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Infertility Related Psychological Distress and Group Based Compassion Focused Therapy: A Conceptual Analysis in Collectivist Contexts

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ABSTRACT

Infertility is a major global public health concern with significant psychological, relational, and sociocultural consequences, particularly for women living in collectivist societies. Beyond its biomedical aspects, infertility often threatens personal identity, marital stability, and social acceptance. In cultures such as Pakistan, where motherhood is closely linked to feminine identity and family expectations, infertility can lead to intense psychological distress characterized by depression, anxiety, shame, and internalized stigma. Understanding these psychological dimensions is essential for developing culturally sensitive therapeutic interventions. The primary objective of this traditional literature review was to synthesize empirical research on infertility-related psychological distress and to examine the potential effectiveness of Compassion-Focused Therapy (CFT), particularly in group-based formats, for reducing shame, self-criticism, and emotional distress among women in collectivist contexts. Additionally, the review aimed to identify research gaps and highlight the need for culturally adapted psychological interventions in South Asian societies. A PRISMA-guided screening process was used to identify relevant studies examining infertility-related psychological distress and compassion-based therapeutic interventions. After removing duplicates and applying inclusion criteria, a total of 60 studies were included in the final review. The selected literature comprised diverse research designs, including quantitative cross-sectional studies (n =24), randomized controlled trials (n =12), quasi-experimental studies (n =8), qualitative studies (n =10), and mixed-method studies (n =6). Studies were evaluated based on methodological rigor, clarity of outcome measures, and relevance to infertility-related psychological experiences and compassion-based interventions. The findings consistently indicate that infertility is associated with high levels of psychological distress, particularly depression, anxiety, chronic stress, and emotional dysregulation. Shame and self-criticism emerged as central emotional mechanisms underlying infertility-related suffering. Evidence suggests that Compassion-Focused Therapy is effective in reducing shame, self-criticism, and emotional distress by strengthening the soothing emotional regulation system and cultivating self-compassion. Group-based CFT interventions further promote normalization, shared experiences, and social support, which may be particularly beneficial in collectivist cultural contexts. Overall, the review highlights the potential of culturally adapted, group-based CFT as a promising intervention for addressing infertility-related psychological distress. Future research should prioritize randomized controlled trials in South Asian populations to validate and culturally adapt compassion-based therapeutic approaches.

Keywords: *Infertility, Psychological Distress, Compassion-Focused Therapy, Self-Compassion, Shame, Collectivist Culture, Group Therapy.*

INTRODUCTION

Infertility is increasingly recognized as a significant global public health concern that extends beyond biological dysfunction to encompass profound psychological, relational, and sociocultural dimensions. The World Health Organization (2023) defines infertility as the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse. Recent global estimates indicate that approximately one in six individuals experience infertility during their lifetime, underscoring its widespread prevalence and public health relevance (World Health Organization, 2023). In South Asian countries, including Pakistan, prevalence rates are estimated to range between 10% and 22%, influenced by socioeconomic disparities, limited access to reproductive healthcare, and untreated medical conditions (Inhorn & Patrizio, 2015).

Although infertility is medically conceptualized as a disorder of the reproductive system requiring diagnostic evaluation and treatment, its lived experience frequently transcends biomedical explanations. The medical model typically emphasizes hormonal imbalances, ovulatory dysfunction, tubal obstruction, sperm abnormalities, or unexplained etiologies. However, such a framework may inadequately address the psychological suffering and sociocultural consequences associated with involuntary childlessness (Greil et al., 2010). In collectivist societies, fertility is closely intertwined with identity, marital stability, and social legitimacy, rendering infertility a multidimensional crisis rather than solely a clinical condition. Motherhood, in many cultural contexts, is not merely a biological function but a socially constructed role embedded within expectations of femininity, virtue, and fulfillment (Ulrich & Weatherall, 2000). In patriarchal and collectivist societies, a woman's social value is frequently linked to her reproductive capacity. Consequently, infertility may be interpreted not simply as a medical difficulty but as a personal inadequacy or deviation from culturally prescribed gender norms (Ali & Malik, 2021). This social construction of motherhood intensifies the psychological burden of infertility, transforming a health condition into an identity-threatening experience.

