Living as an infertile woman: A qualitative analysis of narratives by Kerala women

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Abstract. Infertility is a significant global health concern, with a particularly high prevalence in India, where women are often held solely responsible for difficulties in conception, regardless of the underlying cause. This qualitative study explores the emotional, social, and cultural factors shaping the experiences of infertile women in Kerala by analyzing linguistic features within their personal narratives. The research addresses how women narrate and construct their experiences of infertility within a pronatalist society, and identifies recurring themes related to coping, social interactions, and personal meaning. Five married women, aged 30 to 50 and representing diverse socioeconomic backgrounds and regions of Kerala, participated in in-depth interviews. Thematic analysis identified eight primary themes: emotional responses to being identified as infertile, postponement of pregnancy, social environment interactions, discouraging comments from others, conflict and understanding between spouses and families, coping strategies, discussions with friends, and perceptions of the meaning of life. The findings highlight the profound impact of cultural and social environments on women's experiences with infertility, emphasizing that societal messages and beliefs heavily influence perceptions of motherhood. The study's linguistic analysis provides insight into the ways women articulate and make sense of their experiences, revealing both stigma and resilience. These findings contribute to a deeper understanding of the cultural and social implications of infertility and may inform the development of counseling and intervention strategies designed to enhance the well-being of women facing infertility.

Keywords: *infertility, thematic analysis, narrative, linguistic features, stigma*.

Асваті Дж Б, Джордж Соня. Життя безплідної жінки: Якісний аналіз наративів керальських жінок.

Анотація. Безпліддя є серйозною глобальною проблемою охорони здоров'я, яка особливо поширена в Індії, де на жінок часто покладають виключну відповідальність за труднощі із зачаттям, незалежно від першопричини. Це якісне дослідження висвітлює емоційні, соціальні та культурні чинники, що формують досвід жінок із безпліддям у

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штаті Керала, шляхом аналізу лінгвістичних особливостей їхніх особистих наративів. Вивчення стосується того, як жінки послуговуються мовою під час опису та конструювання свого досвіду безпліддя в пронаталістському суспільстві, а також виявляє повторювані теми, пов'язані з подоланням труднощів, соціальними взаємодіями та особистим осмисленням. У глибинних інтерв'ю взяли участь п'ять заміжніх жінок віком від 30 до 50 років, які представляють різноманітні соціально-економічні верстви та регіони штату Керала. Тематичний аналіз дав змогу виокремити вісім основних тем: емоційні реакції на діагноз безпліддя, відкладення вагітності, взаємодія в соціальному середовищі, зневажливі коментарі з боку оточення, конфлікти та взаєморозуміння між подружжям і сім'ями, стратегії подолання труднощів, розмови з друзями та сприйняття сенсу життя. Отримані результати підкреслюють глибокий вплив культурного та соціального середовища на досвід жінок, пов'язаний із безпліддям, та вказують на те, що суспільні настрої та переконання значною мірою впливають на сприйняття материнства. Лінгвістичний аналіз дослідження дає уявлення про те, як жінки формулюють та осмислюють свої переживання, виявляючи як стигму, так і стійкість. Ці результати сприяють глибшому розумінню культурних та соціальних наслідків безпліддя та можуть стати основою для розробки стратегій консультування та втручання, спрямованих на покращення добробуту жінок, які стикаються з безпліддям.

Ключові слова: *безпліддя, тематичний аналіз, наратив, лінгвістичні особливості, стигма*.

Introduction

Infertility, defined as a disease of the male or female reproductive system characterized by the failure to achieve pregnancy after 12 months or more of regular unprotected sexual intercourse (WHO, 2018), affects millions of individuals of reproductive age worldwide, impacting their families and communities. Historically, infertility has posed a significant challenge (Burns & Covington, 1999) and remains a global health issue (Cousineau & Domar, 2007). Childlessness or infertility carries serious personal, demographic, social, and health implications (Ganguly & Unisa, 2010). Approximately 85 % of women become pregnant within one year of attempting conception (How Long Does It Take To Get Pregnant?, 2023). Global estimates indicate that between 48 million couples and 186 million individuals are affected by infertility (Infertility Prevalence Estimates, 1990–2021, n.d.).

