Background: The study was conducted in the background of paucity of studies examining the sexual and psychosocial functioning of women with infertility. Aims: The study explored sexual functioning in women with infertility problems, their beliefs about sexuality and their quality of life. Settings and Design: A single group exploratory design with non-probability purposive sampling was used. A total of 30 participants diagnosed with primary infertility were included in the study. Materials and Methods: The data were obtained by individual administration of the following tools: Semi-structured interview schedule, Female Sexual Functioning Inventory, Sexual Dysfunctional Beliefs Questionnaire, World Health Organization Quality of Life Scale – BREF Version and General Health Questionnaire-12. The data obtained were analyzed using descriptive statistics and non-parametric tests. Results: About half of the participants had sexual dysfunction. Pain-related problems were most commonly reported (50%). Factors contributing to dysfunction included inadequate knowledge about sex, sexual stimulation and sexual communication. Along with inadequate self-image, negative childhood experiences, financial difficulties and marital discord in parents influenced the perception of self. Majority of the women had dysfunctional beliefs about sexuality (56%), and greater beliefs were found to be in the domain of sexual conservatism. The overall quality of life was poor, and 56% of women experienced psychological distress. There was significant positive correlation between sexual conservatism and experience of pain and overall sexual functioning. Conclusion: Women with infertility bear dysfunctional beliefs and suffer from problems in sexual functioning, have low quality of life and high psychological distress. Keywords: Beliefs about sexuality, infertility in women, psychological distress, quality of life, sexual dysfunctions

INTRODUCTION

Infertility is defined as the inability to conceive after 1 year of unprotected coitus.[1] According to recent studies, approximately 8–9% of couples are facing some kind of infertility problem.[2] A little more than half of the cases of infertility are found to be resulting because of female conditions, and the remaining are due to sperm disorders or by unexplained factors.[3] Sexual dysfunctions can delay conception besides leading to infertility.[4] Sexual dysfunctions in women may result in infertility, because it leads to limited or absent sexual activity. Vaginismus and dyspareunia are the two sexual disorders that are frequently implicated as cause for infertility.[5] In a study on women undergoing treatment for infertility (n = 136), the common sexual problems identified were lack of sexual interest/desire (30%), difficulty with orgasm (15%) and vaginal dryness (14%).[6] Similarly, Bayar et al.[7] in their study on infertile couples found that arousal (20%), orgasmic (10%) and desire (10%) disorders were the most...
frequency reported problems in women. Psychological factors implicated in the development of female sexual disorders are discord in relationships, beliefs and attitude towards sex, emotional problems such as anxiety, depression; insufficient stimulation, physical conditions such as fatigue, chronic medical illnesses; past negative sexual experiences and sexual dysfunction in partner.\(^5\)

Among the aforementioned factors, sexual beliefs and myths about sexual functioning are considered to be potential factors that predispose an individual to develop sexual dysfunction.\(^8\) Recent studies have established the role of cognitions (lack of erotic thoughts, abuse, failure and disengagement thoughts) in orgasmic dysfunction in women.\(^9\)

Sexual disorders may be caused or exacerbated by the diagnosis, investigation and management of infertility as well. The diagnostic procedures act as a significant source of stress particularly for women, because they are confronted with increasingly invasive, time and money-consuming procedures.\(^10,11\) Treatment processes can adversely effect the sexual functioning of women in terms of sexual intercourse, because it becomes more or less timed, the spontaneity of the act is lost and the focus of sex becomes solely conception rather than pleasure. Over the course of treatment, the psychological pressure to conceive leads to decreased satisfaction and a subsequent loss of intimacy in relationship.\(^12,13\)

Women undergoing in-vitro fertilization (IVF) reported significantly lower sexual interest, desire, orgasm, satisfaction, sexual activity and overall sexual functioning.

It was also noted that sexual problems predicted the overall poor quality of life.\(^6\) The lower quality of life scores were reported in all dimensions such as general health, physical, emotional and social functioning in women with infertility compared to controls.\(^12\) Marital distress arising from infertility as well as unsuccessful treatment attempts put women at an even greater risk of anxiety, feelings of loss of control, diminished self-esteem, depression, chronic bereavement and psychological distress.\(^14,15\) It was noted that the couple undergoing medical treatment for infertility scored higher than controls and those who were not receiving treatment for infertility on depression, internal and external shame and greater adjustment difficulties.\(^16,17\) Hence, the overall quality of life is significantly affected by the psychosocial impact of infertility diagnosis and the treatment course.