The association between fertility and feminine identity is particularly salient in cultures where lineage continuation, family honor, and intergenerational expectations are central social values (Inhorn, 2003). Women may internalize beliefs that motherhood validates womanhood, and infertility may therefore disrupt their sense of self, purpose, and belonging. Accordingly, infertility is best understood within a biopsychosocial framework in which medical, emotional, relational, and cultural factors converge.

The psychological impact of infertility has been widely documented in empirical literature, with distress levels often comparable to those observed in individuals coping with chronic illness or bereavement (Domar et al., 1993; Greil et al., 2010). Repeated treatment failures, invasive medical procedures, financial strain, and persistent social questioning contribute to cumulative emotional burden, significantly impairing mental health and relational functioning. Depression and anxiety are among the most frequently reported psychological outcomes of infertility (Cousineau & Domar, 2007). Women experiencing infertility often describe persistent sadness, hopelessness, rumination, sleep disturbances, irritability, and diminished self-worth. The cyclical nature of fertility treatments characterized by anticipation and disappointment may intensify emotional instability, with each menstrual cycle symbolizing renewed loss and reinforcing helplessness.

Chronic stress further exacerbates vulnerability to psychological disorders. Continuous monitoring of ovulation cycles, repeated medical consultations, and uncertainty regarding treatment outcomes place individuals in a prolonged state of anticipatory anxiety (Greil et al., 2010). Sustained activation of stress responses may lead to emotional exhaustion and dysregulation. Emotional dysregulation often manifests as heightened sensitivity to criticism, social withdrawal, tearfulness, and intrusive thoughts related to failure or inadequacy. Importantly, infertility-related distress may evolve into clinically significant

depressive and anxiety disorders, particularly when compounded by societal pressure and limited emotional support (Cousineau & Domar, 2007). The interaction between chronic stress and maladaptive cognitive appraisals creates a feedback loop that perpetuates psychological suffering. Beyond depression and anxiety, shame has emerged as a central emotional response to infertility (Haslam et al., 2020). Unlike guilt, which pertains to specific behaviors, shame targets the global self, leading individuals to perceive themselves as defective or fundamentally flawed. Women confronting infertility may internalize societal narratives equating womanhood with motherhood, thereby experiencing infertility as evidence of personal inadequacy (Ali & Malik, 2021).

Public stigma surrounding infertility contributes substantially to emotional distress. Social inquiries, unsolicited advice, and comparisons with fertile peers may trigger humiliation and exposure. Cultural rituals centered around childbirth can intensify exclusion and marginalization. Repeated exposure to stigmatizing attitudes may result in internalized stigma, wherein individuals adopt society's negative beliefs into their self-concept (Cousineau & Domar, 2007). Infertility exerts substantial strain on marital relationships. While some couples report increased solidarity, many experience communication difficulties, sexual dissatisfaction, and emotional distancing (Greil et al., 2010). The medicalization of intimacy where sexual activity becomes scheduled and outcome-focused may diminish relational warmth and spontaneity. Women may also experience fear of rejection or abandonment, particularly in cultural contexts where remarriage or polygamy is socially permissible (Inhorn, 2003). Even without explicit threats, perceived marital vulnerability may heighten anxiety and emotional withdrawal. Couples may avoid discussing infertility to protect one another from distress, inadvertently reinforcing isolation. Sustained emotional withdrawal can weaken attachment bonds and reduce relationship satisfaction. Therefore, infertility-related distress extends beyond individual suffering, affecting dyadic functioning and relational security.

In collectivist societies such as Pakistan, infertility is embedded within honor-based social systems where family reputation and lineage continuity are highly valued (Ali & Malik, 2021). Marriage is conceptualized not merely as a partnership between individuals but as an alliance between families, rendering childbearing a collective expectation. In-law pressure represents a significant psychosocial stressor. Extended family members may exert explicit or implicit expectations regarding reproduction, sometimes recommending spiritual remedies, medical interventions, or alternative marital arrangements. Such dynamics may heighten feelings of surveillance and inadequacy.

Cultural silence surrounding infertility further compounds distress. Reproductive challenges are often framed as private or shameful, limiting open discussion and access to support. Women may suppress emotional pain to preserve family harmony, thereby internalizing distress.

