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Effectiveness of Self-Compassion Therapy on Loneliness and Health-Related Quality of Life in Infertile Women

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A B S T R A C T

Objective: This study aimed to evaluate the effectiveness of self-compassion training on reducing loneliness and improving health-related quality of life in infertile women.

Methods: A randomized controlled trial design was used, involving 30 infertile women recruited from a specialized infertility treatment center. Participants were randomly assigned to an experimental group (n = 15) receiving eight sessions of self-compassion training or a control group (n = 15) with no intervention. Assessments were conducted at baseline, post-intervention, and at a five-month follow-up using the Loneliness Questionnaire and the Health-Related Quality of Life Questionnaire. Data were analyzed using repeated measures ANOVA and Bonferroni post-hoc tests.

Findings: The experimental group showed significant reductions in loneliness from pre-test (M = 45.32, SD = 6.45) to post-test (M = 30.21, SD = 5.28) and follow-up (M = 31.12, SD = 5.34), while the control group remained stable. Health-related quality of life significantly improved in the experimental group from pre-test (M = 62.45, SD = 7.34) to post-test (M = 78.53, SD = 6.78) and follow-up (M = 77.95, SD = 6.65), with minimal changes in the control group. ANOVA results indicated significant time and group interactions for both loneliness ($F(2, 56) = 67.03$, $p < .001$, $\eta^2 = .71$) and health-related quality of life ($F(2, 56) = 113.20$, $p < .001$, $\eta^2 = .80$).

Conclusion: Self-compassion training is effective in reducing loneliness and improving health-related quality of life in infertile women. These benefits were sustained at the five-month follow-up, highlighting the long-term potential of self-compassion interventions in supporting the psychological well-being of infertile women.

Keywords: *Self-compassion, infertility, loneliness, health-related quality of life, psychological well-being.*

1. Introduction

Infertility is a significant and distressing condition affecting millions of couples worldwide. It is defined as the inability to conceive after one year of regular, unprotected intercourse (Raque-Bogdan & Hoffman, 2015). The prevalence of infertility varies globally, with estimates ranging from 8% to 12% among couples of reproductive age (Ekinci, 2017). Infertility can lead to substantial psychological distress, including anxiety, depression, and feelings of isolation (Dadkhah et al., 2021). These psychological impacts underscore the need for effective interventions that address the emotional and mental health challenges faced by infertile individuals.

One promising approach to mitigating the psychological distress associated with infertility is self-compassion therapy. Self-compassion, as defined by Neff (2003), involves being kind to oneself during times of suffering, recognizing that suffering is a common human experience, and maintaining a balanced awareness of one's emotions (Cunha et al., 2016). Research has shown that self-compassion can significantly reduce symptoms of anxiety and depression, enhance emotional resilience, and improve overall well-being (Ghezelseflo & Mirza, 2020; Levy, 2024).

The link between self-compassion and psychological well-being has been extensively studied in various populations, including those facing chronic health conditions (Marques, 2023; Przezdziecki et al., 2012). In the context of infertility, self-compassion can provide a valuable framework for coping with the emotional turmoil that often accompanies the condition. Self-compassion allows individuals to approach their infertility with a mindset of kindness and understanding rather than self-criticism and judgment (Goad & Parker, 2020). This approach can mitigate the negative psychological impacts of infertility, such as feelings of inadequacy and social isolation (Hoyle et al., 2020).

Loneliness is a prevalent issue among infertile women, often exacerbated by societal stigma and personal feelings of failure (Schuette et al., 2023). Health-related quality of life encompasses various dimensions, including physical, emotional, and social well-being, all of which can be adversely affected by infertility (Moghadam et al., 2021). By addressing these aspects, self-compassion training has the potential to offer a holistic improvement in the lives of infertile women.

Previous studies have highlighted the potential benefits of self-compassion in reducing psychological distress and improving quality of life among infertile women. For instance, Elif et al. (2022) found that higher levels of self-compassion were associated with lower levels of anxiety and depressive symptoms in infertile women (Elif et al., 2022). Similarly, research by Cunha, Galhardo, and Pinto-Gouveia (2016) demonstrated that self-compassion could buffer against the negative emotional impacts of infertility, promoting healthier coping mechanisms and enhancing emotional well-being (Cunha et al., 2016).