The literature on sexual functioning in infertile women shows that these women are likely to suffer from numerous psychosexual problems. Such problems and beliefs about sexuality may have a cause and effect relationship with infertility or may be incidental to infertility or presented in the disguise of infertility. The psychological distress reported is significant, and there is reduced quality of life compared to those without infertility. This study was conducted because there is scanty literature in the Indian context with regard to sexual problems, beliefs and the impact of infertility on the mental health of women undergoing medical treatment for the same. The objectives of the study are to assess the sexual functioning and its relation to various socio-demographic details, sexual beliefs and the quality of life in women with infertility.

**Materials and Methods**

The study sample consisted of 30 married women with infertility problems undergoing treatment in infertility clinics. The study was exploratory in nature with a single group and purposive sampling. Women in the age range of 18–45 years, who could speak English, Hindi or Malayalam, were included in the study. Those diagnosed with chronic psychiatric or physical illness and with organic conditions that could interfere with sexual functioning were excluded.

**Measures**

**Semi-structured interview schedule**

Semi-structured interview schedule developed for the study assessed socio-demographic details and sexual history. Demographic details included age, education, occupation, the duration of treatment for infertility and details about spouse and marriage. Sexual history was based on the assessment module proposed by Hawton.\(^18\)

**Female Sexual Functioning Inventory**

Female Sexual Functioning Inventory (FSFI)\(^19\) is a brief self-report measure; it addresses the multidimensional nature of female sexual function. Six domains of sexual function are desire, arousal, lubrication, orgasm, satisfaction and pain/discomfort. Individual domain scores are obtained by adding the scores of the individual items. The full-scale score is obtained by adding the six domain scores. Higher score indicates greater sexual functioning. High inter-item correlations were observed for all six items (Cronbach’s alpha value of 0.82 and higher). The overall test–retest reliability was found to be relatively high for all of the domains \((r = 0.79–0.86)\) and for the total scale \((r = 0.88)\).

**Sexual Dysfunctional Beliefs Questionnaire – Female version**

Sexual Dysfunctional Beliefs Questionnaire – Female version (SDBQ)\(^20\) is a 40-item questionnaire assessing stereotypes and beliefs presented as predisposing factors to the development of male and female sexual dysfunctions. The questionnaire presents male and female versions that assess specific gender-related beliefs.
The six domains of the scale are sexual conservatism, sexual desire and pleasure as a sin, age-related beliefs, body-image beliefs, affection primacy and motherhood primacy. Test–retest reliability of four-week interval for the total scale was $r = 0.73$ and $r = 0.80$, respectively. Internal consistency for the total scale was 0.81 for the female version. The individual domain scores are calculated by adding the scores of items under respective domains. Higher scores indicate stronger beliefs.

**The World Health Organization Quality of Life Scale – BREF version**

The World Health Organization Quality of Life Scale – BREF version (WHOQOL-BREF)\(^\text{[21]}\) contains 26 items constituting four domains – physical health, psychological health, social relationships and environment. The domain scores have demonstrated good discriminant validity, content validity, internal consistency and test–retest validity. It also includes one item each on the overall quality of life and on general health. Each item is rated on a 5-point scale. Greater the score, the better the quality of life.

**General Health Questionnaire-12**

GHQ-12\(^\text{[22]}\) is a 12-item self-administered questionnaire and screening tool, which examines psychological distress among individuals. The items are scored by giving a score ranging from 0 to 3 for each response. The test–retest reliability ranges from 0.70 to 0.95, and the concurrent validity is 0.80. The total score ranges from 0 to 12. Higher the score, greater the psychological distress.

**Procedure**

The study protocol was approved by the Institute Review Board. Samples were collected from three infertility clinics. Written informed consent was obtained from the participants. Psychological help was offered for those with distress. A total of 55 patients were screened. Four participants were excluded due to the presence of health conditions of diabetes mellitus and hypothyroidism. Twenty-one patients refused to give consent for participating in the study. Thirty participants who gave consent were interviewed, and tools were administered. The interview together with the administration of questionnaires took about 45 mins for each participant.

**Statistical analysis**

The analysis of data was performed using descriptive statistical measures such as frequencies, percentages, mean and standard deviation. The comparison of variables was performed by using correlation and non-parametric methods such as Mann–Whitney $U$ test and Kruskal–Wallis test.

**RESULTS**

The mean age of the women was 30 years, and the majority were below 30 years of age. Most of them were homemakers, educated, belonged to joint/extended families and reported satisfactory relationship with spouse [Table 1].

