Experiences of Infertile Couples of West Bengal With Male Factor, Female Factor, and Unexplained Infertility Factor: A Qualitative Study

Devika De¹, Pritha Mukhopadhyay², and Prasanta Kumar Roy¹

Abstract

Background: Infertility is a very stressful life state of a couple. The consequences of infertility have a considerable differential effect not only on couples but also on culture and social strata. Inability to conceive can be a very troublesome matter for a couple and potentially it can turn into a traumatic experience with far-reaching consequences. Qualitative understanding of strain can be helpful for in-depth understanding of factors that might need psychosocial intervention.

Objective: The purpose of this study is to zero in on the multiple psychosocial aspects of infertile couples, ranging from male etiology, female determinants, and unexplained domains of infertility.

Materials and Methods: This was a qualitative cross-sectional content analysis study. 15 couples were interviewed with the mean age of (27± 2.95) years for females and (30±2.43) years for males. Data collection strategies employed in this research included semi-structured open face-to-face interviews and field notes.

Results: Qualitative data analysis identified 5 themes—negative emotional reactions, social pressure, marital and sexual dissatisfaction, decreased quality of life, and treatment problems.

Conclusion: The various psychosocial crises (unfulfilled maternal instinct, emotional support, unmet social role, diminished social security) related to various types of infertility are evident. Addressing those issues might be helpful to improve the quality of life of couples.

Keywords
Primary infertility, couples experiences, qualitative method, psychosocial

Introduction

According to World Health Organization (WHO), the term primary infertility is employed when a woman has never been able to conceive and secondary infertility is the incapability to conceive in a couple who has had at least one successful conception in the past.² Primary infertility has a global prevalence of 12% to 15%.³ The WHO estimates the overall prevalence of primary infertility in India to be between 3.9% and 16.8% (WHO 2009). Infertility in women was ranked the fifth highest serious global disability among populations below the age of 60 (World Report on Disability 2011). From the etiological point of view, infertility is categorized as organic (male structural anomaly and female structural anomaly) and unexplained type.

In the Indian society, infertility is taken as women’s problem and she is blamed for not being able to procreate. As a dutiful wife she is expected to start a family immediately after marriage and when she fails to do so, she is blamed for her role failure and often subjected to negative remarks and blame from in-laws and neighbours.³ Motherhood is considered a power for the new bride and lack of which makes...
her vulnerable for critical comments. For men, remarriage is the most common solution, as it is generally assumed that infertility is largely a woman’s problem, even though the view emanates from a patriarchal society. Women have a constant fear of husband’s remarriage under social pressure. Women with infertility are considered less than others as they are not able to fulfill the predesigned role of a female as approved by the society.3 India, being a patriarchal society, considers the male as the head of a family. In patriarchal culture, a woman is supposed to be submissive and must agree to the decisions taken by her husband in order to prove herself as a dutiful wife. Treatment seeking is also decided by family members and if it is not as per their choice, couple is not allowed to go for it. A male partner cannot have any problem, and his medical examination becomes a family issue.

The overall experience of infertility and an attempt to conquer that state is part of a process that is dynamic in nature, with a different course for each individual.4,12 Often infertile women feel that they are responsible for couples’ infertility problems (Toivanen et al, 2004), whereas the men with infertility problem are more worried about their partner’s reaction to the problem than about their own emotion. As a result, they might feel guilty of infertility and conceptualize infertility as a punishment of some wrong deed.6

Since ages, many couples in India have been distressed with childlessness. Many of them have probably tried all possible methods to conceive. Due to high social pressure and stigma, infertility can bring about intense feelings of guilt or low morale, adjustment difficulties and mood disturbances in the couple, especially, the woman.7 Feeling of shame, jealousy, or anger along with disbelief are common emotions experienced by the infertile couples. All these may even lead to social alienation for them (Wischmann et al, 2009).13 In some, relatives, primarily from the husband’s family, make frequent interactions with the women on this and this builds the pressure even more. However, studies on psychological burden of infertility have focused primarily on females, not on the males. Moreover, different types of infertility may have diverse emotional reactions on the couples and it might be necessary to explore those for better psychosocial care.

