

Infertility Related Issues and Challenges: Perspectives of Patients, Spouses, and Infertility Experts

Bushra Naz & Syeda Shahida Batool
Department of Psychology
G C University Lahore

The study was conducted to explore 'psychosocial problems' of infertile men and women in Lahore, Pakistan. Semi structured interviews were used to collect the data from thirty participants (10-infertile men and women, 10-spouses and 10-infertility experts). Purposive sampling technique was used to collect the data from the participants selected from infertility departments of four hospitals. Interviews were audio recorded and transcribed for thematic analysis. After analyzing the data, eight major themes emerged that highlighted the problem areas; 1) social problems, 2) family pressure, 3) personal concerns, 4) psychological problems, 5) sexual problems, 6) marital conflict, 7) treatment related concerns, and 8) coping. Despite the fact that both men and women were experiencing comparable psychosocial problems (e.g., curious and pinching questions by family and society); emotional disturbance (e.g., depression, anxiety and stress); personal problems (e.g., self-desire to become parents); marital conflict (e.g., threat of separation and dominant attitude of partner), the data also revealed gender specific infertility related problems. Men predominantly reported disorientation about the problem, masculinity ego, hiding their infertility, showing resistant to treatment. Whereas; the women reported to be undergoing family and social pressure, social maladjustment, agony of diagnosis and treatment procedures, and stress related to monthly cycle. The results suggest gender specific problems to be taken into account while dealing with infertility related issues. It was concluded that the understanding of social and psychological context of infertility related problems will later on provide the basis for effective psychosocial intervention plan.

Keywords: infertility, psychosocial problems, social maladjustment, thematic analysis.

World Health Organization (WHO) defines infertility as an inability of couples to conceive or to bring a pregnancy to term after one year of unprotected intercourse. Primary infertility refers to couples who have never conceived whereas the secondary infertility refers to couples who are unable to conceive after one year of unprotected intercourse following previous pregnancies (Zegers-Hochschild et al., 2009). The reported prevalence of infertility is more than 72 million people worldwide (Boivin, Bunting, Collins, & Nygren, 2007; Ombelet, 2014). Noorbala et al. (2008) reported that approximately 10-15% of couples suffer from infertility globally, although, the range of infertility varies from 5 to over 30% in this context. In developing countries, the rate of infertility is quite higher (Cousineau & Domer, 2007) for example, in Pakistan infertility rates are around 22% that includes 4% primary and 18% secondary infertility, which means infertility in Pakistan occurs one in every five married couples (Ali et al., 2011).

Studies suggest that infertility is associated with increased psychological distress and social burden among men and women (Domer et al., 2005; Kazmi, Jadoon, & Rehman, 2016). Greil, Slauson-Blevins, & McQuillan (2010) in a review critiqued socio-psychological impact of infertility and argued that literature showed little regard for the social construction of infertility, treating infertility as a medical condition with psychological consequences. However, things are changing and many professionals are now moving towards situating infertility in social contexts along with

clinical focus of earlier work (Audu, Ojua, Edem, & Aernyi, 2013; Rouchou, 2013).

In Pakistan, society in general and family in particular expect children after marriage, and consider marriage as a vehicle to conceive and bear children. Pakistanis generally consider children as a symbol of fortune for the parents, source of pride (especially if it is a boy) for the patriarchal lineage, protecting the honor of the family, old age security, and continuation of the family's name (Sami & Ali, 2006). In Pakistan, like many other societies, manhood is equated with fatherhood; and womanhood with motherhood if married couples have children (Ali et al., 2011; Armuand, Wettergren, Rodriguez-Wallberg, & Lampic, 2015). Moreover, reproduction has immense value in extended family system and childlessness is unacceptable, and failure to adhere to meet family expectations and cultural norms (Dhami & Sheikh, 2000; Hampshire, Blell, & Simpson, 2012). In this context, Sami and Ali (2012) reported that childlessness is disastrous with social consequences that have been documented well, especially for women. Children are considered as binding force between husband and wife. A childless woman faces severe emotional, physical and social consequences (Batool & de Visser, 2014; Hakim & Sultan, 2001). Women face taunting, verbal harassment, social exclusion from important events; like, weddings, exclusion from their marital home and sometimes physical abuse. Women have reported the psychosocial consequences such as depression, sadness, dejection and suicidal ideation (Kazmi et al., 2016). In Pakistani cultural context, women are blamed regardless the fact that husband might have the infertility problem. Childbirth is considered women's domain only (Mumtaz, Shahid, & Levay, 2013).

