict, domestic violence, loss of prestige and social isolation. A recent descriptive study from Turkiye

(Kaya, et. al., 2024) involving 352 women with primary infertility showed a strong positive correlation between infertility stigma and infertility-related distress and a moderate negative correlation between self-efficacy and stigma levels.

In a wider context, a cross-national study involving 458 women and 89 men in the U.S., Europe and Canada examined infertility stigma and openness with others, finding that higher personal stigma was significantly associated with depressive symptoms and a search for meaning in life. Conversely, higher openness such as sharing with others was related to fewer depressive symptoms and a stronger presence of meaning. These studies illustrate how infertility interacts with identity, self-worth and social belonging. In pronatalist societies, women internalize societal expectations of motherhood and when these expectations are unmet, the result is shame, self-blame and exclusion (Peterson, et. al., 2025).

Access to Treatment, Biomedical Interventions and Structural Constraints

While earlier literature focuses on psychosocial dimensions of infertility, recent literature increasingly recognizes the role of structural and biomedical constraints in shaping women's experiences. In many developing countries, women often face delayed or inadequate infertility diagnosis, low access to assisted reproductive technologies (ART) due to high cost and scarce counselling or psychosocial support (Naz & Batool, 2017). Empirical evidence highlights reliance on non-medical pathways in such contexts. For example, in Nigeria, a large cohort study of 1,463 infertility cases found a primary-to-secondary infertility ratio of 1:3 with as many as 55.6% of couples restoring to herbal concoctions highlighting the prevalence of non-biomedical treatment pathways and the interlacing of cultural and biomedical responses.

Repeating ART failure appears as an additional burden. A recent 2024 study of women with multiple failed IVF cycles reported that 60% had depression and 75% experienced sexual dysfunction, emphasizing the bi-directional link between infertility and mental health. These findings demonstrate that beyond issues of access, the experience of infertility treatment itself is characterized by uncertainty, invasiveness, cost and unpredictable outcome variability becomes a psychosocial stressor.

Coping Strategies and Informal Support Mechanisms

A substantial body of research consistently documents that infertile women employ a wide array of coping strategies some formal, many informal. For instance, in a Brazilian study of infertile couples (Casu et al., 2018) spirituality was found positively associated with quality of life, both directly and indirectly by reducing infertility-related stress. In Mali, a mixed-method study reported that religious faith practices, herbal treatments and social isolation were common coping strategies among infertile women (Hess et al., 2018)

An Indian mixed-method study of 120 infertile women found high levels of distress (43.3% moderate, 41.7% severe) and found social support to be the most commonly employed coping mechanism (80%), followed by emotion-focused (70%) and problem-focused coping (60%) strategies. More recently, Al Sabbah, et. al (2025) investigated how perceived social support significantly moderated the effect of infertility stigma on fertility-specific quality of life. It found that social support significantly buffered the negative impact of stigma ($\beta = .512$). These recent empirical findings underline that while infertility imposes burdens, the availability and quality of

social support networks family, friends, partner and counsellors can meaningfully alter negative outcomes (Al Sabbah, et. al., 2025).

Despite the growing body of research, several important gaps persist, which the present study seeks to address. First**,** much of the existing research relies on quantitative cross-sectional designs or small qualitative samples drawn from clinical populations. while such designs provide valuable prevalence and association data, but underexplore the lived, contextual meanings that women ascribe to their infertility experiences in urban South Asian settings. For example, qualitative studies conducted in Iran Behboodi-Moghadam (2013) and Nepal, Bista (2015), provide insights in Iranian and Nepalese women respectively, their small purposive samples and distinct sociocultural settings limit transferability to the urban Pakistani environment.

Second**,** although Pakistani research has begun to chart attitudes and service gaps (Ali et al., 2011; Naz & Batool, 2017), there remains a scarcity of in-depth qualitative work that centres the voices of primary infertile women in major metropolitan centres like Lahore. Such urban settings present unique intersections of biomedical availability, media exposure, shifting gender norms and persistent cultural continuity yet remain understudied.

Thirdly, while coping strategies and spirituality are acknowledged, fewer studies analyse how multiple coping strategies coexist or conflict within family networks and across socioeconomic strata. For instance, how do women negotiate between ART, herbal remedies and faith practices? What role do husbands, in-laws and health professionals play in shaping these decisions? The dynamic interplay remains underexplored (Casu et al., 2018; Karakaş, 2025).