In the female reproductive system, infertility may be caused by a range of abnormalities of the ovaries, uterus, fallopian tubes and the endocrine system. Infertility can be primary or secondary. When a person has never achieved a pregnancy, it is "Primary infertility", and when at least one prior pregnancy has been achieved, it is "secondary infertility" (WHO, 2018). Especially in developing countries, sexually transmitted infections (STIs) are generally considered the leading preventable cause of infertility worldwide (Ganguly & Unisa, 2010). With a record of 27.5 million couples wanting to conceive but suffering from

infertility, there is an alarming increase in infertility complications in India due to a multitude of reasons (Guptha, 2021). In India, about 10-15 per cent of couples are said to have fertility issues (All India Institute of Medical Sciences). According to the Indian Society of Assisted Reproduction, about 10 to 14 per cent of the Indian population is affected by infertility, which is higher in urban areas where one out of six couples seems to be impacted. Kerala is the state in India with the lowest fertility rate. In Kerala, it is estimated that above 20 % of couples are infertile. (Agiwal et al., 2023, pp. 287-292)

Infertility adversely affects the health of married couples, with women experiencing a disproportionate impact (Ofosu-Budu & Hanninen, 2020). Approximately 30 % of fertility problems originate in females, 30 % in males, and 40 % are attributable to both partners or unknown causes. However, in some communities, the inability to conceive is almost exclusively attributed to women, who are often blamed for infertility regardless of the actual cause (Van Balen & Gerrits, 2001). Physical, mental, emotional, social, and cultural factors significantly affect women, particularly in the Indian context, where procreation holds substantial cultural and religious importance (Kumar et al., 2025, pp. 5589-5596).

Indian Culture and Infertility

Infertility is a global issue, with particularly high prevalence in India. In this pronatalist society, infertility is especially problematic, resulting in stigma, shame, and blame that are predominantly directed at women. The consequences for women include discrimination, social exclusion, and abandonment, all of which elevate the risk of mental health distress. Furthermore, mental health remains highly stigmatized, and specialized care is largely inaccessible (Roberts et al., 2020). Given the cultural emphasis on childbearing as a mandatory expectation, women who are unable to conceive experience both loss of status and heightened stigma, further increasing their vulnerability to mental health problems (De, Roy & Sarkhel, 2017). The present study explores the mental, emotional, and social challenges experienced by infertile women through analysis of linguistic features and themes present in their narratives. This study aims to identify factors associated with infertility among women by analyzing the linguistic features of their narratives. Specifically, the paper addresses the following research questions:

1. What are the primary emotional, social, and cultural factors influencing the experiences of infertile women in Kerala?

2. How do women narrate and linguistically construct their experiences of infertility in a pronatalist society?

3. What recurrent themes emerge from the narratives regarding coping, social interactions, and personal meaning?

Method

Sample

The study sample comprised five participants. The inclusion criteria were as follows: female participants aged between 30 and 50 years; residents of Kerala only; participants diagnosed with primary infertility by reproductive medicine departments at various fertility hospitals in Kerala; experienced infertility for at least five years; represented diverse socioeconomic backgrounds and regions within the state; who provided informed consent to participate in the study. The exclusion criteria included participants with severe chronic diseases, identified psychological disorders, and those who were illiterate. Although the sample size is small, five participants were sufficient to achieve thematic saturation, as no new themes emerged after the final interview. This ensured a depth of exploration of each narrative while maintaining methodological rigor.

Participants were recruited using purposive sampling to ensure the inclusion of individuals with specific knowledge and experiences relevant to the study objectives. This sampling approach facilitated access to a hard-to-reach population while minimizing the risk of overgeneralization. Participants were initially contacted by telephone, during which the aims and objectives of the study were explained in detail. Following the provision of informed consent, mutually convenient dates and times for data collection were arranged. All participants chose their homes as the preferred location for the interviews. The corresponding author attended each participant at their residence and conducted interviews. The study was conducted over a six-month period in 2025.

The participants were as follows:

1. Married woman; undergraduate; Duration of infertility – 12 years; Primary infertility; Hindu; rural area
2. Married woman; Postgraduates; Duration of infertility – 10 years; Primary infertility; Christian; rural area
3. Married woman; PhD; Duration of infertility – 12 years; Primary infertility; Christian; Urban area
4. Married woman; PhD; Duration of infertility – 5 years; Primary infertility; Hindu; Urban area
5. Married woman; PhD; Duration of infertility – 7 years; Primary infertility; Hindu; Urban area.

Research Design

Semi-structured interviews were employed to collect data, given the private and sensitive nature of the subject matter. An interview guide was developed by reviewing relevant literature on female infertility and consulting with experts in reproductive health and qualitative research. The questions were designed to address emotional, social, and cultural aspects of infertility while ensuring sensitivity to participants' experiences. The guide was piloted with two women who met the study criteria but were not part of the final sample. Based on their feedback, specific wording and sequencing were adapted to improve clarity, comfort, and cultural appropriateness. This iterative process helped ensure that questions supported open, meaningful dialogue and respected participants' backgrounds.

A qualitative method was used for both data collection and analysis, facilitating an understanding of the phenomenon through the meanings ascribed by individuals or groups (Creswell, 2003). These interviews provided direct insight into the experiences of involuntarily childless women. Thematic analysis was conducted to explore descriptions and potential remedies for infertility, associated factors, and the meanings constructed by participants. The study examines the effects of living with infertility and the meanings derived from participants' narratives.