Many researches regarding infertility worldwide including Pakistan have focused on women distress, and paid little attention on problems that arise in men from infertility. Our goal is to identify infertility related psychosocial problems in men and women in Pakistan through a qualitative study, providing an in-depth

understanding of the psychosocial problems of infertile men and women. This we hope will fill the gaps in current knowledge about comparable psychosocial problems in infertile men and women.

Methodology

Study design

A qualitative design consisting mainly of semi-structured interviews, which varied a bit across patients, their spouses, and the infertility experts.

Participants

Sample 1. Ten patients (six women and four men) attending the outpatient (called OPDs) of two public hospitals and two private infertility clinics in Lahore were contacted to understand their infertility related psychosocial problems. The researcher interviewed the patients diagnosed with, irregular menses, follicle problem, polycystic ovarian syndrome, endometriosis, low semen count, and azoospermia who were attending OPDs for the purpose of evaluation and treatment in Lahore. Selected patients had at least one-year history of infertility with unprotected coitus. Patients with comorbid illness, severe illness, and secondary infertility were not included in the study. Interviews of 10 patients out of 13 were included in the thematic analysis.

Sample 2. Ten spouses (five women and five men) accompanied with patients attending OPDs were also selected because spouses make important decisions regarding, choice of treatment, and type of health care and follow ups on this shared problem. The researcher interviewed these ten spouses and after seven to eight interviews; and since no new themes emerged we stopped interviewing more spouses after ten interviews.

Sample 3. This group consisted of ten female gynecologists (MBBS with FCPS) working in infertility centers in Lahore to explore experiences of medical professionals who were dealing with infertile patients. Four male infertility experts were also contacted but they did not agree to participate and referred to their female colleagues for interviews.

Procedure

The study was approved by the Advanced Studies and Research Board (AS&RB) of GCU, Lahore, Pakistan and permission was taken from the relevant heads of hospitals. Purposive sampling was used, infertile patients diagnosed by gynecologist, spouses accompanied with patients, and infertility experts working in the field of infertility were selected. The participants were made aware of the objectives of the research and an informed consent was obtained before data collection.

Semi-structured interviews with infertile patients, their spouses and experts were conducted in Urdu. Similarly, all the professionals/physicians were interviewed in their offices. The patients and spouses were interviewed in separate rooms attached to the outpatient clinics. Interviews lasting 30-40 minutes covering psychological, social, family and personal impact of infertility. Moreover, marital conflicts, sexual problems, treatment related issues, expectations and, coping mechanism were also explored. During the interviews, an empathetic relationship was developed due to the sensitivity of information. Anonymity and confidentiality were also assured to all participants. Interviewer was interested not only to

identify infertility-related problems but was also interested gaining information that would be used in future to improve the wellbeing of these patients.

A total of 30 interviews in Urdu were carried out and transcribed. A six steps thematic analysis approach suggested by Braun and Clark (2006) and Braun, Clarke, and Terry, (2012) was used to analyze the data qualitatively. Transcripts were coded on case by case basis. They were read and analyzed repeatedly to identify emergent themes according to their conceptual coherence. The first author did the transcription and case by case coding and discussed preliminary themes with the second author developing agreed upon themes. Once all interviews had been coded, comparisons were made between gender to understand and identify the psychosocial problems of infertile men and women.

Results

Thematic analysis was used to yield major themes from transcribed interviews with infertile men and women, their spouses, and infertility experts. Most patients described medical symptoms as their main concern, the spouses on the other hand described that desire for children and family demands were the main reason for bringing patients to the hospital. This information was further validated by infertility experts. All the patients felt that the infertility had affected their lives emotionally and socially. Results below illustrate eight major themes, with quoted extracts from selected participants.

Social problems

For most men and women, infertility had manifold social consequences. They reported negative experiences within their communities because of childlessness. Childbearing is highly valued and childlessness is highly engendered in the Pakistani community. Children are considered social prestige and survival in the community. In a collectivist culture like Pakistan, most of the couples live in a joint family system and have extended family relations. Patients reported to face the cynical and curious questions by the society. For example;

“People ask about a child at every meeting from infertile couples.... the same question again and again. Sometimes husband and wife do not bother about the problem but they are distressed due to others” (Infertility expert, years of experience: 20).