Fourth, although many studies advocate for psychosocial interventions, there is limited grounded description of the informal support systems such as peer networks, spiritual communities and extended families that might be leveraged for culturally-appropriate interventions. Research focusing on actionable program design with local relevance remains weak.

The current qualitative study responds directly to these gaps identified in existing literature. By centering the experiences of ten primary infertile women living in Lahore and using semi-structured interviews, it captures nuanced psychosocial experiences, self-perceptions of infertility, support systems and coping strategies within an urban Pakistani context. In doing so, the research thereby extends the regional body of work (Ali et al., 2011; Naz & Batool, 2017) and provides richly textured accounts that can inform both local clinical practice and community-level psychosocial programming. Specifically, the study seeks to;

- Explore how infertile women in an urban, resource-diverse setting interpret their infertility in social, cultural and religious terms;
- Illuminate the interplay among biomedical diagnosis/treatment, social stigma, familial and spousal influence and coping behaviors;
- Identify informal support and resilience pathways including family, spouse, friends, adoption, faith and work which may be harnessed in future interventions;
- Bridge the gap between numeric prevalence-based quantitative studies and culturally sensitive, contextually grounded qualitative research that provides depth and meaning to the lived experiences of infertile women.

Through these contributions, the present research contributes to narrowing the empirical divide and lays a foundation for culturally attuned psychosocial support frameworks appropriate for urban Pakistani women experiencing infertility.

CONCEPTUAL FRAMEWORK

This study is guided by Albert Bandura's Social Learning Theory (1977) and the Biomedical Model of Health**,** both of which provide complementary perspectives for understanding infertility as a biopsychosocial phenomenon.

Integration of Theoretical Perspectives

According to Social Learning Theory, human behavior and beliefs are shaped through observation, imitation and the reinforcement of social norms. Individuals learn how to perceive themselves and others based on the attitudes, behaviors and emotional responses modeled by family, community and broader cultural systems. In patriarchal societies such as Pakistan, gender roles and reproductive expectations are learned early through cultural conditioning. Women are socialized to view motherhood as a central marker of identity and worth. Thus, when infertility occurs, women may internalize social messages of failure, guilt and inadequacy.

In contrast, the Biomedical Model conceptualizes infertility as a physiological dysfunction of the reproductive system. However, when viewed through the lens of Social Learning Theory, it becomes evident that infertility is not only a medical issue but also a deeply socially constructed condition. Women's understanding of infertility, their help-seeking behaviors and their emotional responses are influenced by the beliefs, expectations and stigmas learned through observation of family, community and media.

Together, these frameworks enable an integrated understanding of infertility as both a biological limitation and a socially learned experience where personal distress and coping strategies emerge from the interplay between medical realities and socially reinforced gender norms. The integration of these theories helps uncover how women in Lahore construct meanings of infertility and how they respond to its psychosocial consequences within a patriarchal cultural context.

Rationale and Significance of the Study

Infertility represents a growing public health concern in Pakistan, affecting approximately 22% of couples**,** with primary infertility accounting for 4% and secondary infertility for 18% (Naz & Batool, 2017). Despite its medical basis, infertility is predominantly treated as a woman's problem, revealing how gendered social learning shapes cultural responses. Within patriarchal settings, childlessness challenges the traditional definition of womanhood, resulting in stigma, marital tension, social exclusion and psychological distress.

The significance of this study lies in its interdisciplinary approach, combining medical and psychosocial lenses to examine how infertile women construct self-perceptions and navigate the multiple layers of stigma and emotional burden. By integrating Social Learning Theory, the study investigates how internalized gender expectations contribute to self-blame and influence coping behaviors. Simultaneously, it recognizes infertility as a biomedical condition that requires both medical and psychosocial support.

This dual-theoretical approach contributes to the existing literature by;

- Bridging the gap between medical and socio-behavioral understandings of infertility;
- Highlighting how social learning processes reinforce gender-based stigma;
- Providing insights for developing gender-sensitive psychosocial interventions and counseling programs
- Informing policy discussions on reproductive health education and awareness in Pakistan.

Ultimately, the study emphasizes the need to re-conceptualize infertility beyond biological explanation by acknowledging its social learning roots, emotional dimensions and gendered consequences to promote empathy, support and social inclusion for women experiencing infertility.