Ethical considerations

Ethical considerations were addressed by providing comprehensive information about the study's purpose, procedures, potential risks, and expected benefits before data collection commenced. An ethical approval was obtained from Government College for Women in Kerala. Each participant gave their informed consent. To ensure privacy and confidentiality, only the personal information necessary for the study was collected, and all data were stored securely. Participation was entirely voluntary, and no financial or other compensation was provided. A cover sheet containing demographic information except for names was coded differently to ensure confidentiality. Specific participant locations are unreported as the reporting could lead to easy identification.

Data Collection

For this study, data were collected through interviews. Given the sensitive and complex nature of the topic, questionnaires were deemed insufficient for capturing the depth of participants' experiences. Therefore, in-depth interviews were selected to elicit a broad range of responses. Thematic analysis was employed due to its suitability for analyzing verbatim responses and enabling nuanced interpretation, particularly for emotionally charged themes. Each of the five participants engaged in one-and-a-half-hour semi-structured interviews.

Considerable time was dedicated to establishing rapport prior to the interviews, which facilitated open expression of concerns and helped mitigate tensions related to class and cultural differences.

Data Analysis

In Braun and Clarke's (2006) reflexive thematic analysis, coding is a systematic, organic process of tagging data segments with labels that capture meaningful features related to the research question. It is a foundation for theme development. Coding is recursive, involving multiple iterations of refining codes, which can be semantic (explicit meaning) or latent (underlying ideas). The thematic analysis of the participants' narratives followed the following six steps (Braun & Clarke, 2006): familiarisation, coding, generating themes, reviewing themes, d*efining and naming themes, and writing up.* The thematic analysis identified common themes within the data, with the primary objective of discerning recurring patterns across the dataset. Interview recordings were transcribed verbatim, resulting in a 34-page document. To enhance the reliability and validity of the coding process, two independent researchers coded the data separately and subsequently compared their results. Any discrepancies were discussed and resolved through consensus. Member checking was also employed by sharing the initial coded themes with participants to ensure accuracy and resonance with their experiences. Statements reflecting these defined themes were extracted based on their prevalence across transcripts.

Results

The results of the researchers' manual data coding are shown in Table 1.

Table 1
Codes, Sub-Themes and Themes in the Participants' Narratives

Codes	**Subthemes**	**Themes**
Emotional trauma Depression symptoms Family Anxiety Victimization Rumination Meaning of life	Social aspect of infertility Emotional aspect of infertility Psychological aspect of	**1.** Women's feelings when identified as infertile. 2. Postponement of pregnancy. 3. Interaction in the social environment.

Sexual life Stigma Information sharing Rumination relief Attitude towards children Conflict Marital adjustment Medical factors Biological factors Positiveness Parenthood Family planning Job	infertility Biological aspect of infertility	4. Discouraging comments from others. 5. Conflict and understanding between spouse and family. 6. Coping with being infertile. 7. Discussion with friends. 8. Meaning of life.

Eight main themes were identified from the participants' narratives. The first theme, 'Women's When Identified As Infertile,' encompasses anxiety, worry, loneliness, guilt, grief, depression, and regret commonly experienced upon learning of infertility. This theme emerged from the narratives of four participants. 'Postponement of Pregnancy' was another theme, identified from the narratives of two participants. In recent years, postponement of pregnancy among married couples has become increasingly common. Societal factors contribute to this trend and highlight the challenges women face in balancing professional responsibilities with childbearing and family caregiving. 'Interaction in the Social Environment' was the third theme, identified from the narratives of four participants. There is a prevailing social perception that married women are recognized primarily through motherhood; otherwise, regardless of their societal contributions, they may be perceived as irresponsible or unproductive. 'Discouraging Comments from Others' was the next theme, identified from the narratives of three participants. A notable characteristic among infertile women is a predisposition to feelings of inadequacy and concern regarding their situation. Consequently, insults or negative remarks serve as reminders of their condition, exacerbating their distress. 'Conflict and Understanding Between Spouse and Family' was a theme identified from the narratives of three participants. Conflict may arise when family members hold differing views or beliefs, or when misunderstandings occur. Unresolved conflicts can result in arguments and resentment. The birth of a child is often considered essential within the marital relationship, and its absence can contribute to familial discord. 'Coping with being infertile' was another theme, identified from the narratives of three participants. Participants employed various coping strategies, including considering relocation and seeking

environments conducive to relaxation. These approaches may be conceptualized as efforts to manage or conceal the stigmatizing aspects of infertility. 'Discussion with Friends' was another theme, identified from the narratives of three participants. While individuals often seek communication with others during times of distress, discussions about infertility with friends may or may not take place. 'Meaning of Life' was identified as a theme from the narratives of two participants. According to Yalom (1980), life is inherently meaningless, and individuals must create meaning for themselves rather than discover it. He posits that a meaningful life results from commitment to a set of ethical-psychological principles established by individuals (Yalom, 1980).

