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Misinterpreting the Biological Realities: Phenomenological Exploration of the Socio-Psychological Challenges faced by the Infertile Women in Multan (Pakistan)

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Abstract

Infertility is the inability of a woman to conceive after one year of uninterrupted intercourse. This medical condition in women is not treated as a biological phenomenon but rather as a socio-psychological one. A sample of 12 infertile women aged 20-36 years was selected from gynecologists working in the private hospitals of Multan city (Pakistan). A phenomenological research approach was used to explore the participants' real-life stories. Thematic analysis identified the major social sufferings as marital strain, social stigma and labeling, social pressure from in-laws and the natal family to get pregnant, social exclusion from gatherings, cultural and religious misinterpretations, and challenging the social identity of womanhood. Furthermore, the data divulged that the psychological sufferings of the infertile women included constant depression about infertility, anxiety, and stress about not having children, along with fear, self-blame, and trauma about infertility. In conclusion, the biological realities of infertility are overlapped by the cultural stereotypes in which womanhood is linked with motherhood. Promoting couple-based counseling programs, along with marital support interventions, and ensuring access to psychological counseling services can reduce the socio-psychological sufferings of the infertile women in the study area.

Keywords: Phenomenological, Biological, Realities, Infertility, Socio-Psychological, Challenges, Cultural stigma, Mental health

Introduction

Infertility is a socio-psychological and public health issue that affects millions of women world-wide, regardless of their age, ethnicity, and geographical location (Ali et al., 2023). The World Health Organization (WHO) defines infertility as an inability to conceive within 12 months of uninterrupted intercourse. Globally, one in six people is affected by fertility disorders during their reproductive years (World Health Organization, 2023). This biological impairment seems to affect the couple's life, but in reality, it affects women more than their male partners. The major biological causes of being childless include hormonal imbalances, PCOS, obesity, endometriosis, low sperm count, genetic disorders, menstrual problems, infection in the vagina, delayed mar-

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riage, and sedentary lifestyle (Nsabimana et al., 2024). Although it may seem like a biological issue, it is rooted in cultural context (Deyhoul et al., 2017).

In Pakistani contexts, patriarchal dominance, gender bias, and cultural conflict determine the severity of the situation for infertile women (Ullah et al., 2021). The major social challenges faced by women suffering from reproductive impairment included social stigmatization, marital conflict, social exclusion from gatherings, discrimination, cultural expectations of motherhood, and pressure from spouses. The psychological sufferings of infertile women included stress, anxiety, depression, fear, low self-esteem, self-blame, inferiority complexes, and even traumatic experiences (Mahmood et al., 2026; Saif et al., 2021). Major factors reported in previous literature included financial constraints, lack of specialized fertility services, religious beliefs, limited healthcare facilities, and social interventions, which affected fertility issues among females in the reproductive age range (Hayat et al., 2025).

The usage of the phrase *"Misinterpretation of the Biological Realities"* depicted the symbolization of the harmful effects of infertility on married women. The social and cultural context depicted that the biological realities about infertility are not considered a health condition, but rather an individual's fault. As evident in the research studies of Bibi et al. (2026) and Diaz & Watkins (2025), these cultural swords are mainly rooted in social stigma, pressure from the natal family and in-laws, self-blame, misinterpretation of religious beliefs, and social exclusion from family gatherings. Although the biological realities are different, they are misinterpreted in the cultural norms that place blame, shame, and psychological burden on women. The title depicted the scientific understanding of infertility and the cultural attitudes that disproportionately burden women, leading to significant socio-psychological suffering.

Based on prior literature, the present study needed to address several research gaps. Previous evidence had a major methodological gap: most articles were quantitative. Therefore, the present research used an exploratory phenomenological design to fill this research gap. Moreover, the lived experiences of childless women also need to be identified (Greil et al., 2010). Therefore, the study was designed to address this issue from an exploratory perspective on women's lived experiences (Zou et al., 2025). These gaps require examining women's demographic, social, and psychological suffering through a cultural lens that attaches specific meanings to the phenomenon (Bhadkaria et al., 2023).

Based on the research gaps, the following research objectives were constructed:

1. To explore the lived experiences of the infertile women in Multan.
2. To investigate the socio-cultural sufferings of the infertile women in the study context,
3. To explore the psychological sufferings of the infertile women that affected their mental health and adjustment in society.