Western therapeutic models, though empirically supported, are frequently grounded in individualistic assumptions emphasizing autonomy and self-expression (Markus & Kitayama, 1991). In collectivist contexts, identity is relational and interdependent. Interventions that neglect familial hierarchies, gender norms, and stigma may therefore lack cultural resonance. Culturally sensitive approaches that address shame, relational interdependence, and social context are thus essential.Compassion-Focused Therapy (CFT), developed by Paul Gilbert (2014), provides a theoretically grounded framework for addressing shame, self-criticism, and emotion dysregulation. Integrating evolutionary psychology, attachment theory, and affective neuroscience, CFT conceptualizes psychological distress as arising from imbalances within evolved emotion regulation systems.

According to Gilbert (2014), three primary affect regulation systems govern emotional experience: the threat system, the drive system, and the soothing system. The threat system detects danger and activates defensive responses such as anxiety and shame. In infertility-related stigma, this system may become chronically activated, leading to persistent self-criticism and fear of social rejection.The drive system

motivates goal pursuit, including the desire for motherhood. Repeated reproductive failures may disrupt this system, producing frustration and demoralization. The soothing system, associated with safeness, warmth, and affiliation, facilitates emotional regulation. Individuals high in shame often struggle to access this system effectively (Kirby et al., 2017). CFT seeks to strengthen the soothing system through cultivating self-compassion, compassionate imagery, and affiliative emotional experiences (Gilbert, 2014). Rather than solely challenging maladaptive cognitions, CFT transforms the emotional tone underlying self-evaluation, enabling individuals to shift from harsh self-judgment toward warmth and understanding.

In the context of infertility, where shame and perceived inadequacy are central, CFT offers a mechanism for regulating threat-based emotions. By fostering self-compassion, women may reinterpret infertility as a shared human experience rather than personal failure. This shift may reduce internalized stigma, improve emotional regulation, and enhance resilience. Furthermore, the affiliative emphasis of CFT aligns with collectivist values prioritizing relational connectedness, supporting its cultural applicability in Pakistani contexts. While Compassion-Focused Therapy (CFT) has demonstrated effectiveness in reducing shame and self-criticism across diverse clinical populations (Gilbert, 2014; Kirby et al., 2017), its application in a group-based format may offer unique therapeutic advantages, particularly for women experiencing infertility-related distress in collectivist contexts.

One of the primary therapeutic mechanisms of group-based interventions is normalization. Women struggling with infertility often experience isolation and the belief that their suffering is unique or indicative of personal defectiveness. Participating in a therapeutic group allows individuals to recognize that others share similar emotional experiences, thereby reducing feelings of abnormality and self-blame. The normalization effect has been shown to reduce internalized stigma and enhance psychological safety in group psychotherapy settings (Yalom & Leszcz, 2020). For women experiencing infertility-related shame, hearing parallel narratives of loss and vulnerability may directly counteract the belief of being fundamentally flawed.

Shared suffering within a structured therapeutic environment can further diminish stigma. Shame thrives in secrecy and perceived social judgment; however, compassionate group contexts encourage openness, validation, and mutual empathy (Gilbert, 2014). When individuals disclose painful experiences and receive acceptance rather than criticism, the threat-based emotional system is gradually downregulated. This affiliative process strengthens the soothing system described in CFT, promoting emotional regulation and self-compassion (Kirby et al., 2017). Thus, group-based CFT may be particularly effective in addressing infertility-related self-stigma by transforming isolation into collective resilience. From a public health perspective, group interventions are also more cost-effective and scalable, particularly in low- and middle-income countries such as Pakistan, where mental health resources are limited. Access to individual psychotherapy remains constrained due to financial barriers, stigma, and limited availability of trained professionals. Group-based CFT allows clinicians to reach multiple clients simultaneously while maintaining therapeutic depth, thereby increasing accessibility without compromising quality (Yalom & Leszcz, 2020). Given the high prevalence of infertility-related distress and the limited integration of psychological services within reproductive healthcare in Pakistan, group-based models represent a practical and sustainable intervention strategy.

Importantly, collective healing aligns closely with collectivist cultural frameworks. In societies where identity is relational and interdependent rather than individualistic (Markus & Kitayama, 1991), healing processes that emphasize shared experience, mutual support, and communal empathy may be particularly culturally congruent. Group-based CFT fosters relational connection, compassionate dialogue, and affiliative bonding elements that resonate with collectivist values emphasizing belonging and social

cohesion. Therefore, the integration of CFT within a group format may enhance both therapeutic effectiveness and cultural relevance for Pakistani women experiencing infertility.