RESEARCH METHODOLOGY

This section provides a comprehensive account of the methodological process used to explore the challenges faced by women experiencing infertility in Lahore, Pakistan. It outlines the research design, sampling technique, participant profiles, data collection and analysis procedures, along with ethical considerations and operational definitions used in the study.

Research Design

A qualitative research design was employed to gain an in-depth understanding of the lived experiences and psychosocial challenges of women facing infertility. This approach was deemed appropriate given the exploratory nature of the study and its focus on subjective meanings and social realities. The design aligns with the study's aim to explore the biopsychosocial dimensions of infertility, grounded in Social Learning Theory and the Biomedical Model**.**

Sampling Technique

The snowball sampling technique was adopted to recruit participants who met the inclusion criteria and were willing to share their experiences openly. This non-probability sampling was suitable due to the sensitive and stigmatized nature of infertility in Pakistani society, which makes open recruitment challenging.

Participants

The study was conducted among ten married women diagnosed with primary infertility. All participants were residents of Lahore, Pakistan and were individually approached through personal and social networks using the snowball technique. Participants ranged in age from 30 to 47 years, and they represented diverse educational, socioeconomic and occupational backgrounds, allowing for varied perspectives on infertility-related challenges.

Inclusion Criteria

Participants were selected based on the following criteria:

- Married women experiencing primary infertility
- Age range between 30–47 years
- Willingness to participate voluntarily and share lived experiences
- A Minimum duration of one year since the medical diagnosis of infertility.

Data Collection Tool

Data were collected through in-depth, semi-structured interviews conducted individually with each participant, that were recorded in Urdu language to ensure comfort, emotional expression and

cultural relevance. The interview guide was developed based on previous research findings and expert opinions. The researcher focused on eliciting the participants' perceptions, psychosocial consequences, coping strategies and available support systems. Each interview lasted between 45-60 minutes and was audio-recorded with informed consent of the participants. The interviews were later transcribed into English verbatim for analysis.

Procedure

Participants were initially identified and contacted based on the inclusion criteria. Each participant was informed about the purpose of the study and ethical principles. A formal written informed consent was obtained before data collection. Confidentiality and anonymity were strictly maintained. Through the snowball approach, ten married women experiencing primary infertility were successfully recruited. The interviews were conducted in a private, comfortable setting to ensure open and honest communication. Audio recordings were carefully transcribed and condensed meaning units were extracted for analysis.

Data Analysis

Thematic analysis was used to analyze the transcribed data following the guidelines of Braun and Clarke (2006). This method involves systematically identifying, coding and organizing patterns within qualitative data to form themes that capture the essence of participants' experiences. The researcher repeatedly read the transcripts to gain familiarity, generated initial codes and categorized similar meanings. Emerging patterns were grouped into broader themes and subthemes representing the psychological, social and emotional challenges of infertility. This analytical process allowed for an integrative understanding of how cultural learning and biomedical realities shape women's experiences. Participant identities were preserved using codes P1–P10. Verbatim are translated to retain emotional tone and meaning.

Ethical Considerations

Ethical principles were rigorously observed throughout the study. Participants' confidentiality, dignity and autonomy were maintained at every stage. No identifying information was disclosed and pseudonyms were used to protect participants' identities. The researcher ensured that participants were not subjected to any form of emotional or verbal harm. Participants were informed of their right to withdraw at any time without penalty. All data were stored securely for academic research purposes only.

ANALYSIS

In the present study, detailed insights were gathered from participants through semi-structured interviews about the issues and challenges they faced due to infertility. The data were analyzed using thematic analysis, which helped in organizing and simplifying the information for clearer presentation. The researcher consolidated findings from thematic analysis tables, aligning them with the study's objectives. The final comprehensive table was developed by merging and integrating their inter-connected themes in major themes, as presented below.