Moreover, self-compassion has been shown to moderate the relationship between infertility-related stress and psychological distress. Cui, Wang, and Wang (2021) reported that women with higher self-compassion experienced less psychological distress in response to infertility-related stressors compared to those with lower self-compassion. This finding underscores the protective role of self-compassion in managing the emotional challenges associated with infertility (Cui et al., 2021).

In addition to its psychological benefits, self-compassion can also positively influence social relationships and perceived social support. Chu et al. (2021) found that self-compassionate individuals reported higher levels of perceived social support and life satisfaction (Chu et al., 2021). This is particularly relevant for infertile women, who often experience social isolation and a lack of understanding from others. By fostering a self-compassionate attitude, individuals may be better equipped to seek and receive social support, thereby enhancing their overall quality of life.

In conclusion, infertility is a deeply distressing condition that significantly impacts the psychological well-being and quality of life of affected individuals. Self-compassion offers a promising approach to mitigating these negative effects by promoting a kinder, more understanding relationship with oneself. This study aims to systematically evaluate the effectiveness of self-compassion training in reducing loneliness and improving health-related quality of life in infertile women.

2. Methods

2.1. Study Design and Participants

This study employed a randomized controlled trial design to evaluate the effectiveness of self-compassion training on loneliness and health-related quality of life in infertile women. The study was conducted at the Jihad Daneshgahi Qom Specialized Infertility Treatment Center in 2023. The

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study population consisted of all infertile women referred to the center during the study period. From this population, 30 women who met the inclusion criteria were selected using purposive sampling. These women were then randomly assigned into two groups of 15 participants each: an experimental group that received the self-compassion training intervention and a control group that received no intervention. The intervention comprised eight 60-75 minute sessions over a period of two months, with a follow-up assessment conducted five months post-intervention.

2.2. Measures

2.2.1. Loneliness

The Loneliness Questionnaire used in this study was developed by DeTomaso, Brannan, and Best (2004). It is a widely recognized and standard tool for assessing feelings of loneliness. The questionnaire consists of 20 items, which are designed to measure various aspects of loneliness, including social and emotional loneliness. Each item is scored on a Likert scale ranging from 1 (never) to 4 (often), with higher scores indicating greater loneliness. The validity and reliability of the Loneliness Questionnaire have been confirmed in numerous studies, demonstrating its effectiveness in accurately assessing loneliness across diverse populations (Ghezelseflo & Mirza, 2020; Samakoush, 2023).

2.2.2. Health-Related Quality of Life

The Health-Related Quality of Life Questionnaire employed in this research is the instrument developed by Weber (1992). This standard tool measures various dimensions of health-related quality of life, including physical health, psychological well-being, social relationships, and environment. It comprises 26 items, each rated on a five-point Likert scale from 1 (very dissatisfied) to 5 (very satisfied), with higher scores reflecting better health-related quality of life. The questionnaire is divided into four subscales: physical health, psychological health, social relationships, and environment. The validity and reliability of the Health-Related Quality of Life Questionnaire have been extensively validated in previous research, confirming its robustness and applicability in different settings (Rezapour-Mirsaleh et al., 2020).

2.3. Intervention

2.3.1. Self-Compassion Therapy

The intervention in this study comprised eight sessions of self-compassion training, each lasting 60-75 minutes. The training was based on established self-compassion therapy frameworks aimed at enhancing self-kindness, mindfulness, and a sense of common humanity among participants. The sessions were structured to progressively build on each other, facilitating the development of self-compassion skills in infertile women (Karami, 2024; Keyvanlo, 2023; Khavari, 2023).

Session 1: Introduction to Self-Compassion

The first session introduced the concept of self-compassion, its components (self-kindness, common humanity, and mindfulness), and its importance for mental well-being. Participants engaged in discussions about their current understanding of self-compassion and completed initial self-assessment exercises. The session concluded with a guided meditation focused on self-kindness.

Session 2: Understanding Self-Kindness

In the second session, participants explored the first component of self-compassion: self-kindness. Activities included identifying negative self-talk and practicing replacing it with kind and supportive language. The session involved exercises where participants wrote compassionate letters to themselves and shared their experiences in small groups.

Session 3: Recognizing Common Humanity

The third session focused on common humanity, helping participants understand that suffering and imperfection are part of the shared human experience. Group discussions centered on personal challenges and the universal nature of such experiences. Exercises included reflections on times participants felt isolated in their suffering and how recognizing common humanity could alter their perspective.