**Objectives**

The aim of this study was to explore the qualitative differences of the psychosocial experiences of infertile couples across male factor, female factor, and unexplained infertility factor.

**Materials and Methods**

**Study Design**

This was a qualitative content analysis study following purposive sampling. Interpretive approach of data analysis obtained from interview of couples from 3 types of primary infertility (male structural anomaly, female structural anomaly, and unexplained infertility) was adopted.

**Selection of Participants**

The study had approval of University Ethical Committee for Research. In this study, recruitment of infertile couples was done from a private fertility clinic in a metro city in India. Males and females were selected between 20 and 35 years, staying together for at least 3 years, suffering from primary infertility (male structural anomaly, female structural anomaly and unexplained infertility), with no history of in vitro fertilization (IVF) or other mode of treatment. As mentioned earlier, 5 couples from each of the infertility groups were selected for interview after getting their consent. The recruitment was done by an experienced gynecologist-cum-infertility specialist and the first author. Couples who had a history of substance abuse and those with organic etiology found in both partners were excluded.

**Data Gathering**

Data gathering techniques that were employed in this research were in-depth semistructured face-to-face interviews and field notes. Demographic questions were about age, partner’s age, level of education, job, causes, and duration of infertility. Directing interviews across 10 sessions assisted us to understand the context of the distress in various areas and take a complete account of the experiences of the couples. The interviews were focussed on the following: (a) How is your experience about sexual behavior? (b) Can you tell about the satisfaction of your social support? (c) Describe your emotional experiences. (d) Describe your quality of life related to your infertility problems? (e) Describe your experiences during the treatment process. All interviews were carried out for 40 to 45 minutes with both husband and wife separately and handwritten with the consent of the participant. In addition, field notes were written closely after each interview.

**Data Analysis**

The data was analyzed using conventional content analysis method. Researcher recorded all interviews by writing everything that the couples had said. All recorded texts were broken into meaning units. Concepts of important words and phrases related to the context of the interviews were found. After ending all of the interviews, the researcher framed concepts into codes. The primary code was designed, each meaning unit was shortened to a “compressed meaning unit” and then extracted codes were achieved. All transcript steps were compared to classify codes, relationships, and dissimilarities. In the next step, differences were discussed and resolved and the final code was achieved. Similar codes were classified into subcategories and subcategories were placed in the main category. Finally, the themes could be identified.
Results

A total of 15 couples (15 males and 15 females) participated in the study. The mean age of the females were (27±2.95) years, whereas the mean age of the males were (30±2.43) years. The mean age of marriage for females was (22±2.63) years and for males was (24±3.87) years. The education levels in the infertile couple were graduates and postgraduates.

Main Themes

Data analysis showed the following themes (refer to Table 1):

1. Negative emotional reactions (hope disappointment cycle): Majority of couples reported that the basic intention behind a marriage is fecundity and raising children. When infertility strikes, the woman thinks that she has surrendered her chief element of being ready to give birth to children. Men’s infertility is regarded as something very shameful for them. As a result, men are more reticent to talk about their problems than women. A 32-year-old male factor male reported: “With failures in transiting from couples to parents, we cannot experience the joy and family honor. I feel unacknowledged in all spheres—personal and professional life.” A 30-year-old male factor male reported: “Everything seems to be dark and gloomy. I feel lost most of the times.” On the other hand, a 27-year-old male factor female reported: “Even though the problem is with my husband, I still feel very angry with myself and I am irritable most of the times.” Another 29-year-old male factor female reported: “I have no energy most of the times and I don’t feel like interacting with anybody.”

A 31-year-old female factor male reported: “Since we had an arrange marriage, I blame my parents as I feel frustrated. Because of my wife I am deprived of all the joys.” A 32-year-old female factor male reported: “I feel dissatisfied with my wife and I hardly feel like talking to her. I feel frustrated most of the times.” A 29-year-old female factor female reported: “I don’t feel like going out or speaking to my friends. I feel like a failure. I have nothing left and nothing to look forward to.” Another 30-year-old female factor female reported: “I have always loved children and now I can’t have my own. I feel sad and lonely most of the times.”