Rationale for the Review

Despite growing recognition of infertility as a psychologically distressing condition, existing literature remains fragmented across medical, psychological, and sociological domains. Many studies have focused primarily on biomedical treatment outcomes, while psychological investigations have often examined distress variables in isolation rather than within an integrated theoretical framework (Greil et al., 2010). As a result, there is limited synthesis connecting infertility-related shame, self-stigma, and emotion regulation processes to targeted therapeutic interventions. Although Compassion-Focused Therapy has demonstrated efficacy in treating shame-based disorders such as depression, trauma, and eating disorders (Leaviss & Uttley, 2015), infertility-specific applications of CFT remain underexplored. Most existing compassion-based research does not directly address the unique sociocultural and relational dimensions associated with involuntary childlessness. Furthermore, empirical investigations examining group-based CFT interventions in reproductive health contexts are scarce, particularly within non-Western populations.

A significant gap also exists in culturally adapted therapeutic models for infertility-related distress in South Asian societies. Psychological interventions developed within Western individualistic frameworks may not fully address collectivist values, gender norms, and honor-based social systems that shape women's experiences in Pakistan (Ali & Malik, 2021). Without cultural adaptation, therapeutic approaches risk overlooking critical contextual factors contributing to shame and self-criticism.

Given these gaps, there is a clear need for a comprehensive synthesis of literature examining infertility-related psychological distress, the role of shame and self-stigma, and the potential utility of group-based CFT in collectivist contexts. A structured review can integrate theoretical and empirical findings, identify inconsistencies and limitations, and provide direction for culturally sensitive intervention development in Pakistan.

Objectives of the Study

The present traditional literature review aims to synthesize existing empirical research on infertility-related psychological distress, with particular emphasis on the multidimensional emotional experiences of women in collectivist societies. Specifically, the review seeks to examine the central role of shame and self-stigma in shaping psychological suffering associated with infertility. Additionally, it aims to evaluate the effectiveness of Compassion-Focused Therapy (CFT) as an intervention for reducing shame, self-criticism, and broader indicators of emotional distress, including depression and anxiety. The review further explores the relevance and potential advantages of implementing CFT in a group-based format, particularly within collectivist cultural contexts where relational identity and communal support are highly valued. Finally, this review endeavors to identify existing research gaps, especially within the Pakistani context, to inform the development of culturally adapted, evidence-based psychological interventions for women experiencing infertility-related distress.