Sexual history revealed that majority of the women had privacy at the home (97%). Adequate sexual stimulation was present in 77%, adequate sexual communication in 73%, and orgasm in 23%. Dyspareunia was reported by 47% and vaginismus by 3%. Physical non-genital stimulation was reported as the trigger for desire and arousal by all the women. Majority of the women reported fatigue and stress as the inhibitors of desire and arousal (60%). Most of them reported moderate sexual satisfaction (80%). Ten percent reported past negative sexual experiences, and other negative childhood experiences were reported by 8%. They were largely not well informed about sex (70%). About 54% of

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**Table 1: Socio-demographic details of the sample**

| $n = 30$ | Frequency | Percentage |
|----------|-----------|------------|
| **Age**  |           |            |
| $<30$    | 19        | 63.0       |
| $>30$    | 11        | 37.0       |
| **Education** | | |
| 10th Grade| 8         | 26.7       |
| 12th Grade/ diploma | 8         | 26.6       |
| Graduation/ postgraduation | 14        | 46.5       |
| **Marital status** | | |
| Married  | 30        | 100.0      |
| Unmarried| 0         | 0.0        |
| **Occupation** | | |
| Employed | 8         | 26.7       |
| Unemployed| 22        | 73.3       |
| **Duration of treatment** | | |
| $<3$ years | 18        | 60.0       |
| $>3$ years | 12        | 40.0       |
| **Duration of marriage** | | |
| $<5$ years | 18        | 60.0       |
| $>5$ years | 12        | 40.0       |
| **Occupation of spouse** | | |
| Government employees | 10        | 33.3       |
| Private company employees | 10        | 33.3       |
| Business | 7         | 23.3       |
| Daily wage worker | 3         | 9.9        |
| **Family type** | | |
| Joint/extended | 15        | 50.0       |
| Nuclear | 15        | 50.0       |
| **Family problems** | | |
| Present | 7         | 23.3       |
| Absent | 23        | 77.0       |
| **Marital problems** | | |
| Present | 8         | 27.0       |
| Absent | 22        | 73.3       |
| **Relationship satisfaction** | | |
| Satisfied | 27        | 90.0       |
| Dissatisfied | 3         | 10.0       |
women had adequate self-image, and 46% reported inadequate self-image. Ninety percent were motivated for treatment. There was no significant medical or psychiatric history reported.

On sexual functioning (FSFI), scores ranged from 14 to 31. The mean score obtained was 25.99, which was below the established cut-off point of 26.55 indicating the risk for sexual dysfunctions. Moderate-to-high ratings on various domains were noted. Relatively lower scores were observed on desire and arousal domains. Forty-seven percent of women had scores below the mean, and 53% had scored above the mean, indicating that about half of them had problems in sexual functioning. There was significant positive correlation between the domains of desire and arousal ($r = 0.76, P = 0.001$) and between pain and lubrication ($r = 0.63, P = 0.001$).

With respect to beliefs (SDBQ), the scores ranged from 76 and 123. The mean score was 99, and highest ratings were noted on the domain of sexual conservatism and lowest on the domain of body image beliefs. About 43.3% of the scores were below the mean score, and 56.7% scored above indicating the presence of sexual dysfunctional beliefs.

The scores on quality of life varied between 57 and 101. Highest rating was on the environmental domain (financial resources, freedom, physical safety and security, health and social care, home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment and transport) and lowest on the social domain (personal relationships, social support and sexual activity). On the GHQ, 56% of them obtained a score above the cut-off 3 indicating the presence of psychological distress.

There was a positive correlation between the sexual conservatism and sexual pain ($r = 0.416, P = 0.022$) and the total score on FSFI ($r = 0.45, P = 0.013$). In addition, there was a positive correlation between the social domain of WHOQOL-BREF (personal relationships and social support) and sexual activity and the arousal domain of FSFI ($r = 0.416, P = 0.022$).

There was no significant difference in the sexual functioning of women below and above the age of 30 years. Similarly, education level (high school educated vs. under-graduation) did not have any role in the sexual functioning. Employed women ($n = 8$) had significantly higher scores on arousal ($13.63 \pm 3.02$; $11.82 \pm 1.96$, Mann--Whitney $U = 44$, $P = 0.03$) and lower scores on pain-related problems ($8.63 \pm 4.1$; $12.41 \pm 2.88$, Mann--Whitney $U = 38$, $P = 0.01$) than unemployed women ($n = 22$). Women undergoing treatment for less than 3 years ($n = 18$) had significantly higher scores on desire ($3.77 \pm 0.844$; $3.10 \pm 0.985$; $P = 0.05$) and arousal ($3.93 \pm 0.755$; $3.33 \pm 0.469$; $P = 0.01$) compared to those receiving treatment for more than three years ($n = 12$).