Major Themes	Connecting Themes
Challenges	Troubled marriage
	Financial challenges

	Physiological challenges Marital disharmony Spousal refusal for fertility treatments Hardships of marital relationship Spousal's attitude towards fertility treatment Unpredictable future Adverse impact of fertility treatment History of husband's first marriage Terms and conditions behind the infertility Uncertainty in adoption Spousal disagreement for adoption Unsuccessful medical interventions Physiological impact of fertility treatments Physiological impact of medical fertility treatment Physiological and symptomatic ailment of PCOS Physiological impact of medical treatment Poor intimacy Husband's cold behavior about infertility Uncertainty in medical interventions People's perception about my infertility Hardships at workplace No household help for chores during medical treatments Spousal reluctance for adoption Failure of medical interventions Future uncertainty Negative beliefs Hardships of marital relationship
Infertility as a Lifetime Crisis	Psychosocial consequences Psychosocial consequence Social consequences Psychological consequences Social challenges Psychosocial consequences of infertility Psychosocial challenges Relationships with in-laws Double standards of in-laws Cold relationship with in-laws Beliefs regarding infertility Self-perception regarding infertility Role of woman in current marriage Reaction of husband regarding adoption Unfulfillment of recreational activities Husband's second marriage Decision of second marriage at menopausal age
Support System	Spousal support Familial support

	In-laws' support
	Younger sister in laws support
	Adopted child
	Adopted baby girl
Coping Strategy	Legal child adoption
	Religious practices
	Faith in Allah
	Rationalization
	Physical and mental engagement
	Practicing some myths
	Financial empowerment
	Accepted reality
	Optimism
	Planning for career pursuing
	Second marriage
	Social isolation
	Social media surfer

Theme 1: Challenges

Participants described infertility as a multilayered hardship affecting marital communication, physical health, finances, work and social reputation. Biomedical problems such as PCOS, fibroids, ART failure were compounded by gendered blame, in-law pressure and workplace stigma.

Selected Verbatims

- P1 (marital communication): "We don't have a special relationship in terms of sex or communication… everyone follows their own routine."
- P8 (sacrifice / social gaze): "It's been 14 years… people begin to say strange things. A woman always has to sacrifice many desires and carry on. A man can never be asked to compromise the same way."
- P6 (abuse / humiliation): "May God never show this time to anyone; I ended up like a servant in my joint family. My husband used to beat me… I sat outside the house at night. I feel like I am paying for my sins."
- P4 (treatment side effects): "Along with weight gain, I have a lot of hair fall and unwanted facial hair growth."
- P7 (treatment failure): "I had five IVF attempts and they failed."
- P3 (work pressure and worry): "When you don't have a child, people assume you can't handle more responsibilities and it harms your job prospects; this disturbs me."

Interpretation: These accounts demonstrates that infertility-related challenges were both biomedical and socio-cultural: side effects and repeated ART failures produced physical distress; family and workplace dynamics magnified emotional suffering.

Theme 2: Infertility as a Lifetime Crisis (Psychosocial Consequences)

Participants experienced infertility as an enduring, identity-shaping crisis rather than a temporary disruption. Their narratives revealed feelings of emptiness, incompleteness, fear of abandonment, chronic shame and social exclusion.

Selected Verbatims

- P2 (regret / imagined alternative life): "I feel that if I had children, my situation would be different. My children would have grown up and supported me; I wouldn't be beaten or driven out of the house."
- P6 (need for legacy): "If I had a child, I would have someone to call mine forever someone who remembers me after I'm gone. That is a comfort I don't have. This is a lifetime crisis I must live with."
- P7 (emptiness): "There is a hollowness an incompleteness. I love other people's children dearly, but inside I feel an empty space."
- P8 (adoption concerns): "I don't know whether my family will accept the adopted girl. If I had my own child, at least I would not have that fear."
- P9 (internalized deficit): "Seeing everyone else with children creates a strong sense of lack; even if it isn't my fault, I feel worth less."
- P10 (fear of stigma): "People think we have no honor without children. Relatives stopped inviting me to celebrations because they were afraid to 'jinx' our happiness."

Interpretation: These statements show how infertility becomes an existential and social identity problem, where learned cultural expectations that equate motherhood with complete womanhood, resulting in chronic distress.

Theme 3: Support Systems

Participants described family memebers including parents, siblings, spouses and in some cases adopted children provided emotional and practical support. However, the family responses were not unifrom and ranged from unconditional support to conditional acceptance and pressure. Adoption, where accepted, became a major source of meaning.