PRISMA Flowchart

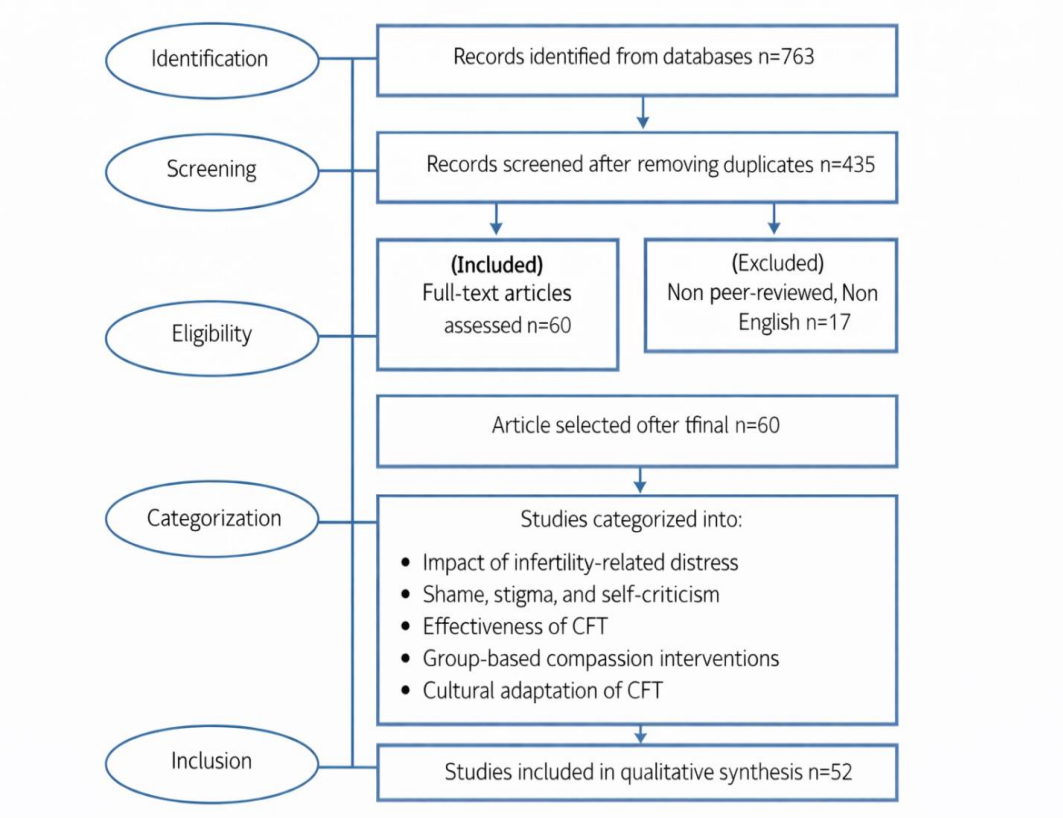
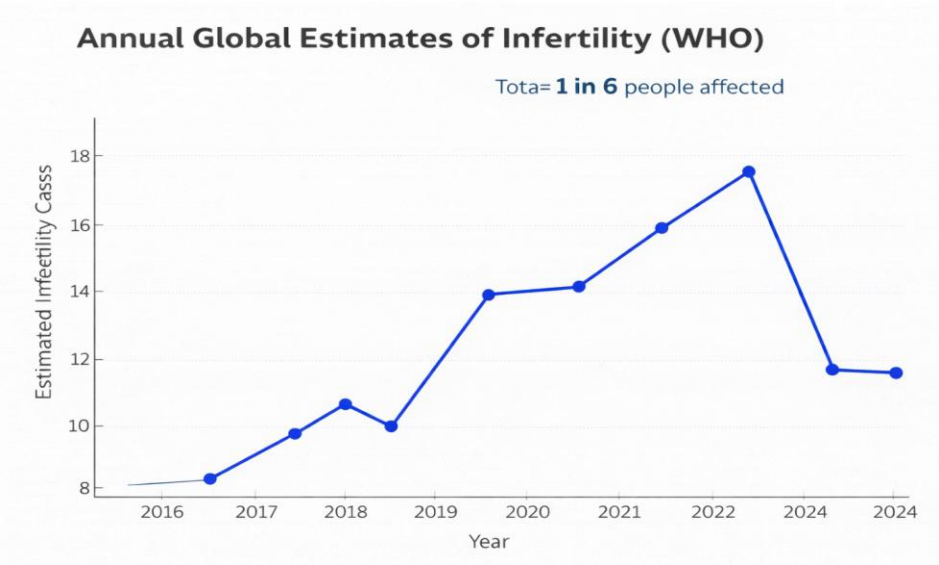


Figure 1: RISMA Flow Diagram of Study Selection Process

Annual Global Estimates of Infertility



LITERATURE REVIEW

A substantial body of research demonstrates that infertility is associated with elevated psychological distress, often comparable to that experienced in chronic medical illness or bereavement (Greil et al., 2010; Rooney & Domar, 2018). Depression and anxiety are among the most consistently reported outcomes, particularly among women undergoing repeated fertility treatments (Cousineau & Domar, 2007; Massarotti et al., 2019). Symptoms commonly include persistent sadness, hopelessness, sleep disturbance, rumination, and diminished self-worth. Chronic stress plays a central role in infertility-related distress. The cyclical anticipation and disappointment inherent in assisted reproductive treatments contribute to sustained activation of the stress response system (Purewal et al., 2018). Prolonged exposure to stress may impair emotional regulation, leading to irritability, tearfulness, social withdrawal, and heightened sensitivity to perceived criticism. Emotional dysregulation has been identified as a mediator between infertility-related stress and depressive symptomatology (Benyamini et al., 2009).