No significant relationship was found between sexual functioning and the duration of marriage, the type of family and family problems (conflicts between the couple and with extended family members). Women who did not have marital problems ($n = 22$) had higher scores on sexual functioning than women who had marital problems ($n = 8$) ($70.27 \pm 9.93$; $65.75 \pm 5.03$, Mann--Whitney $U = 45$, $P = 0.04$). Those who experienced stress at work ($n = 18$) reported less orgasm compared to those reporting no stress at work ($n = 12$) ($10.11 \pm 2.13$; $11.75 \pm 1.81$, Mann--Whitney $U = 41.5$, $P = 0.004$). Women with adequate stimulus reported more satisfaction ($n = 23$; $13.43 \pm 1.59$) than women with inadequate stimulation ($n = 7$; $11.57 \pm 1.39$, Mann--Whitney $U = 33$, $P = 0.02$).

Similarly, women with adequate sexual communication ($n = 22$) were found to have high sexual satisfaction ($13.50 \pm 1.59$; $11.63 \pm 1.30$, Mann--Whitney $U = 35$, $P = 0.01$) and orgasm ($11.32 \pm 1.42$; $9.25 \pm 3.1$, Mann--Whitney $U = 47$, $P = 0.05$) compared to those with inadequate sexual communication ($n = 8$). There was also significant difference between those who reported high sexual satisfaction ($n = 6$) and those who reported moderate sexual satisfaction ($n = 24$) with respect to desire ($6.83 \pm 0.41$; $5.58 \pm 1.66$, Mann--Whitney $U = 30$, $P = 0.03$) and arousal ($14.33 \pm 1.03$; $11.79 \pm 2.35$, Mann--Whitney $U = 27$, $P = 0.02$).

Women who were well informed about sex ($n = 9$) had significantly lower scores on the pain domain ($12.48 \pm 2.9$; $8.89 \pm 3.98$, Mann--Whitney $U = 41.5$, $P = 0.01$) than women who were not well informed ($n = 21$). Those with adequate self-image ($n = 15$) had higher scores on arousal ($13.07 \pm 2.31$; $11.15 \pm 2.03$, Mann--Whitney $U = 55$, $P = 0.04$), lubrication ($17.33 \pm 2.22$; $14.38 \pm 1.75$, Mann--Whitney $U = 25.5$, $P = 0.001$) and overall sexual functioning ($72.33 \pm 6.32$; $65.38 \pm 1.38$, Mann--Whitney $U = 52$, $P = 0.03$) than those with inadequate self-image ($n = 13$). In addition, women with negative childhood experiences ($n = 4$) had lower scores on arousal ($8.5 \pm 2.12$; $12.65 \pm 2.2$, Mann--Whitney $U = 3$, $P = 0.04$), lubrication ($12 \pm 2.82$; $16.48 \pm 2.29$, Mann--Whitney $U = 0.3$, $P = 0.04$) and overall sexual functioning ($47.5 \pm 16.26$; $71.04 \pm 6.37$, Mann--Whitney $U = 1$, $P = 0.02$) compared to those who did not ($n = 23$).

**DISCUSSION**

The age of the sample indicates that the majority were well within the best age for child bearing. The education level and the employment status of the sample go well with the employment status of urban middle class women. The duration of marriage and consultation indicates that those
who consulted infertility clinics were young women. The fact that half the sample lived in joint or extended families and that about half had family problems indicates towards interpersonal difficulties in those living in joint and extended families. Those with marital problems reported it to be caused or exacerbated by the diagnosis of infertility. Other researchers have also reported higher scores on depression and internal and external shame, with greater adjustment difficulties in infertile women than controls. In addition, women undergoing IVF have reported that stress associated with infertility and unsuccessful treatment as having negative impact on marital quality.

Overall, most women were satisfied with the relationship with spouse, indicating no major adjustment problems in the marriage, either because of infertility or otherwise. This may be understood in the background that most of them were married for <5 years and, hence, may still be hopeful, and infertility has not had much impact on the relationship though they experienced distress. Sixty percent of women reported stress due to work. When we understand this finding in the context of the number of women who were employed, the women reporting stress due to work was almost double, indicating that the stress resulted from household work in unemployed women.