Linguistic Manifestation of Themes in the Narratives

Theme 1: Women's Feelings When Identified As Infertile. One participant reported that in a situation where her husband had an infertility problem, she was forced to remove her uterus for a minor cause. Then she came to the infertility group, where she is desperate and feels depressed and regretful. She said:

> The only issue I was dealing with was a tiny tumor in my uterus. The physician explained that it wasn't a major issue, not even for getting pregnant. Despite the potential, my husband urged that the uterus should be removed, and I had no interest in doing so. I regret it now.

A participant reported that she was not at all surprised when diagnosed with infertility. But eventually, now she feels worry and anxiety:

> The fact that I was having infertility issues didn't surprise me. Upon initial medical examination, no issues were discovered. Two years after the pinot, a medical examination revealed an infertility problem. Prior to now, my menstrual cycle wasn't quite on schedule. However, I'm nervous right now.

Another participant reported that she was happy when she had a miscarriage for the first time. But now she is undergoing secondary infertility. That condition is unbearable to her:

> To be honest, I was overjoyed on the day I lost my baby. I unintentionally became pregnant. We didn't know how to handle it. We made the decision not to have kids right away after the wedding. We didn't think we were old enough for that. Nothing in our early years had changed. Concerned about my pregnancy was me. It had put more pressure on me than I could handle. By the third month, I was feeling a lot of strain. We learned that the baby was aborted the fourth month. After that, I was relieved. I was not

> sure what to do though. I felt bad about my thoughts and had regret about them afterwards. Right now, I desperately need a baby.
> After I had the examination, I learned from that study that I had a fallopian tube blockage, polycystic ovarian syndrome, and an inverted uterus. That day was a complete mess. It seemed as though there was no reason to live. I've been completely depressed.
> I feel ashamed. I want a child now. But I believe that my condition makes it impossible.
> Occasionally, I experience guilt. I have a hunch that due of my medical issue; it is too late for me to start a family. When I become pregnant, that was unexpected at the time and it was really challenging to process. I felt comfort the day when the abortion took place, but I am disturbed that I can't become pregnant right now.

Another participant reported that it was terrible to be infertile. Her desperation to have children was so prominent:

> It really depresses me. It was a shaky experience. My spouse was okay with his infertility when I discovered that I had a problem with it. I was very depressed since then. Even after we solved the issue, there was still another factor contributing to the infertility problem. My situation in life was really challenging. Every time we try to conceive, it ends in failure. We make physical touch when it's appropriate because we desire a child. However, my thoughts were constantly diverted. The family stressed me out so much.

Theme 2: Postponement of Pregnancy. A participant reported that they postponed the pregnancy due to job and career stress. She was 30 years old at that time when she made the decision. Now she is 36 years old.

> We made the decision not to have children right away after the wedding. We didn't think we were old enough for that. Nothing about our early years has altered.The workload at that time was too much to bear. Despite working in the central government's highest position, my job was extremely demanding. Despite working in the same department, we frequently have to put in lengthy hours. There was not much time for us to spend together. This was the situation of many, not just me. Working day and night made me feel under pressure.

Another participant reported no postponement at all. She married at the age of 28, and now she is 50years old:

> There had been no delay at all. Our goal was to become parents as soon as possible. We also tried to conceive as soon as possible after marriage, since it was deemed desirable at the time.

A participant explains how the couple's decision about postponement of pregnancy was altered by family pressure. In a way, it is a common occurrence in Kerala:

> We were interested in pregnancy postponement. We actually even properly planned it. We were youngsters at that time. But since we are in a conventional family, we had pressure from the side of family to have baby.

Another participant explains that her partner's decisions now make her regret it. It also indicates the nature of Kerala patriarchal society:

> There is not much age difference between me and my spouse. We got married a little late. That is why I wanted to have children soon. But my spouse did not agree with that decision. He decided that we would have children after we were a little more financially settled. I also agreed with that. But now I regret that decision.

A participant reported that she was disappointed about the postponement of her pregnancy:

> I saw postponing pregnancy as a natural thing. We had taken safety measures for that. But when we couldn't do it in the situation of wanting a baby, I was completely devastated. Later, I underwent many medical treatments. Nothing worked. Now I feel like I shouldn't have postponed the pregnancy then.

Theme 3: Interaction in the Social Environment. A participant reported she feels uncomfortable interacting with children and with parents having children:

> I found it difficult to interact with kids, particularly with infants. Then I will cry when I realize I am a childless woman. After that, I'll completely stop talking. I found it really challenging to take part in public activities. I began to distance myself from everything. I was anxious about spending time on Sundays in church. Regarding childlessness, everyone will have questions.
> When I hear questions related to my infertility, I will be in a lot of trouble. But prayer used to be a big part of my life, and I did it every time. I attend church on Sundays and occasionally on other days. I go to the "Velankanni" church and perform certain ceremonial tasks. I also enjoy writing and reading.
> Infertile women have low social status in society. She is always being the victim even though she is not the reason for it. I suffered it a lot. So, I know about it.