Importantly, infertility distress is cumulative rather than episodic. Repeated treatment failures reinforce maladaptive cognitive appraisals and contribute to a feedback loop of anxiety, helplessness, and emotional exhaustion. Beyond general distress, shame has emerged as a central emotional experience in infertility (Galhardo et al., 2011). Unlike guilt, which is behavior-specific, shame involves global negative self-evaluation and a perception of defectiveness. In societies where motherhood is equated with feminine worth, infertility can trigger profound identity threat. Public stigma surrounding infertility often manifests through intrusive questioning, unsolicited advice, and social comparison with fertile peers (Greil et al., 2011). Over time, external stigma may become internalized, resulting in self-stigma characterized by self-blame, secrecy, and avoidance (Goffman, 1963). Internalized gender role beliefs further intensify this process, particularly in patriarchal contexts where reproductive responsibility is disproportionately assigned to women.Self-criticism functions as a key psychological mechanism linking stigma to depression (Gilbert, 2009). Women experiencing infertility may engage in harsh self-judgment, perceiving themselves as inadequate wives or daughters-in-law. Fear of rejection whether explicit or perceived further compounds distress, particularly in collectivist societies where marital stability is closely linked to childbearing.

Self-compassion, conceptualized as self-kindness, common humanity, and mindful awareness of suffering, has been shown to buffer against shame and psychological distress (Neff, 2003). Individuals high in self-compassion demonstrate lower levels of depression, anxiety, and self-criticism across clinical and non-clinical populations (MacBeth & Gumley, 2012). Neuroscientific research indicates that compassion-based practices activate neural systems associated with affiliation and emotional regulation, including regions linked to safety and soothing (Klimecki et al., 2014). Compassion practices are associated with reduced amygdala activation and enhanced parasympathetic regulation, suggesting biological pathways for stress reduction.

In infertility populations, self-compassion has been inversely associated with depression and infertility-related shame (Galhardo et al., 2013). Women with higher levels of self-compassion report improved emotional regulation and reduced rumination, highlighting its relevance as a protective factor. Compassion-Focused Therapy (CFT), developed by Gilbert (2010), was originally designed to address chronic shame and self-criticism in individuals with complex mental health difficulties. Empirical evidence supports its effectiveness across a range of conditions, including major depressive disorder (Craig et al., 2020), trauma-related disorders (Lee & James, 2013), and eating disorders characterized by high shame and body dissatisfaction (Goss & Allan, 2014).

CFT operates through the regulation of three affect systems: threat, drive, and soothing (Gilbert, 2014). Clinical trials have demonstrated that strengthening the soothing system reduces self-attacking cognitions and enhances emotional resilience. Meta-analytic findings suggest moderate effect sizes for compassion-

based interventions in reducing depression and anxiety symptoms (Kirby et al., 2017).Given that infertility-related distress is heavily shame-based, CFT offers a theoretically coherent and empirically supported framework for intervention.Group-based compassion interventions have demonstrated unique therapeutic benefits beyond individual formats. Shared vulnerability and narrative exchange facilitate normalization of suffering, reducing perceived isolation (Braehler et al., 2013). The group context enables participants to witness others' struggles, fostering common humanity and reducing internalized stigma.

Mechanisms of change in group CFT include emotional mirroring, corrective affiliative experiences, and attachment repair. Compassion cultivation within a supportive group can activate affiliative affect systems more robustly than individual therapy alone (Gilbert & Procter, 2006).In collectivist cultures, group-based formats may align particularly well with communal values and relational identity structures. The shared experience of infertility within a culturally safe space may promote collective healing and reduce shame-based secrecy. Although compassion-based interventions have been widely studied in Western contexts, research in non-Western populations remains limited. Emerging evidence from Asian and Middle Eastern samples suggests that compassion interventions are culturally adaptable when contextualized appropriately (Asano et al., 2017).

However, collectivist cultures present unique barriers, including stigma surrounding mental health, reluctance toward emotional disclosure, and hierarchical family structures. Cultural tailoring strategies such as incorporating culturally relevant metaphors, acknowledging family dynamics, and integrating spiritual frameworks have been recommended to enhance engagement and acceptability.Given the strong relational orientation of CFT, its emphasis on affiliation and common humanity may resonate deeply within collectivist societies when adapted sensitively. Nonetheless, empirical studies specifically targeting infertility populations in Pakistan remain scarce, highlighting a significant research gap.

Quality Assessment

The quality assessment process followed a structured screening procedure consistent with PRISMA guidelines. Duplicate records were removed prior to abstract screening. Titles and abstracts were independently evaluated for relevance to infertility-related psychological distress and compassion-based interventions. Full-text articles were subsequently assessed against predefined inclusion and exclusion criteria.