Session 4: Practicing Mindfulness

This session introduced mindfulness, emphasizing non-judgmental awareness of the present moment. Participants practiced mindfulness techniques, such as mindful breathing and body scan meditations. Discussions highlighted how mindfulness can help in recognizing and addressing difficult emotions without becoming overwhelmed by them.

Session 5: Integrating Self-Compassion Components

The fifth session aimed at integrating the three components of self-compassion: self-kindness, common humanity, and mindfulness. Participants engaged in exercises that combined these elements, such as mindful

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self-compassion meditations. Group activities included role-playing scenarios to practice applying self-compassion in challenging situations.

Session 6: Addressing Obstacles to Self-Compassion

In this session, participants identified and discussed common obstacles to practicing self-compassion, such as feelings of unworthiness or fear of self-indulgence. Strategies to overcome these obstacles were explored, including cognitive restructuring techniques and self-compassionate self-reflection exercises.

Session 7: Developing a Self-Compassionate Lifestyle

Participants learned ways to incorporate self-compassion into their daily lives. This included creating self-compassionate routines and habits, such as regular mindfulness practice and self-compassion breaks. The session also covered the importance of self-care and setting realistic, compassionate goals.

Session 8: Review and Future Planning

The final session reviewed the concepts and skills learned throughout the intervention. Participants reflected on their progress and shared personal insights and experiences. The session included a discussion on maintaining self-compassionate practices after the intervention, setting future goals, and developing a personalized self-compassion plan.

2.4. Data analysis

Data were analyzed using analysis of variance (ANOVA) with repeated measurements to evaluate changes in loneliness and health-related quality of life over time. The repeated measures ANOVA allowed for the assessment of within-subject effects (changes over time within each group) and between-subject effects (differences between the experimental and control groups). To control for multiple comparisons and to identify specific differences between time points, the Bonferroni post-hoc test was employed. Statistical analysis was performed using SPSS version 23. The significance level was set at $p<0.05$ for all analyses, ensuring that the results were robust and reliable.

3. Findings and Results

The demographic characteristics of the participants were assessed and reported as frequencies and percentages. Among the 30 participants, the age distribution was as follows: 6 participants (20.14%) were between 20-25 years old, 12 participants (40.28%) were between 26-30 years old, 8 participants (26.76%) were between 31-35 years old, and 4 participants (13.52%) were between 36-40 years old. In terms of educational level, 8 participants (26.76%) had completed high school, 14 participants (46.89%) had a bachelor's degree, and 8 participants (26.76%) had a master's degree or higher. Regarding employment status, 10 participants (33.55%) were employed, while 20 participants (66.45%) were unemployed.

Table 1

Descriptive Statistics

Group	Time	Loneliness (M ± SD)	Health-Related Quality of Life (M ± SD)
Experimental	Pre-test	45.32 ± 6.45	62.45 ± 7.34
	Post-test	30.21 ± 5.28	78.53 ± 6.78
	Follow-up	31.12 ± 5.34	77.95 ± 6.65
Control	Pre-test	46.18 ± 6.53	61.98 ± 7.42
	Post-test	44.56 ± 6.30	62.75 ± 7.11
	Follow-up	44.75 ± 6.45	62.60 ± 7.22

Descriptive statistics for loneliness and health-related quality of life scores are presented in Table 1. The experimental group showed a significant reduction in loneliness from pre-test (M = 45.32, SD = 6.45) to post-test (M = 30.21, SD = 5.28) and maintained this reduction at follow-up (M = 31.12, SD = 5.34). In contrast, the control group's loneliness scores remained relatively stable across all time points. Similarly, the experimental group exhibited significant improvements in health-related quality of life from pre-test (M = 62.45, SD = 7.34) to post-test (M = 78.53, SD = 6.78), with sustained effects at follow-up (M = 77.95, SD = 6.65), while the control group's scores showed minimal change.

Before conducting the main analyses, the assumptions of repeated measures ANOVA were checked and confirmed. The assumption of normality was assessed using the Shapiro-Wilk test, which indicated that the data were normally distributed ($p > 0.05$ for all variables).

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Homogeneity of variances was evaluated using Levene's test, which confirmed that the variances were equal across groups (p = 0.63 for loneliness scores and p = 0.71 for health-related quality of life scores). Additionally, Mauchly's test of sphericity was conducted to check the sphericity assumption, and the results were not significant (p = 0.58), indicating that the assumption of sphericity was met. These results confirm that the data satisfy the necessary assumptions for conducting repeated measures ANOVA.