Selected Verbatims

- P1 (parental empathy): "God knows how long this has been; with parents it is easier to pass the time after parents, surviving becomes very hard."
- P2 (sister's help / adoption): "My older sister supported me a lot… my younger sister gave me her child to raise so my house could be settled."
- P3 (parental prayers and adopted sister): "My parents pray for me constantly… and my adopted sister supports me a great deal."
- P4 (spousal support): "My husband gave me a lot of support; our relationship feels stronger. He says if God wills it, it will happen."
- P7 (in-law support): "My in-laws never pressured me; they were always cooperative and prayed for me."
- P8 (adopted child as meaning): "I adopted a baby girl… I work and run everything myself and she has brought light back into my life."

Interpretation: the findings suggest that social support functions as a critical protective factor but often remains ambivalent within patriarchal family systems; when family acceptance exists, it mitigates distress. Adoption and productive engagement were meaningful coping solutions for several women.

Theme 4: Coping Strategies

Participants employed a wide range of coping strategies that reflected both personal agenccy and cultural resources available to them. These strategies include spiritual acceptance, practical engagement in productive activities such as work, study and tutoring, adoption, social withdrawal, folklore and ritual practices and medical attempts. Women actively re-framed meaning through faith, work and care for others' children or adopted children.

Selected Verbatims

- P1 (faith and willpower): "I pray to Allah and ask for health and strength. I want to stand on my own feet and not be dependent."
- P2 (work and adoption): "I continued leading a health center and tutoring to keep busy; I adopted my sister's daughter to sustain a home."
- P3 (engagement and social media): "I keep myself busy with household work and social media. These activities help me relax."
- P4 (education / plans): "I'm thinking of starting an online course or continuing my studies."
- P5 (acceptance and routine): "I believe Allah will give in His time… work keeps me occupied."
- P6 (substitute parenting and entrepreneurship): "I love my sister-in-law's children as my own; I have six cats and also started an academy of 20–22 children to keep busy."
- P7 (internal strength): "I stopped crying in public and made myself strong; I keep everything between me and Allah."
- P8 (adoption and acceptance): "I adopted a baby girl and managed the process myself; that child has brought brightness into my life."
- P9 (caregiving): "I love my relatives' children as my own; this keeps me going and I have accepted the truth."
- P10 (adoption as safety): "I adopted my husband's sister's child so that no one would feel the baby was a stranger; after that my life improved."

Interpretation: these narratives illustrates that coping among infertile women is both adaptive and varied. Spirituality, engagement in meaningful activities and adoption emerged as especially potent strategies for restoring purpose, emotional stability and a sense of belonging.

DISCUSSION

The present research reveals infertility as a deeply layered experience encompassing biological complications, psychological strain and strong social judgment. Participants' accounts reflected how the problem of infertility is never confined to the medical sphere alone; rather, it is intertwined with the moral, cultural and emotional dimensions of their lives. Viewing the findings through both the Biomedical Model and Social Learning Theory offers a comprehensive understanding of how physical realities intersect with social expectations, shaping the personal and relational experiences of women struggling with infertility in patriarchal settings.

Challenges: Biomedical Problems Under Social Pressure

Participants described infertility as a physically and emotionally exhausting and painful journey that extended far beyond the medical diagnosis. Several women narrated their struggles with hormonal treatments, side effects such as weight gain, hair loss and fatigue, along with the emotional burden of repeated failed procedures. As one participant said, "Every time the treatment

failed, I felt like I was losing a piece of myself." These experiences mirror the findings of Hu et al. (2025), who observed that repeated failures of assisted reproductive treatments heighten psychological distress and often lead to treatment discontinuation.

Beyond medical treatment, the data also revealed how social environments worsen the medical struggle. Participants reported the experiences of facing blame, social gossip and even verbal or physical abuse. Some women reported being neglected by their husbands, while others faced constant taunting from in-laws. These stories align with Xie et al. (2023), who confirmed that women are usually held responsible for infertility, even when medical evidence shows male factors. The reluctance of men to undergo fertility testing, also reported by participants, reflects a widespread cultural pattern in South Asia that delays diagnosis and increases the emotional toll on women (Biggs et al., 2023).

Therefore, infertility cannot be viewed merely as a biological disorder. Instead, it functions as a social and psychological wound where cultural expectations and gendered blame intensify the suffering. These findings suggest the need for psychological support within fertility centers and for couple-based counselling to address trauma, promote shared responsibility and reduce stigma.