With respect to sexual practices and factors affecting sexual functioning, there were no problems related to privacy; this may be because most of them belonged to middle class. Inadequate sexual stimulation and communication was reported by about a quarter of them. This finding when understood along with the finding that the majority (75%) experienced orgasm only occasionally indicates a link between the two. The findings indicate that anorgasmic women and their partners reported significantly more discomfort than the controls in discussing sexual activities.

The percentages of women reporting dyspareunia, vaginismus and anorgasmia are in accordance with the psychosexual profile of infertile women. One case of unconsummated marriage due to fear of intercourse and vaginismus was reported in the study. Although the majority reported moderate sexual satisfaction, a decrease in sexual satisfaction was reported as the duration of infertility increased. The findings are corroborative of the other studies on satisfaction and intimacy over the course of treatment. All participants in the study reported physical non-genital stimulation as the main trigger of desire and arousal. The finding is in keeping with earlier studies that arousal in women depends on the factors such as relationship, intimacy, romance, and emotional closeness. With regard to the inhibitors of desire and arousal, most frequently reported factors were fatigue and stress; other factors included negative sexual experiences, fear of outcome, marital and family problems. Negative childhood experiences such as comparison with siblings on the basis of appearance, financial difficulties and marital discord in parents were reported by two women. The majority did not have adequate knowledge about sex. This is in keeping with the findings of studies indicating lack of knowledge as one of the main reasons for sexual dysfunctions, myths and misconceptions among Indian women. About half of the sample was dissatisfied with their appearances, which were a result of weight or facial features. Body image is considered as one of the important factors contributing to the acceptance of oneself and confidence in participating in sexual activity with the partner.

On sexual functioning, the lower mean score indicates the risk for sexual dysfunctions in the sample [Table 2]. Similarly, lower ratings on the domains of desire and arousal indicate problem in these domains. Sexual desire and arousal are largely determined by the emotional factors. The finding may be explained by the fact that infertility leads to significant stress on performance and the fear of outcome, thus impacting desire and arousal. Studies similarly reported that the normal range of scores in all five domains was found only in 7% of infertile women. In addition, sexual dysfunction is highest in the arousal-sensation domain and lowest in the orgasm domain. Their study also showed that individuals with infertility had lower frequency of intercourse and masturbation, and 40% of them met the criteria for sexual dysfunctions. A positive correlation was found between the domains of desire and arousal followed by pain and lubrication. The findings seemed to indicate the fact that when there was no desire, arousal did not happen; similarly, in the presence of pain, desire and arousal did not happen, and thus there was lack of lubrication.

With respect to beliefs about sexuality, the highest rating was on the domain of sexual conservatism, which indicates the presence of conservative ideas about sexual behaviour, for example, masturbation, oral and anal sex are considered as deviant and sinful. The domain of sexual desire and pleasure as sin also had high mean score. This dimension is dominated by the idea that sex is a male activity, and women must control their sexual urges and pleasure because these are sinful experiences. About half the sample scored above the mean indicating that the sample holds ideas about sexuality that are dysfunctional. The studies from Indian context substantiate the fact that attitudes to sex and variant sexual practices remain broadly traditional and conservative, and there remains a remarkable gender difference (passive and receptive sexual role of female) in attitude; in addition, sexuality still remains a taboo.
The women with infertility problems have poor quality of life. The lowest score is on the social relationships domain (poor personal relationships, social support and sexual activity). The literature indicates that infertility not only impacted emotional and sexual quality of life but also predicted overall poor quality of life.[6,32] The lower quality of life scores were reported in all dimensions such as general health, physical, emotional and social functioning compared to controls.[12]

The mean GHQ score indicates the presence of significant distress. A good number of infertile women experienced significant psychological distress. It is reported that a substantial percentage of childless women experience depression, anxiety, complicated grief and distress.[33]

The positive correlation between FSFI total score, sexual conservatism and pain is in the expected direction, indicating that sexual conservatism leads to dysfunctional beliefs, which contributes to women experiencing pain. The finding emphasises the role of beliefs in sexual functioning.[8] The socio-cultural context largely contributes to conservative beliefs. The positive correlation between the social domain of quality of life and the arousal domain emphasises the role of social and personal relationships in sexual functioning. As relationship problems can interfere in sexual functioning, infertility may affect relationships as well. Marital, emotional and sexual dysfunctions, problems in social functioning and physical fatigue were reported more in women with infertility.[34]