Conceptual framework based on the theoretical underpinnings

For the present study, the conceptual framework was developed to explain how cultural norms, social expectations, and biological conditions interact to shape infertility. The following theoretical underpinnings were used to highlight how socio-cultural contexts shape the biological realities of infertility.

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Social stigma theory

Erving Goffman put forth social stigma theory, explaining that society expects a person to remain socially acceptable. On the other hand, society labels individuals who are socially undesirable and unacceptable. The theory remains important for understanding discrimination, shame, social exclusion, and changes in an individual's identity (Goffman, 1963). This theory is directly related to infertile women, whose identity is questioned in society. As they do not fit societal expectations, they are judged, stereotyped, and even excluded from society. The theory has two aspects: virtual and actual social identity. In the virtual social identity, society expects women to become mothers shortly after marriage. In reality, the actual social identity of the infertile woman is that she is unable to conceive despite the social expectations. These women faced physical and character stigma. This theory clearly demonstrated that the infertile women in the study vicinity suffered from low self-esteem, humiliation, social inferiority, and were always in a threatened situation of a second marriage. These women were stigmatized as barren (Banjh), which caused them to avoid social gatherings. These accumulated stigmas questioned the social identity of these women, as they faced mental health issues.

Feminist theories

Feminist perspectives offer diverse explanations of gender inequality in society that target women. These perspectives claim that women are discriminated against due to patriarchy, unequal power relations, and social injustice (Lindsey, 2020). The major nexus of these theories revolves around male dominance, which deprives women of their basic reproductive rights. The basic assumption of these theories is that gender is socially constructed, where women are expected to be mute, shy, emotional, and caring beings. On the other hand, males are expected to be strong, authoritative, and dominant. The assumptions also divulged that society is male-dominated, where the reproductive rights of married women are controlled by their husbands and in-laws. “Real womanhood” is embedded in motherhood, which gives women the ultimate status in society. The patriarchal system gives the definitive right to the husband to control their wife through societal reproductive expectations and control them socially, economically, and culturally (Thompson, 2002). The application of the theory demonstrated that the study area is dominated by a system where infertile women are unfairly blamed for their childlessness. These women face stigmatization, discrimination within marriage, and are deprived of equal decision-making power. They also face pressure from in-laws for childbirth and are threatened for their husband's second marriage.

Conceptual model

Based on the above theoretical explanations, the following conceptual model was constructed. This model is grounded in two theoretical underpinnings: social stigma theory and feminist theories. These theories explained the socio-psychological sufferings of the infertile women in the Pakistani context. The mechanisms of patriarchy, social pressure, non-supportive behavior of the natal family and in-laws, along with cultural and religious misinterpretations, complicated the cultural context of the study area. Resultantly, the infertile women faced social and psychological challenges due to their biological impairment.