Infertility as a Lifelong Crisis: Identity, Shame, and Social Exclusion

The participants' reflections depicted infertility as a persistent emotional and identity-related crisis rather than a temporary medical condition. Feelings of emptiness, fear of social exclusion and a deep sense of failure dominated many accounts. One woman expressed, "I have made peace that it was God's will, but every family event reminds me of what I don't have." This expression of acceptance mixed with grief reflects the internal conflict many infertile women continue to endure over time.

Such findings are consistent with Lee et al. (2025) and Xie et al. (2023), who found that infertility-related stigma exerts long-term effects on women's emotional health and overall quality of life. According to Hu et al. (2025), infertility may become a chronic psychosocial condition in societies where motherhood defines a woman's identity and social value. Participants' remarks also revealed peristent counterfactual thinking, how they imagined alternative life paths what their lives might have been like if they had children. This inner dialogue echoes the premise of *Social Learning Theory* (Bandura, 1977), which suggests that behaviors and beliefs are shaped through social models. Women internalize messages from families, communities and media that link womanhood with motherhood; hence, infertility disrupts not only biological function but also the socially constructed meaning of femininity.

Support Systems: Family as Comfort and Conflict

Findings from this study demonstrate that family systems occupy a paradoxical position, acting simultaneously as a source of comfort and distress. Supportive spouses, siblings and parents provided crucial emotional strength that helped participants cope with the crisis. As one woman shared, *"My husband's understanding is the only thing that gives me peace."* However, others described severe pressure from in-laws and extended families who viewed infertility as personal failure. One participant said, "My mother-in-law always reminds me that I have failed her son."

This dual role of family resonates with previous research showing that supportive family relationships can lower stress and improve treatment compliance, whereas negative family

dynamics worsen emotional suffering (Yazdani et al., 2017; Tantry, 2025). Thus, the familial attitude can either protect against or perpetuate distress depending on its attitude.

Adoption emerged as a major theme of resilience within participants' narratives. Several women who adopted children or assumed caregiving roles for relatives' children found renewed meaning and purpose in life. As one participant mentioned, "Since adopting my niece, my home feels complete again." This experience is consistent with the work of Casu et al. (2018), who found that adoption helps women reconstruct a positive identity and sense of belonging. However, social stigma, religious beliefs and legal complications often prevent adoption from being a widely accepted solution in local contexts.

Given these findings, involving family members in fertility counselling and awareness programs can play a vital role in changing traditional attitudes. Educational interventions that address gender bias and encourage empathy could transform the family from a site of pressure into a space of healing.

Coping Strategies: Faith, Activity and Withdrawal

Participants' coping strategies reflected the cultural and personal resources available to them. Many women relied on faith and spirituality, considering infertility a divine test rather than a form of punishment. As one participant stated, "I believe Allah has planned something better for me." Such spiritual acceptance served as a protective factor against despair and is consistent with findings of Karakaş (2025), who found that religious coping reduces stress and promotes psychological resilience among infertile women.

Employment, education and productive engagement also appeared as important coping resources. Women who maintained active roles in work or study expressed greater self-confidence and emotional stability. Zhao et al. (2025) similarly found that economic participation strengthens women's sense of control and lessens infertiliy-related stigma.

Adoption and caregiving roles were seen as ways to regain a sense of motherhood, while some participants resorted to social withdrawal to protect themselves from judgment. However, while temporary isolation may reduce stress, research shows that long-term withdrawal can increase loneliness and depressive symptoms. The recent studies therefore emphasized the importance of combining emotional support with meaningful social and productive activities to promote lasting psychological well-being and recovery.

Theoretical Reflection: Integrating Biomedical and Social Learning Perspectives

The Biomedical Model conceptualizes infertility in terms of physiological dysfunctions such as hormonal imbalance, PCOS, blocked tubes or sperm abnormalities, thereby highlighting the importance of medical intervention as central to treatment. Participants' medical histories including use of fertility drugs and assisted reproductive techniques, support this framework. However, while the biomedical explanations alone cannot capture the emotional and cultural depth of women's experiences.

Social Learning Theory (Bandura, 1977) adds another layer of understanding by explaining how cultural norms and family expectations shape women's perceptions of self. Through early socialization, women learn that motherhood defines success and identity; infertility therefore

becomes not just a biological issue but a violation of learned social ideals. Recent studies support this interpretation, showing that cultural learning and gendered expectations mediate psychological distress and social exclusion in infertility (Tantry, 2025; Al Sabbah et al., 2025).