The age did not have any bearing on sexual functioning mostly because most of them were in their best age of child bearing. Unemployed women had lower scores on arousal while employed women showed more pain-related problems. This could be substantiated with the data that 60% of women both employed and unemployed reported to experience stress from work, and also pointed it out as an important inhibitor of desire and arousal. Women undergoing infertility treatment for less than 3 years had better desire and arousal than those undergoing treatment for more than 3 years. This may well be because, as the treatment and investigations progressed, there was significant increase in stress and decrease in marital functioning and sexual functioning.[35] Similarly, the presence of marital problems significantly affected sexual functioning in women.[36]

There is significant relationship between satisfaction (global sexual and relationship satisfaction) and sexual stimulation and communication. Basson[27] pointed out that “when a woman is willing to become aroused and is provided with the stimulation as she wishes, she achieves

| Table 2: The scores on domains of sexual functioning (FSFI), domains of sexual dysfunctional beliefs (SDBQ), psychological distress (GHQ) and quality of life (WHO-QOL-BREF) |
| --- |
| **Mean** | **SD** |
| **FSFI** |  |
| Desire | 3.50 | 0.95 |
| Arousal | 3.69 | 0.71 |
| Lubrication | 4.73 | 0.77 |
| Orgasm | 4.31 | 0.94 |
| Satisfaction | 5.00 | 0.69 |
| Pain | 4.56 | 1.44 |
| FSFI Total | 25.99 | 3.45 |
| **SDBQ** |  |
| Sexual conservatism | 29.43 | 3.19 |
| Sexual pleasure and desire as sin | 16.90 | 2.56 |
| Age-related beliefs | 15.20 | 2.91 |
| Body image beliefs | 11.67 | 2.83 |
| Denying affection primacy | 13.03 | 3.34 |
| Motherhood primacy | 12.77 | 2.01 |
| SDBQ total | 99.00 | 11.48 |
| **WHO-QOL-BREF** |  |
| Q1 | 4.00 | 0.74 |
| Q2 | 3.7 | 1.02 |
| Physical | 21.10 | 4.62 |
| Psychological | 19.93 | 3.83 |
| Social | 11.50 | 2.03 |
| Environmental | 30.47 | 5.51 |
| WHQQL (Total) | 83.0 | 11.0 |
| Total score | 4.47 | 3.12 |

FSFI = Female Sexual Functioning Inventory; SDBQ = Sexual Dysfunctional Beliefs Questionnaire; WHO-QOL-BREF = World Health Organization Quality of Life Scale – BREF version; GHQ = General Health Questionnaire.
sexual satisfaction’. This meant that better communication of woman’s sexual needs with her partner resulted in better sexual functioning.[37]

Women who experienced orgasm occasionally had high desire, arousal, satisfaction and overall sexual functioning compared to women who experienced orgasm every time. This seems to indicate that orgasm alone may not determine sexual satisfaction in women. Pain-related problems were less in women who had adequate information about sex, which is self-explanatory that a lack of knowledge contributes to sexual dysfunctions. Self-image seems to play an important role in sexual functioning, for example, women with inadequate self-image were found to have low scores on lubrication domain.[36]

Some of the limitations of the study are stated herewith. Small sample size restricted the generalizability of the results to women with infertility. Time and space were constraints to conduct detailed interviews, as the interviews were conducted in the gynaecology Out Patient Departments (OPD), resulting in patients not being comfortable to provide complete information on personal- and problem-related areas. The details of spouse’s dysfunction and infertility were not recorded, which is an important aspect known to have a role in infertility as well as sexual dysfunction in women. In addition, the causes of infertility were not recorded due to time constraints as well as unavailability of case records to the researcher. The study has some important implications because it has investigated an area that has just begun to be explored. The findings of the study show that the consequences of infertility are manifold such as psychological distress, decreased quality of life and disturbed sexual functioning, and the psychosocial factors seem to play an important role. Hence, a comprehensive evaluation of psychosocial factors is necessary. The fact that the majority have difficulties in sexual functioning and have maladaptive beliefs contributing to infertility may be useful for health professionals for providing intervention for individuals diagnosed with infertility. Future research may consider qualitative studies on the perception and experience of infertility with respect to social, psychological, marital and sexual consequences, which may give a more accurate picture of experiences of women in our context. Furthermore, issues related to female sexuality such as values, attitude, self-esteem, body image and sexual awareness may throw light on factors contributing to sexual functioning and infertility.

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There are no conflicts of interest.

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