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Social Support, Coping Strategies, and Quality of Life among Young Infertile Women with Primary and Secondary Infertility

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ABSTRACT
This study investigates the quality of life, coping strategies, and perceived social support among young women experiencing primary and secondary infertility. Using a quantitative research design, data were collected from 50 infertile women aged 25–35 years through standardized measures, including the WHOQOL-BREF, the Multidimensional Scale of Perceived Social Support (MSPSS), and the COMPI Coping Strategy Scale. Reliability analysis indicated acceptable to high internal consistency for all scales. Pearson correlation analysis revealed significant associations among various domains of quality of life, social support, and coping behaviors, particularly highlighting strong links between environmental well-being and overall quality of life. Independent sample t-tests showed notable differences in psychological and environmental domains between women with primary versus secondary infertility, as well as between women in love and arranged marriages. Furthermore, Multivariate ANOVA demonstrated that previous pregnancy and relationship quality with the husband significantly influenced environmental well-being and overall quality of life. The findings emphasize that infertility affects women not only physically but also emotionally and socially, underscoring the need for strengthened psychosocial support systems, counseling interventions, and family-inclusive care approaches. The study provides valuable insights for healthcare professionals working with infertile women.

Keywords: *Infertility, Quality of Life, Coping Strategies, Social Support, Primary Infertility, Secondary Infertility, MSPSS, WHOQOL-BREF, COMPI Scale, Psychological Well-being.*

1. INTRODUCTION

In almost all culture the individuals have a desire to have their own child (Tobang & Adongo, 2013). Majority of couples want to naturally conceive a child, have a successful pregnancy and enjoy their role as a parent (Covington & Burn, 1999). Reproduction is almost every human's wish and if it is not been fulfilled it can affect quality of life. The problems of infertility have no geographical boundaries as it exist in every social class, culture and country (Hirsch & Hirsch, 1995). Not having a child is often viewed as a deviation from societal norms and is mostly not accepted in our society. We are living in postmodern era and despite of modern technology and treatment methods, infertility is still a challenge for our society (Inhorn & Patrizio,2015).

A lot of couples are facing the problems of infertility but there is still a need to address this problem in different cultures that how this inability to conceive a child effects the quality of life and what are the ways by which a couple cope with it. Mental health professionals who are dealing with infertile patients are aware of the mental health problems that can arise by this

disease. But there is a need of an indigenize research that how we can we cope with this psychological problem in our culture.

The most vital role that our Pakistani society demands from a woman is motherhood. The reproduction is given such an important role in our society that being infertile is considered a taboo here. Although infertility has a bad effect on both gender but it effect women more as they have more pressure to conceive the child. In this matter the infertility is destructive in its nature in both psychological and social manner. Thus this current research is an attempt to find out that how social support and the coping strategy used by an infertile women affect her quality of life.

1.1. Infertility

According to World Health Organization (WHO) "A disease of male and female reproductive system defined by the inability to achieve pregnancy after the unprotected sexual intercourse of 12 months or more is called infertility". According to statistics one out of six couples faces the problem of infertility (Shoberi & Hazaveihe,2014).

According to the International Committee for Monitoring Assisted Reproductive Technology (ICMART) and WHO infertility is the "inability to achieve a clinical pregnancy after one or more year of regular, consistent and unprotected sexual intercourse".(Zegers Hochschild et al.2009).

1.2. Types of infertility

Infertility is mainly of two types. First one is Primary infertility and the second one is secondary infertility.

1.2.1. Primary infertility

The type of infertility in which the couple is unable to conceive a pregnancy after the unprotected sexual intercourse of 2 years or more is called primary infertility. Moreover in primary infertility the couple had not a prior chance to achieve pregnancy. (Schmidt,2006;A.D.A.M.Medical Encyclopedia,2005).

According to WHO:

"If a couple achieved pregnancy that leads to a miscarriage or if the pregnancy outcome is a still born it would be also called primary infertility".

1.2.2. Secondary infertility

This is the type of infertility in which the couple achieved the pregnancy successfully in the past but now the couple is facing problem to achieve pregnancy (Schmidt, 2006; encyclopedia, 2005).