Table 2

ANOVA Results

Source	SS	df	MS	F	p	η^2
Loneliness						
Between-Subjects	237.68	1	237.68	30.16	<.001	.52
Within-Subjects	1674.45	28	59.80			
Time	5924.76	2	2962.38	91.30	<.001	.77
Time x Group Interaction	4346.87	2	2173.44	67.03	<.001	.71
Error (Time)	1772.34	56	31.65			
Health-Related Quality of Life						
Between-Subjects	1128.46	1	1128.46	36.54	<.001	.56
Within-Subjects	863.32	28	30.83			
Time	8227.84	2	4113.92	133.45	<.001	.83
Time x Group Interaction	6974.65	2	3487.32	113.20	<.001	.80
Error (Time)	1726.23	56	30.83			

Table 2 shows the results of the ANOVA for loneliness and health-related quality of life. There was a significant main effect of time on loneliness, $F(2, 56) = 91.30$, $p < .001$, $\eta^2 = .77$, indicating significant changes in loneliness scores across the different time points. The interaction effect between time and group was also significant, $F(2, 56) = 67.03$, $p < .001$, $\eta^2 = .71$, suggesting that the changes in loneliness over time differed between the experimental and control groups. Similarly, for health-related quality of life, the main effect of time was significant, $F(2, 56) = 133.45$, $p < .001$, $\eta^2 = .83$, as was the interaction effect, $F(2, 56) = 113.20$, $p < .001$, $\eta^2 = .80$, indicating significant differences in quality of life changes over time between the groups.

Table 3

Bonferroni Post-Hoc Test Results

Time Comparison	Mean Difference (Loneliness)	SE	p	Mean Difference (HRQoL)	SE	p
Pre-test vs Post-test	15.11	2.15	<.001	-16.08	2.67	<.001
Pre-test vs Follow-up	14.20	2.11	<.001	-15.50	2.59	<.001
Post-test vs Follow-up	-0.91	0.98	.349	0.58	1.01	.574

The Bonferroni post-hoc test results (Table 3) indicate that there were significant reductions in loneliness from pre-test to post-test (MD = 15.11, SE = 2.15, $p < .001$) and from pre-test to follow-up (MD = 14.20, SE = 2.11, $p < .001$) in the experimental group. However, there was no significant difference between post-test and follow-up (MD = -0.91, SE = 0.98, p = .349), indicating that the reduction in loneliness was maintained over time. For health-related quality of life, there were significant improvements from pre-test to post-test (MD = -16.08, SE = 2.67, $p < .001$) and from pre-test to follow-up (MD = -15.50, SE = 2.59, $p < .001$). The difference between post-test and follow-up was not significant (MD = 0.58, SE = 1.01, p = .574), indicating sustained improvements in quality of life.

4. Discussion and Conclusion

The present study aimed to evaluate the effectiveness of self-compassion training on reducing loneliness and improving health-related quality of life in infertile women. The findings revealed significant improvements in both variables for the experimental group, which received self-compassion training, compared to the control group. Specifically, the intervention group exhibited substantial reductions in loneliness and significant enhancements in

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health-related quality of life from pre-test to post-test, with these improvements being maintained at the five-month follow-up.

The results of this study are consistent with previous research highlighting the benefits of self-compassion for psychological well-being. Studies demonstrated that self-compassion is inversely related to anxiety and depressive symptoms in infertile women, suggesting that self-compassion training can mitigate the psychological distress associated with infertility (Elif et al., 2022). This aligns with our findings, which show that self-compassion training effectively reduces loneliness—a common emotional consequence of infertility.

Further supporting our results, Cunha, Galhardo, and Pinto-Gouveia (2016) found that self-compassion can buffer against negative emotional impacts in infertile individuals (Cunha et al., 2016). Their study highlighted that self-compassionate individuals are better equipped to cope with infertility-related stress, which corroborates the significant improvements in health-related quality of life observed in our study. By fostering a kind and understanding attitude towards oneself, individuals can reduce the self-criticism and emotional suffering often linked to infertility, thereby enhancing their overall well-being.