“I am living in a village, people make me think that my husband will leave me and will do the 2nd marriage. I am tense to hear all this stuff” (Female patient, Age: 37 years).

The patients reported that most of the time they tell a lie in response to public inquisition about their last menstrual cycle, low semen count and follicle issues.

“People are interested to know the reason of infertility. They are curious to know whether the problem is with me or lies with my wife. Problem is in me but I most of the time remain silent and do not share. Most of the times I say it’s due to Allah’s will” (Male patient, age: 37 years).

The participants shared that people intervened in their lives that increased irritability and frustration. People used to ask for good

news of conceiving children from them. They asked personal questions which made them worried and they felt pressurized. Patients felt that it was a continuous reminder from them on social gatherings, at a job place by their colleagues and people even they did not have direct relationship with them. They felt socially isolated in gatherings. Moreover, they were compared with the couples of same and younger ages who had children.

“People ask time and again ridiculous questions about fertility and treatment. We are two brothers and both have fertility problems. We face questions like why you don't have children. When will you have children? Did you go for assessment and treatment? etc.” (Male patient, age: 37 years).

Men patients appeared to hide their problems from the society and family. They too had a tough time because of the childlessness. They shared that they were called names such as ‘namurad, and ‘banjh’ by friends, family and others and people passed absurd remarks on their condition. To avoid such remarks, the participants reported to avoid such gatherings and used to tell lies about their reports. They reported that these jokes were hurtful and insulting. Majority of the men reported that their childlessness affected their social status and hurt their manhood.

“I hide my reports from my family and wife and have asked doctors not to share with my wife. I do not want to listen the ridiculous jokes of friends and family” (Male patient, age: 26 years).

“My family and husband have no problem due to my infertility but my colleagues give me a constant reminder. I become irritated due to their daily based queries of the child. They have irritating styles while asking about the child e.g., we think you have adopted some family planning method, you have enjoyed much, now you should think to have a child, give us some good news” (Female patient, age: 33 years).

Another important concern that infertile men and women reported was that they wanted children due to the pressure of society, which indicated that they were bearing the burden of social influence.

“Either highly qualified or illiterate, people closer to the patient expect to have children immediate after marriage. The patients have approximately same pressure from society and family. People question regarding their marital relations. Ask multiple questions why you do not give birth, when you will give birth, threat of 2nd marriage. Sometime patients want children just to satisfy significant others” (Infertility expert, years of experience: 6).

Family pressure.

People in Pakistan normally live in a joint family system and interference of extended family members in the personal lives of couples is a common phenomenon. Family as reported by the respondents stigmatized the infertile couples by different humiliating words and stopping them to participate in wedding and others ceremonies. Women in their in-laws used to blame and taunt infertile women frequently. One infertility expert (20 years of experience) said

“Woman's parents do not interfere, tease and ask questions but man's parents do this”.

It is in-laws who forced in early years and bring these women for assessment and treatment, as one of the infertile patients reported

“My mother-in-law, very early, started taking me to midwives and doctors for examination... my husband does not like me and come home after two months or more, and my mother-in-law thinks that children will induce care and love in my husband” (Female patient, age:23 years)

The infertile women themselves reported that in-laws degraded them by assigning multiple household duties and spared their other daughter in-laws from these duties because they had children. As one infertile patient (32 years) said

“I have to do extra work at home as I have no children”.

One significant family pressure to bear children was to maintain the family lineage and inheritance.

“As there would be no body to inherit the property and ultimately it will be distributed within relatives” (Infertility expert, years of experience: 20).

Men spouse reported that women's parents were more worried due to the infertility of the couple.

“My mother and sisters pressurized me for treatment and bear a child at any cost. They assume my life will be ruined without children and property will be distributed among relatives. They said your family name would be vanished. But I believe in Allah and will not adopt any illegitimate method to conceive a child. Woman cannot do anything if husband marry again for a child” (Female Patient, age: 38 years).

Only one spouse reported family support in this regard.

“My family does not ask for children and mother is against the 2nd marriage. She said giving children is in Allah's control” (Male spouse, age: 32 years).

Personal concerns.

To become a parent is considered as developmental milestone which is highly valued in Pakistani culture. The women showed more grief and sorrow due to a desire to have children and reported devastating experience and saddened feelings due to their inability to have children. Infertile men and women had shared their deep desire to have their own biological children.