1.3. Prevalence of infertility

Inability to conceive is a major and global disease which affects the people of every race, country and ethnicity. According to WHO statistics there are almost 48 million couples and 186 million individual who are suffering from this disease. Around 10-15 of people are facing distress according to infertility (Noorbala et al.2008). The prevalence of not able to conceive a child is relatively greater in the developing countries than developed countries (Couineau & Domar, 2007). For example in Pakistan the prevalence of childlessness is 22 percent in which there is only 4 percent primary infertility and rest of 18 percent is secondary infertility. This statistics means that out of every five married couple in Pakistan, one is suffering from infertility (Hakim & Sultan, 2001; Shaheen, Subhan , Sultan & Tahir , 2010).

1.4. Causes of infertility

Infertility can be caused by many which: (1) female factor, (2) male factor, (3) unexplained factor. Around 40 percent infertility problems are due to female factors, 40 percent are due to female factors and the other 20 percent are due to unknown factors (Anderson,Nisenblat & Norman, 2010; Sadlock & sadock , 2003).

Female factor of infertility:

Infertility in women is mostly due to the structural abnormalities in fallopian tubes, obstruction of fallopian tubes, and weight of the woman, hormonal problems, PCOS, fibroids, cervical mucus issues and endometriosis.

Male factor of infertility

Around 40 percent infertility problems are male factor. Common problem that contribute to men infertility are poor sperm quality, vasectomy, hormonal imbalance, smoking, problems with sexual functions, damage of vas deference and genetics.

Unknown factors

Treatment of infertility mostly starts after one year of attempting to conceive. If the doctor is unable to find a medical cause of infertility after assessment then the diagnosis of "unexplained factor infertility" is assigned. IUI and IVF is the treatment for unexplained factor pregnancy.

1.5. Treatment of infertility

Treatment of infertility varies according to the cause of infertility. For the treatment of hormonal imbalance in women having ovarian dysfunction, ovarian stimulation is used. (Bergh & Hagenfeldt; 1998; Gottlieb, 2001). ART are also used for the couple who is having difficulty to conceive. Assisted reproductive technologies (ART) are the fertility intervention that helps in the management of egg and sperm (CDC, 2007). Some women can be cured by changing their lifestyle, some need medications and some also need intrusive treatment.

1.6. Experiences of infertility

The life experiences of infertile women in Pakistan are very heart wrenching. In backward areas the value of women depends on her fertility. According to a research women who experience infertility suffer more from psychological distress than fertile women (McQuillan & Jacob 2003). One main negative experience by which an infertile woman suffers from is role failure. Inability to conceive makes women depressed and sad which leads to the failure of their role as a wife (Covington & Burns, 2006).

Infertility is a taboo in Pakistan. It affects the woman's mental health as people try to keep their children away from infertile woman. After facing such kind of stigmatization it'll be very difficult for a women to attain a good social and married life (Diamond, 1999).

Another experience an infertile woman has to deal with is social exigency. Social exigency is the pressure on a woman to adopt motherhood. Everyone in their society pressurize them to have a child as they see them as an incomplete woman. Due to negative behaviour of people, infertile women also experience social malfunctioning. They avoid going to gatherings which make them separated and detach from society (Inhorn & Balen, 2002).

1.7. Consequences of infertility:

The result of every negative experience from which an infertile woman pass through results in severe outcomes such as anxiety, stress and depression. A woman feels sad and depressed when she can't perform her role duties. There is always a fear that what she'll not be able to give her husband a child resulting in the second marriage of his husband. Certain cognitive distortions and irrational thoughts make her psychological health bad. Sometimes their husbands are understanding and try utmost to reassure their wives about their strong relationships but the stress a woman facing can't make her comfortable. She constantly thinks that she is unable to enjoy happiness.

Most of the time there is male factor infertility but there is a stigma in our society that infertility is only due to female factors. That's why mostly the women are blamed for a couple's childlessness. Men suppress their emotions and desire for having a child for a long time. But

around 40 percent of infertile people face psychological and emotional distress (Peronance, 2007).