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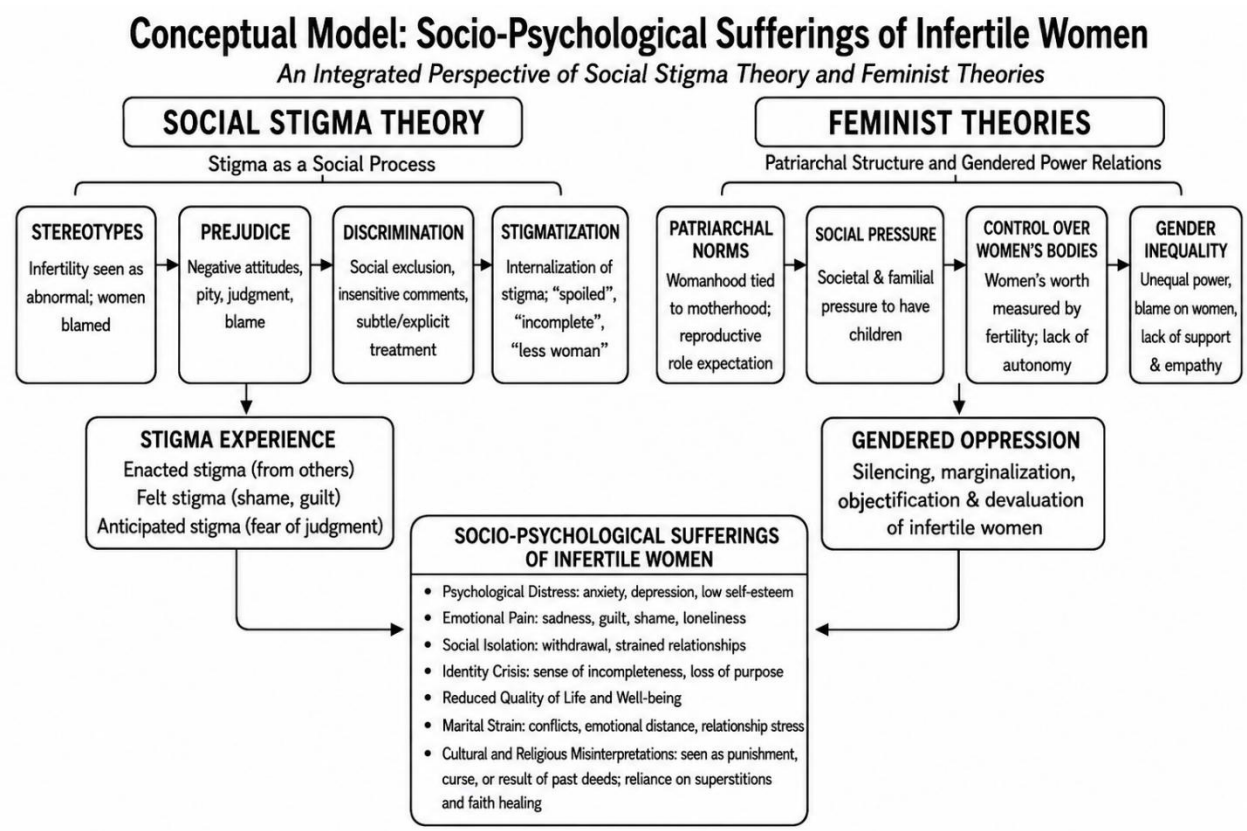

Methodology

The present study used a qualitative research design to explore the subjective responses of married women about their experiences of infertility. Although infertility is a biological phenomenon, its intensity directly affects participants' feelings and emotions. The methods and materials described below captured these childless women's subjective responses and insights.

Universe

The universe of the present study was all the infertile married women living in Multan, Pakistan. The study context comprised obsolete normative traditions in which womanhood is safeguarded by the presence of their husband and children. The context depicted that women who are unable to reproduce a child are always questioned in their character, future security, and place in the household.

Target population

The target population was women who underwent treatment by gynecologists at private clinics. The inclusion criterion for the selection of infertile women is subsequently mentioned: i) Women who were in the age bracket of 20-36 years. This age span is considered the natural peak and declining phase of female fertility. ii) Both educated and uneducated infertile women were included to compare the social criticism and cultural intensification towards their biological deprivation. iii) The women from the nuclear and joint family systems (especially those residing with their in-laws) were included to compare the contextual differences in infertility regarding the family type. iv) Women who were under treatment in private gynecological clinics were included.

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Research approach

The phenomenological research approach was used to explore the meanings and real-life experiences of the infertile women in their natural context. This interpretive research approach focuses on the lived experiences of these participants, which helps to understand their emotional sufferings, social stigma, family pressures, interpersonal challenges, and various psychologically distressing situations. Moreover, this interpretive method also helped the researchers to understand the cultural context, social structure, and psychological distress associated with the women who are unable to reproduce children in the study vicinity.

Gatekeeper and sampling technique

The gatekeepers who granted access to the infertile women were gynecologists working in private clinics. These gatekeepers were well-educated and could help provide information about the history and current medical condition of women diagnosed with infertility. After approaching the gynecologists, the first author began data collection from infertile women, taking into account the inclusion criteria. Data collection continued until saturation, ensuring interviews continued until responses began to repeat. Regarding this, 10 infertile women were interviewed through referrals from gynecologists. Although some overlapping responses were gathered at this stage, the researcher still collected the data from 2 more infertile females. Therefore, a sample of N=12 infertile married women was selected using a purposive sampling technique.

Research Technique

The primary research technique used in this study was face-to-face interviews with participants. The main reason is that the topic under study was sensitive and private; therefore, detailed, evidence-based information sharing was needed. 9/12 interviews lasted 35-45 minutes. 3/12 interviews lasted more than 1 hour because participants shared detailed, complex information. The interviews depicted the social and psychological challenges participants faced in the study area. In addition, the clarity of the meanings attached to the lived experiences reflected the phenomenon's intensity and context-based sharing.