A 30-year-old unexplained factor male reported: “I feel frustrated and angry why we can’t have a baby when everyone is having.” A 32-year-old unexplained factor male reported: “I sometimes think that I must have done something in my previous birth to go through this torture.” A 27-year-old unexplained factor female reported: “I am tense and nervous most of the times as no clear-cut conclusion can be reached about our infertility problem.” Another 30-year-old unexplained factor female reported: “In laws keep blaming me though there is no fault of mine. I feel guilty for no reason.”

2. Social pressure: The idealistic image of couples in this society is supposed to be fulfilled through the birth of a child and couples can see their own image in a child. This theme has two subthemes, which are stigmatization and social isolation. Due to the importance of children in life, every female after marriage is asked by other females, relatives, and friends questions related to pregnancy. A 30-year-old male factor male reported: “There is a constant pressure to continue the family lineage. Parents, brother everyone is always enquiring about my personal life.” Another 33-year-old male factor male reported: “I don’t feel like going out with friends because they too keep asking about children or are constantly speaking about their own.”

A 28-year-old male factor female reported: “I find it embarrassing to speak about the infertility issue; hence, I take the blame for the infertility problem.” A 26-year-old male factor female reported: “Even though my in-laws know it’s my husband’s fault, they keep talking to me sarcastically and tell everyone that it’s my fault.” A 31-year-old female factor male reported: “My parents don’t want me to continue with the marriage as my wife has endometriosis and is not conceiving. They tell me almost every day that I should remarry.” Another 33-year-old female factor male reported: “Everyone behaves very rudely with my wife. As everyone has children in our house they keep taunting my wife and telling her a lot of things.” A 29-year-old female factor female reported: “What people say makes me feel worse. I am not allowed to attend baby showers as I am treated as inauspicious. My in-laws ignore me and give preference to my sister-in-law. They say I am jealous of her”. A 27-year-old female factor female reported: “I feel like an outcaste. No one mixes with me; even my own friends have become distant.”

Table 1.

| Main Themes | Sub Themes |
|-------------|------------|
| Negative emotional reactions | Low self-esteem, Low mood, Anger |
| Social pressure | Stigmatization, Social isolation |
| Decreased quality of life | Decreased social circle, Increased husband wife conflicts, Difficulty in moving on with career |
| Decreased sexual satisfaction | Increased premature ejaculation, Low female desire during the times of less probability of pregnancy, Offensive thoughts during sex |
| Treatment problems | Cost of treatment, Inadequate treatment information |
A 32-year-old unexplained factor male reported: “Everyone is eager to know why we are not having a baby. I have stopped attending social gatherings due to this inquisitiveness of others.” A 31-year-old unexplained factor male reported: “People don’t want to support. They are just nosy people who want to interfere in everybody’s life.” A 27-year-old unexplained factor female reported: “Though all my tests are fine, everyone thinks it’s my fault. At times I wonder whether God is punishing me for my past sins.” A 25-year-old unexplained factor female reported: “I don’t feel like getting intimate with my husband anymore. Sex somehow reminds me of my failure.”

A 26-year-old male factor female reported: “My husband is not being able to perform the way he used to. This is making me irritable most of the times.” A 30-year-old male factor female reported: “I keep comparing my sexual life with others and I feel angry that I deserve better.” A 31-year-old female factor male reported: “The doctor has given us a particular schedule for intercourse and this seems like someone is infringing on our privacy”. A 33-year-old female factor male reported: “I always feel the only reason my wife wants to have sex is to have a baby. This makes me feel like an object at times.” A 25-year-old female factor female reported: “I don’t feel like getting intimate with my husband anymore. Sex somehow reminds me of my failure.”

3. Decreased quality of life: Often infertile women feel that they are responsible for couples’ infertility problems. It causes feeling of guiltiness, and infertility can be seen as a punishment. They reported that dreams about creating something together with one’s partner are bargained away. A 31-year-old male factor male reported: “I can’t concentrate on my work and everything seems too much of an effort. I feel worn out most of the times.” A 30-year-old male factor male reported: “I only stay at home other than going for work. I derive no enjoyment from anything.” A 26-year-old male factor female reported: “I always feel that my husband is not putting enough effort and is concentrating more on his work”. A 29-year-old male factor female reported: “There is nothing interesting happening in my life. I just push myself through every day.”