Taken Together, these frameworks clarify how infertility operates as both a biomedical condition and a socially constructed phenomenon. Healing therefore requires an integrative approach that extends beyond medical treatment to include psychological counselling, social support and a cultural shift toward empathy and inclusion.

CONCLUSION

The findings of this study may be meaningfully interpreted through Bandura's social learning theory, particularly the concepts of modeling and learned helplessness. Women's narratives show how repeated exposure to blame, social comparison and observing other women being valued primarily for motherhood reinforces feelings of inadequacy and loss of control. Over time, failed medical treatments combined with persistent familial and social pressure contribute to a sense of helplessness, wherein efforts to conceive are perceived as futile and self-worth progressively declines. At the same time, participants who reported access to supportive spouses, affirming family environments, or alternative role models demonstrated higher levels of self-efficacy, reshaping their identities beyond motherhood. These women adopted adaptive coping strategies such as faith-based acceptance, work engagement or adoption, reflecting learned resilience rather than helplessness. Overall, the study underscores that infertility within patriarchal contexts is not merely a biomedical condition but a socially learned and emotionally internalized experience. Addressing infertility related distress therefore requires changing models of support, recognition and agency to restore women's psychological well-being.

Limitations

Several limitations should be acknowledged in this study. First, the small sample size and reliance on snowball sampling limit the generalize-ability of the findings. Second, the exclusive focus on women experiencing primary infertility in urban Lahore excludes rural populations, men and couples. Finally, reliance on self-reported interviews may reflect personal perceptions or socially influenced responses rather than a full representation of broader infertility experiences.

Implications and Recommendations

- Integration of psychosocial services into fertility care**:** Routine screening for depression and anxiety along with availability of trained counsellors within fertility clinics can reduce treatment dropout rates and improve overall psychological well-being.
- Family-inclusive educational interventions**:** Programs that target in-laws and spouses to reduce stigma, encourage male diagnostic participation and change reinforcement patterns would be effective.
- Support adoption-friendly policies and counseling**:** As adoption emerged as meaningful coping pathway for several participants, awareness campaigns and legal-cultural dialogues may reduce stigma and increase adoption acceptance. Recent regional studies recommend culturally adapted adoption counselling.
- Enhancement of women's economic and educational engagement**:** Facilitating work or online learning increases resilience and self-efficacy an evidence-based buffer against infertility-related distress.

- Training healthcare staff in culturally sensitive communication: Capacity building initiatives for medical staff can reduce re-traumatization during treatment and prevents insensitive referrals or comments. This may lead to more empathetic and patient-centered care.

References:

Abu-Rabia, A. (2013). Infertility and surrogacy in Islamic society: Socio-cultural, psychological, ethical, and religious dilemmas. *The Open Psychology Journal, 6*(1), 54-60.

Al Sabbah, S., Tantry, A., & Bayliss-Pratt, L. (2025). Do perceived social support mitigate the influence of infertility stigma on fertility quality of life? *Frontiers in Global Women's Health, 6*, 1-10.

Al-Bar, M. A., & Chamsi-Pasha, H. (2015). *Contemporary bioethics: Islamic perspective*. Springer.

Ali, S., Sophie, R., Imam, A. M., Khan, F. I., Ali, S. F., Shaikh, A., & Farid-ul-Hasnain, S. (2011). Knowledge, perceptions, and myths regarding infertility among selected adult population in Pakistan: A cross-sectional study. *BMC Public Health, 11*(1), 760.

Bandura, A. (1977). *Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 84*(2), 191-215.

Begum, B. N., & Hasan, S. (2014). Psychological problems among women with infertility problem: A comparative study. *Journal of the Pakistan Medical Association, 64*(11), 1287-91.

Behboodi-Moghadam, Z., Salsali, M., Eftekhar-Ardabili, H., Vaismoradi, M., & Ramezanzadeh, F. (2013). Experiences of infertility through the lens of Iranian infertile women: A qualitative study. *Japan Journal of Nursing Science, 10*(1), 41-46.

Biggs, S. N., et al. (2023). Psychological consequences of male infertility. *The Lancet Psychiatry, 10*(4), 321-33.