Data Collection Tool

Data were collected using an exploratory, open-ended, and wide-scope interview guide. This interview guide was divided into the following sections, i.e., i) demographic profile, ii) social sufferings, and iii) psychological sufferings of the infertile women. In addition to this, two questions at the end of the tool were designed to explore the recommendations suggested by the infertile women to lessen the distressing situations faced by them during their infertility era.

Data Analysis

Thematic analysis was used to analyze the qualitative data. All interviews were audio-recorded with participants' consent, and verbatim transcripts were written. The interviews were recorded in Urdu and Saraiki and then converted into English. Data familiarization was ensured through a thick description and by continuously reading the interview transcripts. These transcripts shed light on the lived experiences, emotions, feelings, perceptions, and cultural contextualization of the infertility process. After transcription, the interviews were translated into English. The essence of the data shared by the participants remained unchanged, as did the speech fillers. After

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translation, the data were coded in detail. Both deductive and inductive codes were used to reflect the concepts, feelings, behaviors, and thought-provoking processes of the infertile women. The codes were then compiled into a codebook, which included code names, definitions, and detailed participants' observations/statements. This codebook enabled the researchers to analyze the data in detail through thick description. Rather than providing summaries, thick description ensured that the rich, well-narrated, and contextualized material was captured and presented. The researchers analyzed the complex cultural framework and the participants' viewpoints on this phenomenon. Afterward, the codes were compared to uncover the essence of the phenomenon under study. For example, the code of family pressure was compared to determine whether it was more severe in the natal family, the nuclear family (with husband and children), or the joint family (with in-laws). In addition to this, the women faced social stigma differently, which was compared across family, relatives, community, and societal levels. Afterward, the codes were conceptualized, and themes were developed.

Ethical considerations

Because the topic was sensitive, personal, and socio-cultural, researchers ensured participants' dignity and emotional well-being. The first author presented her ethical considerations to the Institutional Review Board (IRB) of the Social Sciences and received approval with minor revisions. First, the researchers ensured participants' confidentiality and anonymity. To this end, participants remained anonymous, and pseudonyms were used instead of their real names. The data provided by the participants (including interviews and recordings) were also kept confidential. Secondly, the participants' psychological and emotional protection was ensured. Formally, the authors of this paper did not consider this, but the IRB board indicated that during the interview conducted with the women about infertility, their traumatic conditions, marital stress, and sadness may be triggered. For this purpose, the board suggested that i) participants should be given a comfortable space, ii) they can skip a few distressing questions, iii) probs related to sexuality concerns and stigmas should be skipped, and iv) avoid judgmental and intrusive questions. Third, the authors considered cultural sensitivity during data collection. In the study context of Multan, the social stigma is associated with women's childbearing capacity. Therefore, the authors considered social norms, cultural values, religious beliefs, and family dynamics related to infertility.

Results

Descriptive analysis

The research was conducted on infertile women under treatment in the private gynecological clinics of Multan city, Pakistan. The thematic analysis section separately described the women's social and psychological suffering. The women's ages ranged from 20 to 36 years. The case studies also showed that 40% of participants were from urban areas, while 60% of those present for treatment were from rural areas. Most participants lived in extended and joint family systems. The monthly income of participants from rural areas was below 35,000 PKR. The younger married participants who were declared infertile were hopeful for some miracle, while the women who were above the age of 30 years were disappointed in their hope to get pregnant. The major reported underlying reason was that the women who were over 30 years of age left within a few years of their reproductive age span.

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Thematic analysis

The thematic analysis also depicted that the infertile women faced numerous social and psychological sufferings related to their biological impairment.

Social sufferings faced by infertile women

The major themes related to the social sufferings of the infertile women are described below in detail. The major social sufferings of the infertile women were marital strain, social stigma and labeling, social pressure from in-laws and the natal family to get pregnant, social exclusion from social gatherings, cultural and religious misinterpretations, and challenging the social identity of womanhood.