Another participant reported that she is not much in conflict with society. It may be because the place she lives in is strange to her and nobody knows her and her husband well. Even in the friend circle, she is not very familiar with others:

> I've never encountered many challenges. Maybe because of the environment I live in, no one asks me if I have children. Additionally, there are fewer acquaintances where I am now—in Shillong. However, that is not how things work in my home country. It is really tough for my parents to go to public events. Our neighbours and locals are quite

> concerned when they inquire about our kids. At home, there are two of us girls. My sister and I don't have any kids. That is a serious issue.
> Our living environment is incredibly significant. We live in a society where many ask about children and childbearing after marriage. Then infertility is bad, especially for women. Society does not care how they treat us. I am not very social and, to some extent, selfish. Hence, I have never encountered significant obstacles. In a typical society, I would occasionally grow weary of being infertile in the face of social inquiries.

The other person was so introverted. She said that, because of her personality, she very rarely participates in social gatherings. But she is aware of the negative stigma circulating in society regarding infertile women:

> I'm not a gregarious person. I don't frequently go to public events. Not having children is an issue for other people and it is one of the causes that I don't opt for public events. Many religious or religious circumstances, like joyous occasions, don't give infertile women any space during the functions.

In the case of a participant, what she said was that in the early days, discrimination and stigmatising situations were difficult for her to handle. There is no difficulty in facing such situations now. She raised her husband's brother's grandchildren until the children grew up.

> What challenge? I am old now. It would have been uncomfortable in the beginning. The grandchildren of this man's sibling are fed by me. I fulfilled all of my obligations through them. Every day at dusk, we watch for them to arrive home from school. Once a month, I would purchase special food for them. However, it seems like those youngsters no longer genuinely care about me (her eyes are full).
> "In the beginning, it felt like loneliness. It doesn't feel like that anymore, and it doesn't exist. I've attended all the family ceremonies now, and nobody has ever abandoned me. I visit temples every day to pray. I used to go to more events, like festivals. Never before have had I felt so different. Additionally, I own a feeling that there is no place/ status in society.

Theme 4: Discouraging Comments from Others. A participant reported her negative experience with family:

> My spouse's family was no longer helpful. From that family, I had to hear and experience many awkward things. The neighbor of my husband's brother's wife had once remarked, "This girl would never have children" That frightened me a great deal.

Some women grieve whenever they encounter insults. These insults, according to some, make them lose both appetite and sleep and lead to unwanted quarrels:

> Whenever insults are directed at me, I take offense...I've had other restless nights since then, and occasionally I've even been unable to eat. That night, I couldn't sleep. I also argue needlessly with my spouse, even though I know it's useless.

A woman reported that her office friends make her feel disturbed:

> Some people in the office have always been rude to me by asking childlessness related topics.

Theme 5: Conflict and Understanding Between Spouse and Family. A participant reported that both her family and her husband's family are supportive, but they are worried:

> My husband is very supportive. I am the person who gets distracted easily, becomes frustrated, and sad. I also have some mood swings. He can understand and tolerate them all. Both my family and my husband's family are supportive, but they are worried. Especially my family shows much consideration towards me. At the same time, they are very sad.

In another case, the husband's family is most concerned about childbirth:

> Family pressure is not present, but my spouse and his relatives are quite worried. My menstrual cycle has always been a source of curiosity for my husband's family. I'm not bothered by it, though. My family has already heard my opinion regarding it.

In another case, her husband was desperate. She has been depressed to some extent mentally, emotionally and sexually. Between them were constantly large and small conflicts.

> He is not worth it. I don't know how much of what you say. He has a fascination with siblings and their offspring. He intended to raise them as well. How about this? If he isn't prepared to visit the hospital, what can I do? Once, I told him to never ever come back to me and I threw him out of my quarters. He has not consented to adoption either.

Theme 6: Coping with Being Infertile. One participant said being infertile was a great hardship. Prayer was the main way to cope. She prayed for hours and regularly went to temples. This work is still being done non-stop. She had shown possession symptoms after the period of uterine removal:

> I am a devotee, and prayer is that which keeps me going. Don't tell anyone that I have a special power. The power will come when I call for it. That power belongs to my grandparents. They can talk to me and I can foretell many things. Bhadrakali will come to my body some times.

Another participant said that reading, painting, and yoga provide a lot of relief:

> Reading, painting and yoga are my resources to overcome my negative thought. I am not a painter but I paint, I like it.

Another woman reported she is holding Prayer as a means for relief:

> I am a great devotee. I used to pray intensively. I would say everything to Jesus. Yes, it is a great relief.