Bista, B. (2015). Lived experience of infertility among community dwelling infertile women. *Journal of Nobel Medical College, 4*(1), 46-56.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Casu, G., Ulivi, G., Zaia, V., Fernandes Martins, M. D. C., Parente Barbosa, C., & Gremigni, P. (2018). Spirituality, infertility-related stress, and quality of life in Brazilian infertile couples: Analysis using the actor-partner interdependence mediation model. *Research in Nursing & Health, 41*(2), 156-65.

Eleje, G. U., et al. (2019). Patterns and management challenges of infertility in a low-resource setting. *African Journal of Reproductive Health, 23*(3), 45-54.

Greil, A. L., Leitko, T. A., & Porter, K. L. (1988). Infertility: His and hers. *Gender & Society, 2*(2), 172–99.

Hess, R. F., Ross, R., & Gililland, J. L. Jr. (2018). Infertility, psychological distress, and coping strategies among women in Mali, West Africa: A mixed-methods study. *African Journal of Reproductive Health, 22*(1), 60-72.

Hu, J.-Y., Wu, Y.-D., Xiao, Z., Yu, M.-T., Liu, Y.-F., Peng, Y.-T., Fu, X.H., & Zhang, Y. (2025). A mixed-methods study on negative psychological states of infertile women. *Scientific Reports, 15*(1), 4332.

Karakaş, Z. (2025). Spiritual coping and emotional resilience in women with infertility: A cross-cultural study. *Psychology of Religion and Health, 36*(2), 155-69.

Kaya, D., Atilla, R., & Mutlu, A. E. (2024). Is the stigma experienced by infertile women related to infertility distress and self-efficacy? *Clinical and Experimental Health Sciences, 14*(4), 987-93.

Lee, J., Kang, T., & Choi, S. W. (2025). Lifestyle factors and health outcomes associated with infertility in women: A case-control study using National Health Insurance Database. *Reproductive Health,* 22, Article 88.

Mascarenhas, M. N., Flaxman, S. R., Boerma, T., Vanderpoel, S., & Stevens, G. A. (2012). National, regional, and global trends in infertility prevalence since 1990: A systematic analysis of 277 health surveys. *PLoS Medicine, 9*(12), e1001356.

Moghadam, A. D., & Mozafari, M. (2017). Exploring the experiences of living with infertility in menopausal women in Iran: A qualitative study. *MOJ Women's Health, 5*(3), 00124.

Naz, B., & Batool, S. S. (2017). Infertility related issues and challenges: Perspectives of patients, spouses, and infertility experts. *Pakistan Journal of Social and Clinical Psychology, 15*(2), 3-11.

Peterson, B., Taubman-Ben-Ari, O., Chiu, B., Brown, D., & Frederick, D. A. (2025). Infertility stigma and openness with others are related to depressive symptoms and meaning in life in men and women diagnosed with infertility. *Reproductive Health, 22*, 1-12.

Saif, J., Rohail, D. I., & Aqeel, M. (2021). Quality of life, coping strategies, and psychological distress in women with primary and secondary infertility: A mediating model. *Nature-Nurture Journal of Psychology, 1*(1), 8-17.

Tantry, A. (2025). Perceived social support and infertility stigma buffering study (Jammu & Kashmir). *Frontiers in Global Women's Health, 3*(2), 1577951.

Tripathy, P., Khosla, P., & Nayak, D. (2020). Coping after infertility: Challenge for primary infertile women. *European Journal of Molecular & Clinical Medicine, 7*(10), 452-60.

Xie, T., Ren, Z., Niu, J., Zheng, Y., Yu, Y., & Li, J. (2023). The impact of stigma on mental health and quality of life of infertile women: A systematic review. *Frontiers in Psychology, 14*, 11945.

Yazdani, F., Elyasi, F., Peyvandi, S., Moosazadeh, M., Galekolaee, K. S., Kalantari, F., & Hamzehgardeshi, Z. (2017). Counseling-supportive interventions to decrease infertile women's perceived stress: A systematic review. *Electronic Physician, 9*(6), 4694-702.

Zegers-Hochschild, F., Adamson, G. D., de Mouzon, J., Ishihara, O., Mansour, R., Nygren, K., & Sullivan, E. (2009). International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) revised glossary of ART terminology, 2009. *Fertility and Sterility, 92*(5), 1520-24.

Zhao, C., Lu, M., Zhong, X., Chen, J., & Chen, L. (2025). Coping strategies among infertile women undergoing IVF in Vietnam: A qualitative investigation. *BMC Women's Health, 25*(1), 118.

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