Marital strain

During interviews, participants reported ongoing marital strain, which mainly centered on the blame and accusations from the husband and in-laws. 9/12 participants exemplified that their mother-in-law accused them of being incomplete and unlucky in reproducing children. The participants cited the terms “naseebo jali,” “baanjh,” “be-olaad,” and “nasal khatam kerne wali” as verbal abuse from their mother-in-law. One participant reported that she even faced physical violence, such as being slapped many times by her mother-in-law for being infertile. The transcripts showed that the spouses' emotional distance increased due to this biological impairment. 11/12 participants claimed that their husbands continuously blamed, shamed, and verbally abused them for being childless. The major cultural context was that the husband's lineage was considered destroyed when the wife was unable to reproduce a child. The women also disclosed being under pressure from their in-laws, including constant questioning about childbirth, criticism about not reproducing children, comparison with the other women of the family who have children, and pressure to seek repeated treatments. 8/12 infertile women also reported that their marital strain peaked when they faced constant threats of a second marriage and the fear of divorce from their husbands. Validating these facts, a young infertile woman who has been married for the last 8 years disclosed that;

> *“Being infertile is not my choice. But because of our so-called traditions, marital strain peaks. As I am barren, I think our marriage will soon end.”*

Social Stigma and Labeling

The infertile women reported that their feminine identity was constantly questioned because of the social stigma of being “infertile.” They said they were deemed socially unacceptable and faced various forms of violence, including name-calling such as “barren (banjh), “infecund,” “not able to please her husband”, and “insecure future.” Moreover, these women faced public humiliation and mockery in the gatherings. They also reported hurtful comments from relatives, and their social circle. These comments included “bache paida nhn kar sakti” “mian ko khush kaise rakhe gi” “aise he reh jae gi” “jo b kar le ab bache nhn hon ge” “isko door rakho kisi bache paida kerne wali orat se.” These participants also shared their stories and said that they were blamed for bringing bad luck to everyone. These women were prohibited from staying near new brides and pregnant women. 11/12 infertile women reported that their stigmatization and labeling were attributed to the concept that *“motherhood is linked with womanhood.”* Participants also

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agreed that motherhood is considered a privilege for the family, and the inability to become a mother is stigmatized as "sterile" and "childless." Endorsing these arguments, an educated participant living in an urban area reported that;

> *"Education has nothing to do with infertility. I explained the biological causes of infertility to my husband, but he always sees infertility through a societal lens. He thought that social stigma and labialization are somewhat justified for the woman who is biologically incapable of reproducing a child."*

Social pressure from in-laws and the natal family to get pregnant

Participants reported that after a year of marriage, they faced constant criticism and demands to get pregnant from their husbands and in-laws. Interviews depicted that although it is a general perception that only in-laws put this pressure on them, the natal family is more insecure about the future of their married daughter. 10/12 women stated that even their neighbors, friends, and relatives constantly asked them when they would get pregnant. Transcriptions revealed that the pressure from the natal family stems from insecurity and a constant threat to the woman's future. On the other hand, 9/12 participants stated that the pressure and constant critical comments and inquiries from the husband and mother-in-law were perceived as a threat to a woman's marital life. The infertile women disclosed that even the gynecologist said they would continue the treatment to get pregnant, but these medical grounds are in vain. 2/12 infertile women reported that their mother-in-law discontinued the treatment from the gynecologist and took her to the spiritual healer (aalim baba) to remove all the evils from her body that made her infertile. Validating these arguments, a young woman aged 25 years, having a degree of BS-Mass Communication, revealed with a saddened expression;

> *"I am young and have been married for 3 years, yet I still face social pressure from my own mother to get pregnant at any cost, or else my husband will remarry. My mother-in-law always finds some way to degrade me for my biological impairment. Education is questioned in the face of social pressures from women for something they cannot do anything about."*

Social exclusion from gatherings

The participants reported being frequently criticized at social gatherings. This criticism makes them feel excluded from their normal life activities. 9/12 women reported avoiding social gatherings, such as festivals and wedding ceremonies. From the transcripts, it was evident that 7/12 infertile women were prohibited from attending any wedding event because it would bring bad fortune to the newly married couple. Similarly, 5/12 women declared that they were not allowed to attend any get-together regarding the birth of a newborn baby. The major underlying reason was that the cultural context believed that the presence of infertile women at newborn baby festivals would bring bad fortune, and that the mother of a child would lose her fecundity and become infertile in the future. Transcripts also revealed that infertile women feel uncomfortable around mothers, as they always question their dignity and biological deprivation. In addition, they said that the elderly women above the age of 60 years put forth ambiguous and nasty questions about their infertility. These questions centered on a woman character from the past, whom they believed had brought misfortune to their present lives. The hurtful words such as "baanjh," "naseebo jali," "shohar ko sukh na dene wali," and "nasal ko khatam kerne wali" forced these women

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to avoid interacting with others. In validation, an infertile woman aged 35 years, who belonged to the joint family system, reported that;