Theme 7: Discussion with Friends. One participant said that she was not interested in sharing her difficulties:

> I do not share my grief to anyone. I think a lot about everything. I thinkI would make my parents upset if I revealed them about my problems. I had no opportunity to talk to my husband's family about my struggles. I didn't have any close pals back then. I was really alone myself there.

Another participant said yes:

> Of course, once we become friends, we talk about these topics. I came to know that many people have had comparable experiences. They'll talk about their experiences as well. Workplace pressure is one of the topics that bring us together to talk. The family is negatively impacted. My spouse and I don't get to spend a lot of time together. I talk about this with my male friends as well.

A woman says she said these things to very close friends, but not to her family:

> I do share certain things with my family and two of my close friends. My friends accepted my ideologies but my family doesn't.

Another woman answered that she shared her grief with her sisters and colleagues:

> Yes, having my sisters around was a huge comfort. Next, my associates provided assistance. They worked together at work without transferring me because I required more than just treatment. They could even detect the smallest frown on my face. In the case of adoption, they gave me encouragement. I've always been the target of harsh questions about childlessness from a few of my coworkers.

Theme 8: Meaning of Life. A woman identified her life as meaningless:

> That was such a troublesome time. My life seemed pointless to me. I began to think about what my life's purpose is. My whole life is engulfed in darkness.

Another participant reported:

> I don't know what to do. I am helpless. My family descent will end with us. I can't find any purpose to live. We are living because we are alive.

One participant reported feeling a sense of meaninglessness in her life and linked it to her past.

> I can't live like this anymore. Why should I live? For whom? I feel like I'm just a puppet. Is it my fault that I don't have children? Sometimes I think it's the result of a previous life. Otherwise, I wouldn't be in this situation. I haven't done anything wrong knowingly.

Another participant said that she is actually pretending to be happy even under her depressive condition.

> I generally interact with people happily. That doesn't mean I'm happy. Sometimes I wonder why I'm living. I think about committing suicide. I get tired. There are children in our family who are much younger than me. When I think about it, my heart hurts. Why have I been in this situation?

Another participant reported how infertility affects the quality of married life and the meaning of life.

> I realized how important children are in my life only when I didn't have children. Until then, I didn't see it as a big deal. Now I have no motivation to move forward. To be honest, I've started to hate married life. The times we spend together are so annoying. Life is tiring. I just want a baby.

Discussion

All over the world, women experience stigma, emotional stress, and diagnostic/treatment burden more than men (Taebi et al., 2021). Women from Kerala also follow the same pattern. So, the result is that infertility studies are crucial for identifying the rising regional and global prevalence of reproductive issues. Various studies report that the infertility rate in Kerala is between 10.3 % and 11.1 %. (Vannya et al., 2025). Infertility affects approximately 3.9 % to 16.8 % of the Indian population (Sarkar & Gupta, 2016). Around 17.5 % of the adult population – roughly 1 in 6 worldwide – experience infertility (WHO, 2018). Female infertility is a major global health concern. Studies show that women often bear a disproportionate share of the social costs, which are easily.

The study's major findings indicate that emotional trauma resulting from infertility is substantial. Infertility often leads to family conflicts, and affected individuals, particularly women, are frequently victimized. Women are commonly blamed for male infertility, and stigmatization is pervasive. Various coping strategies, such as painting, reading, and practicing yoga, are employed

to manage negative emotions. Support from spouses and families is essential, and caring for others' children can provide some relief, though it may be challenging. A supportive environment mitigates emotional distress, but age only partially alleviates the difficulties associated with infertility. Infertility can render life meaningless for some, and concerns about ending family lineage are prevalent. Adoption is considered a viable option, but it requires mutual agreement between spouses. Attitudes toward childbearing significantly influence the efficacy of fertility treatments. Spousal support and understanding are critical in reducing conflict. Societal context plays a significant role in the emotional well-being of infertile individuals, and family members are influential in decisions regarding adoption. Job stress is a contributing factor to pregnancy postponement. Miscarriage is traumatic, particularly for those desiring children. Social status is diminished for infertile women, and couples face considerable pressure from families to have children. Close friendships are important for sharing emotional burdens, and women are consistently victimized due to various life circumstances.

In establishing themes, we extracted statements with meanings that emerged in most transcripts. Reproduction in Eastern cultures is highly valued, and when childbearing seems impossible, a probable psychological crisis sets in (Wiersema et al., 2006). Women with infertility experience a greater psychological impact. For women, pregnancy and motherhood are developmental milestones that are highly emphasised by our culture (Strauss, Appelt & Ulrich, 1992). Several studies have reported that couples with infertility are prone to experiencing depression (Schweiger, Schweiger & Schweiger, 2018), anxiety (Biringer et al., 2018), sexual intercourse problems, marital problem (Luk, & Loke, 2015), decrease in self-confidence (Ozan & Okumuş,2017), and low levels of psychological well-being (Moeenizadeh & Zarif, 2017) and quality of life (Ma et al., 2018).