“I have no family pressure on me and my wife. But I want to have children purely due to my own and my wife's staunch desire” (Male patient, age: 26 years).

Infertile people appeared to compare themselves with other relatives and colleagues.

“When I saw my cousins and junior colleagues with children, I felt that it was too late, now I should have my own children” (Female patient, age: 35 years).

Infertile patients considered child as their life goal, even more important than their career and other life goals and were worried primarily because of age related issues as well.

“Doctors induced fear that age was passing ... you should do hurry for treatment” (Male spouse, age: 32 years).

“Two three years I did not bothered for children but gradually I realized to have children. I and my wife have great desire to have children. When I come back from my office, I feel worried to see my wife and mother alone silent at home. This is the most troubling thing in my life. I want to expand my business but my first priority is to solve my infertility related issues then I will think about the business” (Male patient, age: 37 years).

Psychological distress.

Psychological distress manifested in the form of symptoms of depression (e.g., sadness, loneliness, weeping episodes, disappointment, hopelessness, excessive worry for child, changes in eating habits, weight gain, guilt, emotional disturbance, grief, feelings of uncertainty, feelings of insecurity, lack of pleasure, lack of concentration, cognitive and somatic problems, and lack of communication); anxiety (e.g., breathing problems, irritability, anxiousness, emotional and cognitive disturbance, increased hormonal and gynecological problems due to infertility, and restlessness); and stress (e.g., frustration, tension, and stress).

“When patients come to our clinic they predominantly show depressive symptoms. Sadness, exhaustion, low self-esteem, weeping and repeated prayers for their normal assessments are common features. The family shows impatient behavior and bring daughter in-laws after two months of marriage and ask questions like why she has menses again, in our family girls conceive within the first month” (Infertility expert, years of experience: 6).

Denial and anger was the common reaction as reported by the patients and their spouse after treatment failure.

“We have done maximum efforts for treatment, spent money, and time but all in vain. I am feeling tired, angry, sad and frustrated” (Male spouse, age: 32 years).

Infertility appeared to lead to isolation as a result of not disclosing the secret of involuntary childlessness by avoiding meeting family and friends. Patients reported disappointment and anger on each menstrual cycle followed by sadness. Depressive symptoms were strongly bounded by infertility-related distress

“I am exhausted, tense and have wasted time, now I put great efforts to have a child but could not. I have become diabetic due to the stress” (Male patient, age: 42 years).

“My husband was disappointed due to infertility, then we came here with a new hope but still feeling uncertain what will happen. Although I will never ever leave him.... But he has the fear of separation because his first wife left him due to his fertility issues” (Female spouse, age: 39 years age).

“I try to give support to my wife because I know stress will disturb all functions and healthy marital relations counts a lot. But still, my wife is worried, depressed and weep bitterly on every menses” (Male spouse, age: 28 years).

A 37 years female patient reported

“In the beginning, I did not take it seriously, but after two years my life seemed aimless. I work for others like a servant. I am feeling alone, disappointed, sad and in a difficult situation (Weeping bitterly during interview).

Sexual problems.

Healthy sexual function and appropriate marital relationship are the foundations of a sustainable relationship and are important aspects of a couple's physical and mental health. Results of the current study postulated that sexual problems had impact on concentration during sex for example; more focus on having child rather pleasure during sex, taking sex as treatment, gradually diminished motivation and interest in sex, missing fertile days postulated anger and disappointment, another disappointment and stress on monthly cycle, and problem with duration of sexual function.

A 30 years female spouse reported:

“Doctors suggested to do sex on fertile days. But my husband has the fear of early discharge and does not do intercourse as recommended by Doctors”.

Patients reported concentration problems during sex as they either think about having child and prayer the verses. Patients reported to think about the worrying thoughts, blaming and troublesome behaviors of others during sex. Gradually they abstained from sex and took sex as an obligation not a pleasure seeking activity. Even if infertility had no reported negative impact on sexual functioning, they reported that they used to think about having child during sexual function.

“When patients come for treatment we guide them about their fertile days and suggest them intercourse on alternative 10 days. Then their focus changes and they do it only for children and for the sake of infertility treatment, not for their own relationships. It becomes treatment and medicine for them. I do not think so, in this way they have proper pleasurable sexual relationship. Whenever they miss those days due to family obligations or any other reason they became angry and depressed” (Infertility expert, years of experience: 6).