> *"How can an infertile woman interact with other people at social gatherings? People treat us like aliens. You can't even imagine the words directed at women who cannot have a child. We are emotionally, mentally, physically, and socially excluded from society for the sin we have not committed."*

Cultural and religious misinterpretations

Transcripts showed that Multan's cultural context is characterized by traditional and outdated patterns that ensured women's future security through husbands and children. 7/12 women argued that society and religion wrongly judge them for infertility. 3/12 educated participants reported that their cultural context is captivated by superstitions related to black magic. In addition, the respect for in-laws, husbands' remarriage for the sake of children, and spousal obedience for the spiritual treatment of infertility were misinterpreted as religious requirements in accordance with the teachings of Islam. The outrageous argument by 4 educated women reflected that the religious scholars (Mullahs) declared that the adoption of new reproductive technologies is a *"sin in Islam."* 9/12 participants put forth a noticeable fact that their mother-in-law believed black magic and the evil eye were the major causes of their infertility. Instead of spending money on their treatment, these women were forced to visit the spiritual healers and believe in and follow the system of charms and amulets through Dam Darood. Participant-11, living in a rural area, endorsed these arguments and divulged that;

> *"The patriarchal structure has used religion as a tool to defend its biased aspects. These teachings only emphasize that infertility should be submissive towards husbands' remarriage, and women's submissiveness in front of society."*

Challenging the social identity of womanhood

Interviews echoed that women's social identity is questioned in the study area. 11/12 participants agreed that infertility always brings an identity crisis for women. Deductive coding showed that these women also feel incomplete without a child, but whenever they are asked to adopt new reproductive technologies to achieve the status of mother, they are always snubbed by their husbands and in-laws. 3/12 participants said their natal family was opposed to this act. The interviewees were disappointed that they would always face questions and incomplete identity labels from society. 10/12 infertile women endorsed feelings of being excluded from society, low self-worth, and internal conflict. In addition, infertility challenges the identity of women, who reported feelings of grief as they feel threatened by the prospect of being replaced by another woman. 3/10 women reported that even financial independence could not help them overcome their identity crises. Aligning these facts, an infertile participant from the urban area and married for the past 10 years declared that;

> *"Women are considered complete, spiritual, and strong characters when they fulfill their reproductive roles by achieving the status of a mother. This is a woman's complete identity. Otherwise, she is considered incomplete, barren, and even her existence is questioned"*

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Psychological sufferings faced by infertile women

The major themes related to the psychological sufferings of the infertile women are described below in detail. The themes are constant depression about infertility, anxiety and stress about not having children, fear and self-blame about being infertile, and traumatic situations about infertility.

Constant depression about infertility

Participants reported that, due to constant social pressures and stigmatization about *"not having a child,"* these women suffered from depressive psychological disorders. The sufferings were linked to persistent feelings of sadness, hopelessness, loss of self-worth, and lack of interest in daily life activities. Data showed that these depressive symptoms arose when marital conflicts peaked due to a woman's declaration of infertility. These psychological sufferings were related to the emotional burden, along with social pressure and self-blame. From transcripts, 4/12 women reported that they were educated enough to know about the biological causes of infertility, yet they blamed themselves for this biological incompetence. These women reported various psychological symptoms of depression, such as loss of appetite, which drastically reduced their weight, loss of skin freshness, and an aged appearance. 10/12 transcripts showed that the gynecologists told them that a woman's pregnancy, motherhood, and healthy menstrual cycle depend on her hormonal balance. But the depression snatches their *"hope to get pregnant."* Endorsing these above facts, an infertile woman who was uneducated and belonged to a rural area declared that;

> *"My gynecologist said that depression would ruin my chances of getting pregnant. But how can I explain to her that this depression is not my creation, but it is attached to every woman who is infertile?"*

Anxiety and stress about not having children

A review of the interviews showed that infertile participants experienced various psychological illnesses, such as worry, uncertainty, and overthinking. The major reported issues related to infertility were socio-economic insecurity, husbands' remarriage, in-laws' bad behavior, exclusion, and societal blame. 9/12 women reported that their cultural context is cruel to infertile women and therefore they suffered from various anxiety symptoms such as restlessness, sleep, and eating disorders, along with rapid heartbeat and panic attacks. The deductive codes showed that the participants faced extensive, mild, and bearable anxiety disorders about not having children. 7/12 women reported being caught in stressful situations due to expectations placed on them to become mothers by their natal families, in-laws, and society in general. 11 transcriptions revealed that every time the women tried to conceive and were still declared infertile, their anxiety and stress levels peaked. Aligning these facts, a woman who was 35 years old and still had no children declared that;