Across the world, couples have been delaying parenthood to an ever later age over the last three decades. The age at which a woman has her first pregnancy affects the health and life of a mother and her baby. Societal factors determine the postponement of childbearing. It is related to the difficulty women often face in combining education, a job, or a career with having children and caring for a family. If women do succeed in becoming pregnant later in life, there is an increased risk of complications during pregnancy and delivery (Velde et al, 2007). Infertility, spontaneous abortions, ectopic pregnancies and trisomy 21 start at around 30 years of age, with more pronounced effects at>35 years, whereas the increasing risk of preterm births and stillbirths starts at around 35 years, with a more pronounced effect at>40 years. Rapid expansion of tertiary education and rising female employment provided

incentives to delay childbearing (Rindfuss et al., 1988). In 2020, the age at childbearing for women in India was 27.4 years. (Mean Age …, 2024)

Societal-level stigmatisations are common among women (Mumtaz, Shahid, & Levay, 2013). Culture and social environment seem to influence the experiences of women with infertility. The way they perceive the importance of motherhood depends largely on societal messages and beliefs. Blame from society, social pressure to conceive, the husband's remarriage, and reputation in society are some influencing factors. Indian society, infertility is taken as a woman's problem, and she is blamed for not being able to procreate. As a dutiful wife, she is expected to start a family immediately after marriage. When she fails to do so, she is blamed for her failure in her role and often subjected to negative remarks and criticism from in-laws and neighbours. Family is the most important social entity in India. Women with infertility are considered less than others as they are not able to fulfil the predesigned role of a female as approved by society. Participants reported feeling like second-class citizens in comparison to those who enjoy fertility (Sheoran & Sarin, 2015).

When infertile women interact with others, no doubt, someone will say something that dismisses her feelings or outright offends her. It will definitely hurt the victim. Parents, in–laws, siblings, and other close relatives, even her husband, will raise humiliating questions. It is common in our society for women to face insensitive comments. The marital family invariably assumed the woman was the infertile partner, even in cases of proven male infertility. This was frequently followed by abuse that included verbal and emotional harassment and physical violence (Mumtaz, Shahid, & Levay, 2013). In this case, a participant reported her negative experience with her family when they verbally abused her. Some women grieve whenever they encounter insults. These insults, according to some, make them lose both appetite and sleep and lead to unwanted quarrels. A woman reported that her office colleagues disturb her by repeatedly asking about her childlessness out of sympathy.

There's no denying the fact that infertility can take a major toll on one's mental and physical health. In studies on infertility, marital issues are increasingly reported to be in part due to the impact of infertility (Laffont & Edelmann, 1994). Couples may have different opinions about who to share information with about their infertility struggle and also when and how to share it. This can cut off couples' potential support systems. According to Tao (2012), infertile females had significantly less stable marital relationships compared to fertile females.

To cope with infertility healthily, it is essential to move forward with parenthood dreams. Increasing the space or distancing oneself from reminders of infertility, instituting measures for regaining control, acting to increase self-esteem by being the best, looking for forbidden meaning in infertility, giving in

to feelings, and sharing the burden with others are some coping methods used by infertile women (Davis & Dearman, 1990).

According to Lazarus and Folkman (1984), social skills are an important coping resource, referring to the ability to communicate and behave with others in ways that are socially appropriate and effective. Abbey et al. (1991) reported that more women than men had spoken with their friends and family about the fertility problem. Women described more benefits and costs of these interactions than men did. For the majority of participants, open and honest communication with others was reported to contribute to feelings of support, empathy, and understanding within the relationship. It also facilitated relationship growth (Hawkey et al, 2021).

Limitations of the Study

Even though five participants were enough for the qualitative analysis, it is still a limited number overall. We could increase the sample size beyond 5 anyway for saturation. Even though the infertility rate is increasing all over the world, tracking infertile people is difficult. Most people keep it a secret. As it is a sensitive issue, people tend to avoid the data collection process. They find it difficult to face an interview, especially when emotionally charged questions arise.

These limitations have important implications for the interpretation and transferability of our findings. The small sample size and challenges in recruitment mean that the results may not be readily generalizable to all infertile women in Kerala or India. Experiences and perceptions may differ across other regions, age groups, or social backgrounds that were not fully captured in this study. Additionally, individuals who elected not to participate may have significantly different perspectives or more pronounced distress. As such, the findings should be understood within the context of a qualitative, exploratory approach, offering in-depth insight into the experiences of a small group rather than broad conclusions for the entire population.