The women reported pains, disappointment, weeping episodes and feelings of another failure. Men reported that they were trying to counsel the partner but they were also disappointed due to the failure of treatment and showed anger. Women reported of telling a lie about their menstrual cycle to the in-laws in response of relative's queries of monthly cycle.

With regard to gender, male factor infertility was identified as a sexual dysfunction, shameful and stigmatized within the society. In local language word 'namurad' is used which means 'not masculine' or 'a man without manhood. Infertility-masculinity linkage was more distressing for men as comparing with women. Women complained

severe pains during and after sex and diminished interest, motivation and greater impact on sexual arousal in women than in men.

“At first when I was not diagnosed with infertility. My family inquired from my wife and ask many questions from her. But now, I showed my reports to them that I have low semen count and erectile dysfunction. They did not say anything. But suggested me to go for treatment. Friends often ask me problem lies with whom..... ‘you or your Mrs.?’ Problem lies with me but I remain silent most of the time in front of people. Mostly, I don’t share it with anyone” (Male patient, age: 26 years).

Another reason why wives of infertile husbands usually were with them was their love, intimate relations with husband and family bonding. The women appeared to sacrifice their emotional desires just not to make their husband guilty. They reported that they tried to counsel their husbands at the best way possible.

“He is my cousin, sometime I become rude but he does not say anything to me. I forced him to take medicine and get treatment. Before getting treatment we avoid to do intercourse due to the fear of early discharge of my husband. But now, due to the treatment, we do as doctor suggested. Because he is my relative so I considered even if no children we will live together” (Female spouse, age: 30 years).

“Male think if they are doing intercourse then everything is fine and they are not willing for examination and treatment. But when couples come to us, more than 50% male cause is there. Our protocol is to examine 1st the male partner to avoid unusual female procedures, then we came to know that problem is in male, low motility, low count or other problems. Pressure is from male and in laws side. No body considered the male factor. If the problem lies with male then most of the time female adjust and try to continue the relationship” (Infertility expert, years of experience: 10).

“Sexual problems are reported in males most of the time because male is active partner. Females most of the time keep silent if they come to know about husband problems. They don’t put pressure on the husband. Only 1% to 2% who boldly tell their parents about husband’s problem, other girls try to adjust and bear the problems” (Infertility expert, years of experience: 20).

Marital conflicts.

Results yielded that infertile men and women had to bear the burden of infertility, they have threats of divorce, separation and 2nd marriage. Although, male partner assured that they would never do this, even then women experienced stress from other family members and their inner negative thought made them helpless and worried about the partner. When men were diagnosed with infertility, women appeared to behave dominantly although most of the women did not demand separation or divorce. There were less percentage of women who discussed male infertility with their families and demand separation and divorce. Dominant attitude of male spouse was more evident as compared with female spouses, in the form of threats of separation, second marriage or divorce, and pressure to conceal husband’s infertility problem from friends and relatives.

“I locked my reports in the locker, I did not share with my wife and family. I told them its Allah’s will and Allah will give us children. I did not share the diagnosis because its masculinity ego and everyone in the family and cousins will look at me differently. I do not have healthy relations with my wife because she has aggressive attitude and argue frequently. I do not like her” (Male patient, age: 35 years).

Infertility expert (28 years of experience) shared

“Most of time, infertile men request the doctors not to share reports with their wives. Sometime women hide the diagnosis to avoid the stigma of being older to their husband and ask doctors not to share their actual age with their husband because at the time of Nikkah their age was deliberately written less on papers. They also request the doctors to hide the fact that their tubes are blocks or manses are irregular”.

Men usually hide infertility related problems in Pakistan. They try to shield their problems by not going for analysis/medical assessment, misconceptions, or telling a lie and hiding the medical reports even men’s family member do not admit that their brother or son has problem. Men have advantage due to dominant attitude and their masculinity concerns.

In some cases, being infertile did not matter for both the male and female. They had supportive spouses, coping relatively well, and giving importance to their intimate relations and marriage. They also believed in Allah’s will and were satisfied with their relation.

“My husband never say any bad word, divorce separation rather, he takes care of me very much. This thing gives me courage and ensures me that my relationship is fine. I have no issue in my marital life. My husband lived abroad when he came, we tried our best but when I menstruated, I felt desperate, started weeping, my husband gave me support. My husband does not say anything but in-laws force him to do 2nd marriage” (Female patient, age: 35 years).