> *"My stress and anxiety levels rose with each attempt to get pregnant, and each one failed. During treatment, the gynecologist told my husband to avoid adding stress to my mind and not to put pressure on getting pregnant, but the quarrels continued because he had been waiting for a child for the past 12 years."*

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Fear, self-blame, and trauma about infertility

Transcripts divulged that the infertile women often remain in a state of fear that something bad will happen soon. This fear stems from their biological inability to conceive after marriage. 6/12 women reported that they believed they were devalued and a source of spousal deprivation for a child. The educated participants said they always blamed their past choices, such as educational and career progression, along with marriage decisions, as a way to justify infertility. Coding indicated that 12/12 participants agreed that they were facing constant mental health disorders ranging from mild to severe fear, self-blame, and trauma. 7/12 women reported that they were in a destabilized mental health condition, afraid of the daily nightmares and persistent negative thoughts. During the interviews, the consensual argument showed that the infertile women were always in a state of constant trauma about *"not becoming a mother ever."* With each passing month, they were brought closer to a hopeless situation. 10/12 women reported that they were facing major traumas, including feelings of incompleteness, questioning their self-worth, and fractured personal identity. These feelings and emotions were intensified by the constant grief and ambiguous loss related to the child's loss. The facts also revealed that the trauma among these participants increased when the women swung between the cycles of hope and hopelessness. Endorsing these facts, a woman married for the past 16 years, living in a joint family system of an urban area, revealed that;

> *"I think I am on a constant grief-hope rollercoaster, and I do not know what my future will be. I am traumatized by the thought of being childless. With each passing year, I am at the limits of my hope as I am at the edge of my biological window."*

Discussion and Conclusion

The present study showed that the context of Multan (Pakistan) exhibited a conservative, traditionally rooted cultural web in which married women were considered secure upon becoming mothers. To explore women's socio-psychological suffering in the study context, the present empirical research employed a phenomenological sampling approach using in-depth interviews. Endorsing these facts, empirical evidence from Pakistan also disclosed that the cultural context of Baluchistan is far more conservative regarding fertility issues. Validating the methodological approach of the present study, this research also disclosed that women in Baluchistan lived in miserable conditions as they were excluded from the social circle and faced many psychological challenges due to infertility (Aziz & Khoso, 2026).

The present study's context showed that childbearing is highly valued, as it is linked to parenthood and encourages fertility. The cultural context pressures women to maintain their womanhood through the interlocking concept of motherhood. A previous study from Pakistan validated these findings and advanced a sociocultural discourse highlighting that community members' attitudes, perceptions, and beliefs shape childbearing (Ali et al., 2023). Another empirical study found that biological, social, psychological, and cultural approaches to infertility reflected gender-sensitive socialization, in which strong beliefs and core values are attached to the social, cultural, and biological aspects of a woman's fecundity (Dabbaghi & Rafieepour, 2022).

In compliance with the present study findings, another piece of evidence from Africa claimed that infertility is a real social and psychological burden for Nigerian women. To validate the present research study's methodology, this empirical study employed a qualitative design using in-

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depth interviews. The results of the study show that the women experienced anxiety, stress, depression, and marital problems. These women were also excluded from social gatherings and faced constant marital conflicts throughout their lifespan (Naab et al., 2019). Another piece of empirical evidence was gathered from the Northern regions of Ghana. This research endorsed the present phenomenological research approach and claimed that infertility among married couples is associated with negative repercussions. The research found that only a few women reported being encouraged by their loved ones to get pregnant. The majority of respondents claimed that they faced marital conflicts, insults, stigmatization, and maltreatment from their husbands and in-laws. Even the women reported that they are at the edge of ending this marital relationship through divorce due to their biological malfunction (Ofosu-Budu & Hanninen, 2020).

Endorsing the current study findings, it is evident from the aforementioned research findings that elevated male domination and suppressed women's identity question the female's inability to reproduce children. Although this is a natural process that can only be treated, the ultimate results are uncertain. Still, the previous empirical evidence also claimed that Pakistan is a male-dominated society where women are deprived of their reproductive rights and blamed for not having children. The study also validated the methodological tools of the present research, in which 15 women in the reproductive age range were interviewed about their social and psychological challenges during infertility (Ali et al., 2023).