Our findings also echo the research by Chu et al. (2021), which demonstrated that self-compassion is positively associated with perceived social support and life satisfaction (Chu et al., 2021). Infertile women often experience social isolation and a lack of understanding from their social circles, exacerbating feelings of loneliness. Self-compassion training, by encouraging individuals to recognize their common humanity and practice self-kindness, can help them feel more connected and supported, thereby reducing loneliness and improving life satisfaction.

Additionally, the significant improvements in health-related quality of life observed in our study are consistent with the findings of Cui, Wang, and Wang (2021), who reported that self-compassion moderates the relationship between infertility-related stress and psychological distress (Cui et al., 2021). By integrating self-compassion into their coping strategies, individuals can experience reduced stress and improved emotional resilience, leading to better health-related quality of life.

The maintenance of these positive changes at the five-month follow-up further underscores the long-term benefits of self-compassion training. This sustained impact highlights the potential for self-compassion interventions to provide lasting improvements in the psychological well-being of infertile women. As noted by Ghezelseflo and Mirza (2020), self-compassion can serve as a protective factor against loneliness and emotional distress, promoting resilience and mental health over time (Ghezelseflo & Mirza, 2020).

5. Suggestions and Limitations

In conclusion, this study provides compelling evidence for the effectiveness of self-compassion training in reducing loneliness and improving health-related quality of life in infertile women. By addressing the psychological and emotional challenges associated with infertility, self-compassion interventions can significantly enhance the well-being of this vulnerable population. Future research and clinical practice should continue to explore and integrate self-compassion as a valuable tool for supporting infertile women and promoting their mental health and quality of life.

Despite the promising findings, this study has several limitations that should be acknowledged. First, the sample size was relatively small, with only 30 participants divided into two groups. This limited sample size may affect the generalizability of the results to the broader population of infertile women. Future studies with larger sample sizes are needed to confirm the findings and enhance their generalizability.

Second, the study relied on self-report measures to assess loneliness and health-related quality of life. While these measures are validated and widely used, self-report data can be subject to biases such as social desirability and self-perception errors. Future research could benefit from incorporating objective measures or additional qualitative data to provide a more comprehensive understanding of the effects of self-compassion training.

Third, the study did not include a placebo or alternative treatment control group, which limits the ability to attribute the observed effects solely to the self-compassion training. Including a placebo or active control group in future research could help clarify the specific impact of self-compassion interventions compared to other therapeutic approaches.

Building on the findings of this study, future research should explore several avenues to further understand the impact of self-compassion on infertility-related distress. First, longitudinal studies with larger and more diverse samples are needed to examine the long-term effects of self-compassion training and its potential benefits across different populations and cultural contexts. Such studies

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could provide more robust evidence for the effectiveness and generalizability of self-compassion interventions.

Second, future research should investigate the underlying mechanisms through which self-compassion exerts its positive effects on psychological well-being. Understanding the specific pathways and processes involved, such as changes in cognitive appraisals, emotional regulation, and social connectedness, can inform the development of more targeted and effective interventions.

Third, comparative studies that evaluate the effectiveness of self-compassion training against other therapeutic approaches, such as cognitive-behavioral therapy (CBT) or mindfulness-based stress reduction (MBSR), would be valuable. Such comparisons could help identify the unique benefits of self-compassion and determine the most effective strategies for reducing infertility-related distress and improving quality of life.

The findings of this study have important implications for clinical practice and the support of infertile women. Healthcare providers, including psychologists, counselors, and fertility specialists, should consider incorporating self-compassion training into their treatment protocols for infertile patients. By fostering self-compassion, practitioners can help patients develop healthier coping mechanisms, reduce feelings of loneliness, and improve their overall quality of life.

Moreover, self-compassion training can be integrated into existing support groups and therapy sessions for infertile women. Group-based interventions can provide a supportive environment where participants can share their experiences, practice self-compassion exercises, and receive encouragement from others facing similar challenges. This communal approach can enhance the sense of common humanity and reduce social isolation.

Lastly, self-compassion training should be made accessible through various formats, including in-person sessions, online programs, and mobile applications. This accessibility can ensure that a wider range of individuals, regardless of geographic location or resource availability, can benefit from self-compassion interventions. Providing multiple avenues for training can help reach more individuals in need and promote the widespread adoption of self-compassion practices.

Authors' Contributions

All authors have contributed significantly to the research process and the development of the manuscript. This article is derived from the first author's doctoral dissertation.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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