All the participants wept during the procedure. It was very heartbreaking. Still, India is a patriarchal society where men dominate, and women are expected to be submissive, and they have very limited voice. In Kerala, procreation is very important. Kerala society expects a child from a newly married couple within 2-3 years. Children hold great significance in religious ceremonies, especially at the funerals of elders and in other contexts. (Thurston, 1906) In the majority of cases, women are victimised for men's infertility issues. Even though Kerala has the highest literacy rate in India, it also follows the same pattern – patriarchy. Many studies prove that in the case of infertility, women face more psychological and social issues directly and indirectly than men. That is why we chose women as our sample.

Conclusions

In Indian society, having a child is of great significance and has religious implications. When a couple is childless, women are generally considered responsible for the situation. She is always victimised and suffers. According to social norms, an infertile female has lesser status and prestige in society and may be subjected to refusal of fulfilment of basic needs in extreme cases. Women face social and financial adversities at times, and this is not limited to low-income or low-education strata. The study recommends using information, educational, and linguistic strategies at the community level to reduce stigma associated with infertility.

CRediT Author Statement

Aswathi J B: Conceptualization, Methodology, Investigation, Resources, Data Curation, Writing – Original Draft, Visualization; **Sonia George**: Conceptualization, Methodology, Validation, Formal Analysis, Writing – Reviewing & Editing, Supervision, Project Administration.

Disclosure Statement

The authors reported no potential conflicts of interest.

Generative AI Statement

During the preparation of this work the author (Aswathy J B) used Grammarly in order to check spelling and grammar, adjust literature to APA7 norms. After using this service, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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Appendix

Interview Protocol

Project Title: [Insert Project Title]
Interviewer: [Name]
Interviewee: [Name/ID]
Date/Time: [Date & Time]
Place:[District in Kerala]
Age:[In years]
Education:[Formal education]
Duration of infertility:[In years]
Type of infertility: [Primary]
Residence:[Urban/Rural]
Religious background:[Hindu/ Christian/ Muslim]
Interview guide

Semi-Structured Interview Guide

1. Interviewer Name
2. Participant ID
3. Interview Date (dd/mm/yyyy)
4. Participant agrees for interview to be digitally recorded
5. Time Interview Began (hhmm-24hr clock)
6. Time Interview Ended (hhmm-24hr clock)

Step 1: Complete Q1-3 above before the interview.
Step 2: At the beginning of the interview, introduce yourself; thank participant for taking part in the interview.
Step 3: Read Section A below to participant.
Step 4: Complete demographic questionnaire
Step 5: Ask participant permission to record interview; tick appropriate box in Q4 above.
Step 6: Turn on audio recorder if acceptable, document time interview begins in Q5 above, and conduct interview.

Step 7: At the end of the interview, thank the participant and ask if she/he has any further questions; document time interview ended in Q6 above.
Step 8: Ask if the participant is interested in being re-contacted with study results; if yes, document appropriate email. Inform participant that her/his email address will not be linked with her/his study data.
Step 9: Complete the Personal Data Disclosure Form
Interviewer: Please read the following to participants at the beginning of the interview.

SECTION A: Information about this study
Hello, thank you for taking time out of your busy schedule to speak with me today. My name is [Name], and I am a psychologist.
Is now still a good time to talk?
Before we begin, I'd like to tell you more about the research we're doing and what we will do with the information you tell us.
This is an interview of getting information about biological, social emotional and psychological experiences of infertility in you.
As described in the informational sheet provided to you earlier, participating in this interview is voluntary. You can choose not to answer a question or you can stop the interview at any time.
We do not think there will be any personal risks or benefits from the interview today. However, there is a risk of loss of confidentiality as with any study of this nature
With your permission, I would like to audio-record the interview. The audio-recording will be stored on a secure server and destroyed after the findings of this research are published.
If you do not want the interview audio recorded, I will take detailed notes throughout the interview instead.
Do you have any questions for me at this point?
[If yes, answer the participant's questions then proceed with the completing the demographic form.] [If no, proceed with the completing the demographic form.]
Is it okay if I turn on the audio recorder now? [If yes, begin audio recording now.] [If no]
That's okay, I'll take detailed notes as we talk.
Ok, let's get started!

SECTION B
Questions
Basic Information
Sample questions:
1. Who initiated the Infertility treatment?
2. How did you feel when you found out you had an infertility problem?
3. What difficulties did you experience due to infertility?
4. What kind of methods was used to get out of the difficulties caused by infertility?
5. Have you blamed yourself for infertility?
6. How is infertility treatment evaluated?
7. Did you share your difficulties with anyone?
8. Did you feel uncomfortable interacting with children and interacting with parents having children? How did you handle it?
9. Have you had trouble attending public affairs and family gatherings, religious rituals?
10. How was the family support?

11. How was the support for partner?
12. Did life feel a half-hearted?
13. Did you Feeling that there is no place/Status in society?
14. Did you think about the adoption option?

SECTION C
Finally, I'd like to close by asking you to reflect on what we discuss.