The present study also illustrated that infertile women faced stigma, pressure, and hurtful comments from their husbands, in-laws, and society. Previous qualitative empirical evidence from Iran, conducted on 17 infertile women, reported that infertile women faced stigmatization, labeling, and negative comments from society (Taebi et al., 2021). Another study from Malawi showed that infertility is associated with multiple verbal abuses and stigmatizations, such as extramarital affairs before marriage, a weak body, and menstrual issues (hidden things at the time of marriage). The consequences of these stigmatizations included social ridicule, a spouse's remarriage, and divorce (Bornstein et al., 2020).

The findings of the present study showed that womanhood is directly linked to motherhood in the given structural context. The present research highlights various social sufferings, such as social stigma, self-blame, social isolation, identity crises, and societal expectations. These empirical findings were corroborated by previous research studies by Alamin et al. (2020) and Kianfar et al. (2026). Using a phenomenological approach, in-depth interviews were conducted, and it was found that infertility can cause emotional strain, self-doubt, and social isolation. The empirical evidence from Basnet & Khatiwada (2025) also showed that being childless caused marginalization, which negatively affected the women's identity.

Thematic analysis also demonstrated various psychological challenges that deteriorated the mental health of infertile women. These sufferings were rooted in an outdated cultural context that questioned these women's social status. The major psychological sufferings reported by the present study were stress, anxiety, depression, fear, self-blame, and trauma from being infertile. A previous empirical study conducted in Turkey interviewed infertile women in the reproductive age span. The results of the study validated the present study findings and stated that negative self-concept, low self-perception, depression, and excessive stress were reported among the Turkish women who were declared to be infertile (Karaca & Unsal, 2015). Another study from past literature in India also endorsed that infertile women suffered constantly from psychological

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problems. The paper highlights that the constant social neglect of these women is the major cause of their psychological stress and trauma (Sharma et al., 2022).

Consistent with the present research findings, previous evidence reported that infertile women in Ethiopia endorsed that they faced stress, anxiety, depression, low self-esteem, weak personality, and traumatic disorders. The paper also suggested that these women must adopt various coping strategies to address their issues (Adane et al., 2024). Another study in the international context of Hungary concluded that infertility is associated with chronic stress and various psychological ailments. Diverging from the present research methodology, this paper investigated the usage of quantitative research methods to investigate whether infertile females have the worst psychological well-being. The paper highlighted that the women reported depression, anxiety, stress, and traumatic symptoms due to social exclusion (Lakatos et al., 2017).

Endorsing the present study findings, another piece of empirical evidence also validated the prevalence, risk factors, and the psychological impact of infertility among women. It was also mentioned in this research that mental health problems were common and reported to distort the physical and mental health of the women who were declared infertile. In addition, the usage of coping strategies was recommended to lessen the negative mental effects of infertility among the infertile women (Taebi et al., 2021). Empirical evidence from Lahore (Pakistan) also disclosed that infertile women faced various psychologically stressful situations that deteriorated their mental health. Diverging from the present research methodology, the study used a quantitative research design to measure depression, anxiety, and stress among infertile females. In addition, low self-efficacy, depressive symptoms, and avoidance of social interaction were the major psychological problems faced by the infertile females (Khalid & Dawood, 2020).

In conclusion, the study area understood and treated infertility through cultural rather than biological lenses. The social sufferings were centered on the social stigma, pressure from society to get pregnant, and exclusion from social gatherings. The psychological sufferings were centered around anxiety, stress, depression, and trauma about not having children. This questioned feminine identity was deep-rooted in the lack of social acceptance for the infertile women, which affected their well-being, dignity, and quality of life.

Recommendations

The researchers proposed the following recommendations for lessening the socio-psychological sufferings of the infertile women in the study area.

1. Promote couple-based counseling programs to make the spouses aware of the underlying biological realities of infertility.
2. Marital support interventions should also be conducted by Sociologists to make the couples aware that they should observe and treat their infertility through biological realities rather than seeing it through a cultural lens.
3. Enhancing the role of media and digital apps through social influencers to raise awareness among the public that infertility should not be harshly treated with negative judgments.
4. Introducing and disseminating cognitive-behavioral counseling services for the psychological well-being of infertile women.

5. Introducing stress management programs to ensure the psychological and emotional well-being of infertile women.

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