Methodological rigor was evaluated based on study design, clarity of outcome measures, sample size adequacy, and transparency of intervention procedures. Among the final 60 included studies, research designs were distributed as follows:

- Quantitative cross-sectional studies (n = 24)
- Randomized controlled trials (RCTs) (n = 12)
- Quasi-experimental studies (n = 8)
- Qualitative studies (n = 10)
- Mixed-method designs (n = 6)

RCTs demonstrated stronger internal validity but were limited in infertility-specific applications of CFT. Qualitative studies provided rich contextual insight into lived experiences of shame and stigma but were limited in generalizability. Overall, while compassion-based interventions show promising efficacy, infertility-specific trials particularly in South Asian contexts remain underrepresented.

DISCUSSION

The trajectory of infertility research demonstrates a clear conceptual evolution over the past two decades. Early empirical investigations primarily focused on descriptive accounts of psychological distress, documenting elevated levels of depression, anxiety, and stress among women experiencing infertility (Cousineau & Domar, 2007; Greil et al., 2010). These studies framed infertility-related distress largely within biomedical stress models, emphasizing treatment burden and reproductive uncertainty. The mid-phase of research shifted toward stigma-based and identity-centered frameworks. Scholars increasingly recognized that infertility distress could not be fully understood without examining shame, self-stigma, and gender role internalization (Galhardo et al., 2011; Greil et al., 2011). Drawing on stigma theory (Goffman, 1963), researchers highlighted how public scrutiny, social comparison, and pronatalist cultural norms contributed to internalized defectiveness and diminished self-worth. During this phase, infertility was reconceptualized not only as a medical stressor but as an identity-threatening condition embedded within sociocultural narratives of femininity. More recent scholarship reflects a therapeutic shift toward compassion-based and third-wave interventions. Emerging trials have examined the efficacy of Compassion-Focused Therapy (CFT) and related compassion-based approaches in addressing shame and self-criticism (Kirby et al., 2017; Craig et al., 2020). This progression indicates a movement from descriptive psychopathology to mechanism-driven intervention research, with increasing emphasis on affect regulation systems and affiliative processes. However, infertility-specific CFT studies remain limited, particularly in non-Western populations, suggesting the field is still in an early translational phase.

Infertility-related distress is deeply intertwined with shame-based emotional processes. CFT conceptualizes shame as an activation of the evolved threat protection system, which triggers self-criticism and social withdrawal (Gilbert, 2010, 2014). In women experiencing infertility, repeated perceived failures to conceive may chronically activate this threat system, reinforcing beliefs of defectiveness and fear of rejection.CFT intervenes by deliberately strengthening the soothing system through practices such as compassionate imagery, soothing rhythm breathing, and compassionate self-dialogue (Gilbert & Procter, 2006). Activation of the soothing system is associated with parasympathetic regulation and feelings of safeness, thereby counterbalancing threat-based arousal (Klimecki et al., 2014). This mechanism is particularly relevant in infertility, where hypervigilance to social evaluation perpetuates emotional dysregulation. Reduction in self-criticism represents another core mechanism. Empirical findings demonstrate that compassion-based interventions significantly decrease self-attacking cognitions, which in turn mediate reductions in depressive symptoms (Kirby et al., 2017). Because infertility distress often manifests through harsh self-blame (“I am inadequate,” “I have failed as a woman”), targeting self-criticism is therapeutically central.

In group-based formats, CFT introduces an additional mechanism: validation through shared suffering. Observing others articulate similar fears and shame experiences fosters normalization and common humanity (Braehler et al., 2013). This collective validation weakens internalized stigma and reduces isolation. For women in collectivist societies, where relational belonging is foundational, group compassion processes may enhance affiliative safety and attachment security more robustly than individual therapy alone. In Pakistan, infertility is situated within a cultural context characterized by strong pronatalist values, extended family involvement, and honor-based social systems. Silence surrounding infertility often prevents open emotional expression, contributing to what may be termed the psychological invisibility of women’s suffering. The cultural norm of maintaining family harmony may discourage disclosure of distress, thereby intensifying internalized shame.