Overall, information about marital conflicts specifically with husband has contradictory information. Some reported that their relationship with their husbands were fine and trouble was being created by in-laws.

Treatment related concerns. Infertility experts described infertility treatment as a long, demanding, exhausting and a financial burden. It also followed certain procedures that made the infertile patients worried, frustrated and uncertain. Treatment plans and procedures are most of the time involve women so it is primarily a medical and emotional burden for women. As shared by one of patients:

“I want to go with my husband as he is living in abroad but first I want to complete my treatment procedures” (Female patient, age: 32 years).

The participants shared their own and people’s conservative point of views regarding the treatment. One spouse said

“even if we agree to follow ART method, there is room for doubt, we will examine the DNA test report after the baby is born, just to know, if the child is our own or not” (Male spouse, age: 37 years).

"We advised patients and counsel them not to share their treatment related procedure (ART) with their family and relatives. Here due to unawareness and illiteracy, things are difficult to absorb by the people" (Infertility expert, years of experience: 20).

In some families, treatment started very early and forced women to go through infertility tests.

"Family bring their daughter-in-law before the completion of first year. They are so in a hurry for children" (Infertility expert, years of experience: 6).

The couple also shared unrealistic expectations related to treatment. They reported that in case treatment method failed, it induced feeling of hopelessness, disappointment and anger. Most of the male patients and spouses postulated anger and protested on negative reports (failure of the treatment). Patients also showed assessment and procedure related worries and apprehension and complained about the long duration of treatment with multiple cycles. Some patients reported multiple treatment from medical resources or faith healers. Patients who belonged to lower or middle class families faced difficulties regarding financial issues and reported they sold their belonging to arrange money for treatment.

Although I did not believe in hakim or faith healer treatment but due to the social pressure, we went for treatment and took 1-month treatment. Because my friends and relatives said, "you are not serious for children and treatment". Just for their satisfaction we took hakim medicine and went to peer" (Male spouse, age: 32 years).

"The financial burden of IUI, IVF and ICSI treatment is more demanding than one's expectations. Sometimes, they collect money for years take loan, sell their property for the diagnosis and treatment. Most of the couple specifically male partner arrange the money for the treatment, so he expresses more financial burden as in Pakistani society women are less working, so the male partner has to bear the burden of finances" (Infertility expert, years of experience: 28).

Coping.

Infertility as a psychosocial problems appeared to threaten the emotional and physical health of couples, however the participants share the coping strategies the infertile couples were using to overcome their stress and social pressure. They shared that they remained silent when people inquired about children, they took strength from counselors and spouses, they kept them busy in work, religious practices, and playing with others' children, and they received adequate information from other people and via internet.

"Counseling was more helpful for infertile couples. We brief them the whole procedure the problems and benefits of the procedures, the success rate according to the age and after effects. We just guide them. But psychological counseling is also very important. If psychological problems are addressed, then we hope for natural conception. Because stress causes irregular menses, weight gain and other morbidity issues. If they get proper counselling, see things

with open mind then they accept the failure of treatment, think about adoption" (Infertility expert, years of experience: 8).

"Now a day's people are well aware. They have more knowledge and use internet to get information. We counsel both husband and wife combine. So they don't blame each other afterwards" (Infertility expert, years of experience: 17).

"They ventilate themselves through weeping men and women both. When we guided them about their problem, they start weeping. They seem depressed then we provide the emotional support" (Infertility expert, years of experience: 20).

Some patients reported they get support, strength and encouragement from their spouses conversely some believed that their spouse brought sufferings. Some professional women and all men reported that they kept themselves busy and concentrated on their work and coped with their infertility. Infertility experts also guided them to do work and remain busy instead of waiting just children. In other way, keeping themselves busy means not taking stress and diverting the attention to work. Results also revealed that men took less distress as compare to women, because they most of the time remain busy in their professional routines as compare to women. Results of this study also illustrate that professional women take less stress and have more problem solving strategies as compare with domestic women who always think about child and pregnancy and listens to the demands of others. The infertile men and women seem to using problem solving coping strategies to come for treatment or try to remove the source of psychosocial problem. They behave actively to resolve their issue.