A 30-year-old female factor male reported: “My wife keeps brooding all the time and hardly wants to go out with me and spend time with me.” A 34-year-old female factor male reported: “I don’t understand how to handle my wife and this creates further problems between us.” A 28-year-old female factor female reported: “I have no interest in any regular activities. I always want to stay by myself.”

A 32-year-old unexplained factor male reported: “Even though I know it’s not my fault, I still feel irritated with myself and my wife. I don’t feel like talking to her much”. A 27-year-old unexplained factor female reported: “I have lost interest in my husband and I don’t feel like talking to anybody. I have stopped interacting with my friends too”.

4. Decreased sexual satisfaction: The couples reported that during the state of infertility, sexual relation becomes more problematic and difficult to sustain. As a consequence, intimate feelings, passion, and even communication get difficult to hold on to. This theme included 2 subcategories: (a) increased premature ejaculation with a timed intercourse and (b) negative attitude of both males and females towards timed intercourse. A 33-year-old male factor male reported: “I have started feeling very jittery and restless during sexual intercourse.” A 31-year-old male factor male reported: “My interest in sexual intercourse is not the same as before. During the act, I always get reminded of my problem.”

A 26-year-old male factor female reported: “Though the doctor made it very clear right at the beginning that the treatment will be expensive, we are finding it difficult to bear the expenses.” A 31-year-old female factor female reported: “I always feel the only reason my wife wants to have sex is to have a baby. This makes me feel like an object at times.” A 25-year-old female factor female reported: “I don’t feel like getting intimate with my husband anymore. Sex somehow reminds me of my failure.”

5. Treatment problems: Therapeutic problems are generally divided into two subcategories: economical and interpersonal (patient–providers) relationships. A 32-year-old male factor male reported: “There was no proper briefing done by the doctor or his assistants, so we were not very clear about a lot of things.”

A 30-year-old male factor female reported: “As my husband felt a little embarrassed, I wanted to clarify certain things, but the clinic staff weren’t very polite while answering questions.” A 34-year-old female factor male reported: “Though the doctor made it very clear right at the beginning that the treatment will be expensive, we are finding it difficult to bear the expenses.” A 26-year-old female factor female reported: “I feel very burdened with the treatment cost and I am constantly guilty that because of me so much money is being wasted.”

A 32-year-old unexplained factor male reported: “We felt if the doctor or the attendants would have been more supportive and would have given us some more information it would have been comforting.” A 27-year-old unexplained factor female reported: “We found the staff a little unfriendly. I had quite a few doubts related to the treatment which were not cleared.”

Discussion

The present study has been designed and targeted to probe into the profound psychosocial experiences of infertile couples in the state of West Bengal in India. The mental ramifications of the state of being infertile have been studied extensively over the years globally, but such a study was much warranted in West Bengal because the social structure, cultural dynamics, credo, and internal stratification are radically different in contradistinction to other parts of the
country. It is interesting to note here that social beliefs and
culturization here, in general, are somewhat dogmatic and
rigid, in the backdrop of enmeshed complicity, which
invariably places a disabling pressure on infertile couples.

The findings in the study definitively revealed an exacting
level of stress and trauma in the participants. It was abundantly
clear how barrenness can lead to low self-esteem, guilt states,
and in contrast to a man's ability to ejaculate. Studies
conducted elsewhere, also converged on to the psychological
impact of infertility in terms of high anxiety level, depressive
proclivities, maladjustment, and disillusionment. Watkins &
Baldo (2004) found that there is a certain parallelism between
infertility-related despair and personal bereavement.

Many infertile couples pass through the characteristic
phases of disbelief, denial, anxiety, helplessness, alienation,
guilt, and the eventual conflict resolution.14

In our society, men’s fecundity is directly related to
sexual virility and procreation. Women are often found to
be shielding their husband’s sterility by taking the blame on
themselves or ascribing it to male physiology.15 It was also
found that infertile women, by virtue of their loss of feminine
ability to conceive, often go on to develop diminished self-
worth, which leads to mental anguish, remorse, and depressive
underpinnings. These revelations have been corroborated in
several studies over the years.16

According to Cudmore,15 several women regard
fecundity and conception, as the unmistakable benchmarks of
womanhood. Women often have a tendency to relegate their
lives as a series of immutable schedule ranging from marriage,
duties, procreation to responsibilities and obligations.6

For men, society has fostered the deeply entrenched
view that a man’s sexual potency is related to masculinity and
physical prowess.5

It is understood unmistakably by most women that
inability to raise children is an abject failure on their part,
which in turn is known to compromise the health index and
mental quotient of those women.