Social blame explicit or implicit frequently targets women regardless of medical etiology. Internalized gender role beliefs may amplify perceptions of personal failure, especially within joint family systems

where reproductive expectations are intergenerational. These sociocultural dynamics intensify threat-system activation and perpetuate emotional suppression. Group-based CFT may offer culturally congruent healing pathways. The communal format aligns with collectivist values emphasizing shared experience and relational interdependence. Rather than positioning distress as individual weakness, group compassion reframes suffering as a common human experience. This reframing may reduce secrecy and normalize emotional disclosure.

Religious integration presents additional possibilities. In Islamic contexts, compassion (rahmah) and patience (sabr) are central moral values. Integrating culturally meaningful spiritual metaphors into compassion exercises may enhance acceptability and therapeutic resonance. However, empirical validation of culturally adapted CFT models in Pakistan remains limited, underscoring the need for localized intervention trials. Cognitive Behavioral Therapy (CBT) has demonstrated efficacy in reducing infertility-related anxiety and maladaptive cognitions by restructuring distorted beliefs and promoting problem-solving skills (Frederiksen et al., 2015). CBT primarily targets cognitive distortions and behavioral avoidance patterns. While effective in symptom reduction, CBT may not directly address deep-seated shame and self-criticism, which are affectively rooted rather than purely cognitive.

In contrast, CFT prioritizes emotional regulation and affiliative system activation. Rather than disputing thoughts alone, CFT modifies the emotional tone underlying self-evaluation (Gilbert, 2014). For infertility populations characterized by shame-based identity threat, this affect-focused orientation may offer distinct advantages. Additionally, individual therapy formats emphasize personal cognitive restructuring, whereas group CFT introduces relational corrective experiences and normalization processes. Research on group compassion interventions suggests enhanced reductions in shame compared to purely individual formats (Braehler et al., 2013). Given the relational nature of infertility stigma in collectivist cultures, group-based approaches may yield greater ecological validity. Overall, while CBT remains a valuable evidence-based modality, CFT may offer a more targeted framework for addressing infertility-related shame and self-stigma, particularly when delivered in culturally adapted group settings.

IMPLICATIONS

The findings of this review underscore that infertility-related distress in collectivist contexts such as Pakistan is deeply rooted in shame, self-stigma, and gendered identity threat rather than solely biomedical factors. Clinically, this highlights the need to integrate compassion-based interventions particularly group-based Compassion-Focused Therapy (CFT) within fertility care settings to address self-criticism, emotional dysregulation, and social isolation (Gilbert, 2014; Kirby et al., 2017). Group formats may be especially effective in collectivist societies by fostering normalization, shared vulnerability, and relational healing. From a research perspective, there is a critical need for culturally adapted randomized controlled trials examining infertility-specific CFT models in South Asia. At the policy level, integrating psychological screening and compassion-based counseling into reproductive health services may promote holistic, biopsychosocial care for women experiencing infertility-related distress.

LIMITATIONS

Several limitations should be acknowledged. First, this review adopted a traditional narrative approach rather than a full systematic review or meta-analysis, which may limit the comprehensiveness and reproducibility of findings. Although PRISMA-guided screening procedures were followed, the absence of formal quality scoring tools may restrict objective comparison of methodological rigor across studies. Second, much of the existing literature on Compassion-Focused Therapy (CFT) has been conducted in Western populations, limiting generalizability to collectivist contexts such as Pakistan. Third, infertility-specific CFT trials remain scarce, with many conclusions drawn from broader shame-based or depression-focused interventions. Additionally, language restrictions (English-only publications) may have excluded

relevant regional research. Finally, heterogeneity in study designs, outcome measures, and intervention formats makes direct comparison challenging.

RECOMMENDATIONS

Future research should prioritize well-designed randomized controlled trials examining culturally adapted, group-based CFT interventions specifically for women experiencing infertility-related distress in Pakistan and other South Asian contexts. Longitudinal studies are recommended to assess sustained effects on shame, self-stigma, marital adjustment, and emotional regulation. Researchers should also develop and validate culturally sensitive assessment tools for infertility-related shame and internalized gender role beliefs. Clinically, fertility centers should integrate routine psychological screening and structured compassion-based support programs as part of multidisciplinary care. Policymakers and mental health professionals are encouraged to promote awareness campaigns to reduce stigma and normalize psychological help-seeking among women facing infertility.

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