Patients' spouses and infertility experts reported that religious people tend to have a greater adjustment and well-being, greater life satisfaction, and lower level of distress. Patients with strong religious faith endured medical crises with better outcomes and showed better adjustment with the problem.

"I put maximum efforts but ultimate decision is Allah's we cannot challenge Allah's plan and will'. I achieve relaxation through prayers" (Female patient, age: 33 years).

"I do my catharsis by weeping alone or at prayer rug and feel lighter and relaxed, sometime my husband consoles me and I forget this strain" (Female patient, age: 35 years).

Discussion

The study aimed to explore infertility related psychosocial issues by considering the perspectives of infertile patients, spouses and infertility experts. The participants were of the view that children were highly valued for social, personal, familial, lineage and inheritance reasons. Prestige and survival of men and women is contingent with childbearing. However, women have to bear the burden of infertility in terms of social pressure, treatment procedures and infertility. This study provides a unique input in scientific knowledge by taking the perspective of infertile patients, spouses and infertility experts to contribute to our existing understanding of the reproductive health needs of both men and women in Pakistan. Eight themes emerged after analyzing the data.

Social problems was one of the major findings of our study. Participants declared that they suffered on account of others'

curiosity and disrespect by asking questions that resulted in avoiding people in general; patients remained socially isolated and felt pressure from society to have a child. They felt embarrassed by the interference of others in their lives as others gave them a constant reminder for breaking the news of when plan to have a baby. They often compared themselves with other people who had children and they fabricated the truth before the people who asked very personal questions. Many researchers (Dolan, Lomas, Ghobara, & Hartshorne, 2017; Wischmann & Kentenich, 2017) have established that people start gossiping about infertile people, create social pressure and express pity for them. Batool and de Visser (2014) in a cross cultural study reported that social pressure from society and extended family was more intense in Pakistan as compare with the infertile people in Britain.

Males felt depressed because infertility was a question mark on their masculine ego. These results are consistent with Peronace, Boivin, and Schmidt (2007) who found that male infertility was considered social stigma, produced negative social stress and generated a culture of secrecy and protectiveness. Male patients try to solve their problems without disclosing them and not sharing this information with others.

The second emergent theme was 'family problem', which included subcategories of interference of the family, stigmatization, blaming and taunting of in-laws, forceful medication by the family, an inquisition by relatives, and issues of property. Married couples are expected to become parents soon after marriage in most of the societies. For couples living in a joint family system, this scenario was more devastating. The results are in line with (Ombelet, 2014) that family creates pressure by asking questions, blaming, taunting and stigmatizing. Batool and de Visser (2014) reported that infertility was not just a personal problem, it was a family tragedy in the patriarchal society like Pakistan. Numerous other studies also highlighted family pressures for infertile couples to bear a child soon after marriage (Abbasi-Shavazi, Inborn, Razeghi-Nasrabad, & Toloo, 2008; Blell, 2017; Daibes, Safadi, Rehman, Anees, & Constantino, 2017; Riessman, 2000).

Third theme was related to, 'personal desire' that included strong longing for a child, child as a life goal, continuous effort for having a child. Strong parental desire can be the base of infertility related psychosocial problems. Men and women reported a greater level of personal desire of child showed greater stress. Men and women had a different levels of personal desires to have their own biological children. Women showed more desperation as they had more personal desire for survival and need of motherhood and this theme is consistent with (Batool & de Visser, 2014; Jordan & Ferguson, 2006; Loke, Yu, & Hayter, 2012) that the long-held desire of parenthood creates a sense of failure, which ultimately creates emotional problems. Men also reported that they wanted children for their wife and family. They added that they did not share much with friends and relatives and tried to hide their deep desire for a child. Malik and Coulson (2008) mentioned that men are in fact equally affected by the unfulfilled desire for a child but are less open about their feelings.

The fourth theme was related to 'psychological distress', and included depression, anxiety and stress symptoms. Poddar, Sanyal, and Mukherjee (2014) suggested many infertile men and women considered infertility as a state of emotional disequilibrium. Depressive symptoms are strongly bounded by infertility-related distress in the literature (Gameiro et al., 2015). The findings are consistent with the studies in India and Iran by (e.g., Pattnaik, Gharai, & Samantaray, 2016; Ramezanzadeh et al., 2004). Female patients

reported disappointment and anger on every menstrual cycle followed by sadness. The researchers who worked on infertility agree that psychosocial care was essential for individuals with infertility because most patients experience emotional distress during and after failure of treatment (Buggio et al., 2017; Knoll, Schwarzer, Pfuller, & Kienle, 2009).