Infertility leading to victimization and condemnation
are very common predicament of barren women. In our
society, motherhood is regarded as the end-all of a woman’s
life. Most women, are made to believe and grow up to
accept that procreation is the final denouement of a genuine
motherhood.9 That is why, a large section of infertile women
regard themselves as failure and are resigned to a life of
misery and dejection.

Many of the participants admitted loss of sexual interest
as they were deficient in their sexual virility. In the course
of infertility treatment, sexual proximity may become the
major stumbling block in togetherness and bonding, which
is notorious to place considerable pressure on the couple’s
life, eventually, creating enormous internal pressure and
unbridgeable rift in the relationship.8 It is ingrained in most
human societies that fertility is the unflinching expression of
sexuality and that a woman’s orgasm is of minor importance
in contrast to a man’s ability to ejaculate.

Many participants complained of exorbitant treatment
costs and almost non-existent insurance support. On the
other side, patient–provider relationship turned out to be a
problematic area in the treatment agenda, which has been
explored by other studies.17

Adequate information dissemination, priming, psycho-
education, and thorough explanation are found to be
of immense value in the treatment acceptance, mental
satisfaction and the eventual treatment outcome.18 It was also
found that many women complained of various symptoms
ranging from headache, body pain, mood swings, depression,
asthma, abdominal distension, and weight gain, which are
known to be the side-effects and unavoidable complications
of the treatment process.

Implication

The findings revealed that infertile couples constitute a
marginalized exclusive group with a multiplicity of problems
and complications. Based on the revelations of this study,
policy makers should formulate a two-pronged approach to
the vexing problem of infertility. First, the potential infertile
couples should be offered rigorous psychological support by
mental health professionals, in order to give a strong impetus
to their waning self-esteem and bolster up their motivation.
And secondly, they should resolve the crucial issue of
victimization and the consequent mental trauma of the infertile
couples, by way of mass awareness and sensitization, taking
recourse to mass media, social campaigns and the academia.

Conclusion

Infertility is an extremely demanding and traumatic
predicament. The cognitive reactivity and verbal responses to
questions asked revealed a wealth of information regarding
individual experiences and the dyad perceptivity to a trying
imbroglio. Rummaging through their accounts and their
behavioral patterns have revealed a convoluted picture of the
mental and physical dimensions of the earth-shattering
experience of being infertile. In fine, the results objectified the
degree of pain, anguish, and the unnerving demands placed on
the lives of the infertile couples, and it also made it very clear
that there lies a world of multidimensional quandaries ranging
from personal problems, social expectations, economic
pressure, relationship tangles to cultural complications. It is
ideal to develop and offer a holistic therapeutic strategy,
especially, empathic and supportive psychotherapy for the
overall betterment, treatment compliance, and a successful
outcome. Psychotherapy could be useful to help them get out
of the crises. The systematic reviews by Ying and colleagues8
(2016) and Chow and colleagues19 both included one
randomized controlled trial (RCT) (Mosalanejad et al, 2012)
that looked at the impact of cognitive behavior therapy (CBT)
on anxiety. The RCT included only females (N = 31); CBT
was performed prior to the start of IVF, over four months, in 15 one and one-half-hour sessions (Mosalanejad et al., 2012). The study demonstrated a significant ($d = 0.95$, $P = .001$) decrease in anxiety (as cited in Ying et al., 2016 and Chow et al., 2016).

**Limitations**

The study was conducted on prior decided sample size. With a small number of sample size from a single center, there is a high possibility of selection bias. A multicenter study could have been more appropriate to avoid such bias. Moreover, the qualitative data or the interview data was not independently coded by at least 2 researchers and that can have impact on the interpretation of the findings.

**Declaration of Conflicting Interests**

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