Sexuality is a core component of couple's intimate relationship. In the fifth theme of 'sexual problems' infertile men and women reported inattention during sex, giving up sex, showed anger after missing fertile days and less sexual satisfaction and motivation. Martins et al. (2016) and McCarthy and Wald (2012) claimed that men and women had undergone various battles when facing childlessness. These battles included anxiety concerning potency; abstain from sex, being masculine and expressing sexual adequacy. The studies also revealed that sexual performance and satisfaction were associated with better mental health. On the other hand stress, depression and anxiety are the predictors of lack of sexual satisfaction (Nelson, Shindel, Naughton, Ohebshalom, & Mulhall, 2008). It is worthy to note that sexual satisfaction was also influenced by the societal attitude towards infertile and couples intimate relations (Monga, Alexandrescu, Katz, Stein, & Ganiats, 2004).

The theme 'marital relations' highlighted a constant threat of second marriage, divorce, separation, dominant attitude of a partner, lack of sharing among spouse, future apprehension, decrease love and overall lack of motivation. The literature reveals that infertility strengthens the marital relationship in some cases and some time it weakens the marital bond. Deep and long relations can protect the couples against the family interference and give intimate protection and love (Greil et al., 2010; Schmidt, Holstein, Christensen, & Boivin, 2005). Parenting often provides a foundation for loving and stable bonding between husband and wife a relationship that strengthens when a couple raises a child. On the contrary all these relationships convert into conflict/discord when couple face the devastating effects of infertility.

The seventh theme is 'treatment-related problems'. Participants experienced psychosocial consequences due to primary infertility diagnosis and medical treatment process. They reported women related procedures were more invasive as compared with men, they showed reservation upon test tube babies, showed anger and protest on treatment failure. People developed unrealistic expectations regarding test tube babies. The infertile couples had a lot of apprehensions related to assessment, long duration and expenses of treatment procedures. Infertility experts had the realization of the need for psycho-therapy to reduce the stress of infertile couples. Greil et al. (2010) believed that the use of therapies was one of the factors that reduced the infertility related psychosocial problems.

Men and women appeared to cope differently with childlessness. Men tended to keep them busy in their workplace, getting adequate information, silence before people, lying about their diagnosis and praying, women try to play with others children, getting strength from spouse, and praying, and were lying about diagnosis and monthly cycles. The researchers have demonstrated how different types of coping helped to reduce infertility specific stress (Rapoport-Hubschman, Gidron, Reicher-Atir, Sapir, & Fisch, 2009). Some recommended coping skills training as a therapeutic intervention for infertile couples (Domer et al., 2005; Kharde, Pattad, & Bhogale, 2012). Most of the infertile men and women talked about their religious belief and practices to cope with this distress. Researchers also recommended that the religious coping demonstrated the positive impact to cope with psychosocial problems. Patients with strong religious faith endured medical crises with better outcome and

adjustment with the problem. Domer et al. (2005) reported, religious people tend to have a greater adjustment and well-being, greater life satisfaction lower level of distress. Physicians and other health professionals also support the religious beliefs that aid in coping, including rituals to mark events (Roudsari, Allan, & Smith, 2014).

Implications

This study has wider implications for health care professionals working with infertile individuals and couples. Specifically reproductive physician, nurses, and psychologists to first identify psychosocial problems, prepare proper assessments tools and provide therapeutic intervention to get the better results out of medical treatment. Unfortunately, in Pakistan, the psychosocial impact of infertility is an ignored issue and not even a single therapeutic center is available to provide intervention for infertility-specific issues. This study highlights the need to focus on social and emotional issues of infertile individuals and develop intervention protocol to reduce the psychosocial problems.

Limitations

Although this study has contributed some important findings regarding the psychosocial issues of infertile men and women, but it has some limitations. As similar with other qualitative research, the results of current study is limited in scope. The study focuses on infertility related issues in Pakistan and may share the problems in other cultures (see Batool & de Visser, 2014). These qualitative results need to be corroborated with quantitative measures to insure assessment validities. Thus a combination of methods can provide the more accurate picture of the findings. Despite these restraints, it is worthy to note that many findings are generally in accordance with past researches.

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