Most of the infertile women became separated from society because she faces constant pressure and rejection from this society (Balen 2004). Due to the constant negative behavior of people the woman starts to blame herself for not having a child. This self-blaming of her leads to the inferiority complex (Jacobs & O'Donohue , 2006).

1.8. Social support:

Social support is the most crucial aspect for a good mental health condition that is why it often studied in psychology. Social support can be defined as the social efforts that are performed by a person from society for a specific person. Knowing that a person has emotional support has a strong effect on an individual mental health. Social support directly affects a person mental and physical health. Social support varies in case of gender as male have more social relationships than women thus it is easier for them to take support.

Social support is of two types. It can be verbal and non-verbal. Any exchange of kindness and companionship between two people that promotes the feeling that a specific individual can control another specific person's life situations (Albrecht & Adelman,1987).

The ability to have unconditional positive regard, kindness, a sense of belonging and attention from family and friends is also called as social support. (Walen & Lachman, 2000).

Emotional support is basically an important form of social support. Emotional support is a feeling of affection and a subtle assumption of being care of and feeling loved. (Cobb, 1976; Cohen & Wills, 1985)

Any physical and emotional relief in someone's problem that is given by family, friends and colleagues is social support. Social support is now getting more importance in medical field such as in acute and chronic diseases, infertility and psychological problems. Social support acts as a shield against the damaging effects of infertility such as stress (Kim & Sherman, 2008).

As we know that social support is necessary for a good mental health but the problem is this that in some cultures people ask for support without hesitation but in some cultures people show reluctance to seek any type of social support. The reason is that in some cultures social support is not much appreciated (Taylor, 2008).

Social support has two main fundamental components. One is that how many persons are available when an individual needs them and second one is how satisfied he is with this support (Sarason et al., 1983).

Social support is negatively correlated with adverse outcomes of pregnancy and is positively correlated with coping with infertility (Orr, 2004).Spouse support also has positive effect on coping with infertility. A partner has a good effect on mental health of person dealing with I fertility (Ying et al, 2015). A recent research also shows that social support enhances active successful coping and cognitive adaption in women dealing with infertility (Martins et al., 2011; Scrignaro et al., 2011).

1.9. Coping strategies:

Coping strategies plays an important role in the general quality of life of women dealing with infertility as the way you cope with a problem mold your cognitions and thinking pattern which prevents you from mental illness. While dealing with infertility every woman use a different coping strategy according to her personality and mind set. According to Schmidt's a woman dealing with infertility pressure can cope with it in four ways which are active-avoidance, active-confronting, passive-avoidance and meaning-based coping. In active confronting, the woman directly tackle the problem by seeking medical treatment so that she can get away from the negative effects of infertility.it is the negative predictor of quality of life. Active

avoidance is opposite of it in which the infertile woman devalue or blame herself and socially withdraw herself. It is the positive predictor of quality of life. Moreover young infertile women who deals with this health condition as a challenge feels less distrubed than women who deals with it as a failure (Hansell at el, 1998). According to a study problem solving positive coping strategies results in good quality of life among young infertile women as it reduces stress (Fekkes et al., 2003; Schmidt, 2006; Verhaak et al., 2007; Chachamovich et al., 2010).

1.10. Quality of life:

Quality of life in accordance to WHO, is the development, growth and wellbeing of an individual by which the position of individual in the community and his goals can be seen. Quality of life and standard of living are often mixed by people but the core difference here is that standard of living is based on money (Ameidaand Costa, 2011).

The quality of life can be seen in different areas of life but its major five dimensions are: material well-being, physical well-being, emotional well-being, social well-being and the last one is development and activity (felce and perry, 1995).

The reduced scores on QOL domain showed that inability to bear a child has negative effects on women (Greil, 1997). Life satisfaction is described as the evaluation of good and bad outcome of an individual's life. Good Health acts as the most important domain of quality of life. As it changes for every individual, the idea of quality of life is strenuous to understand. The important things that need to be addressed is that quality of life also varies from culture to culture and different population. (Theofilou, 2013).

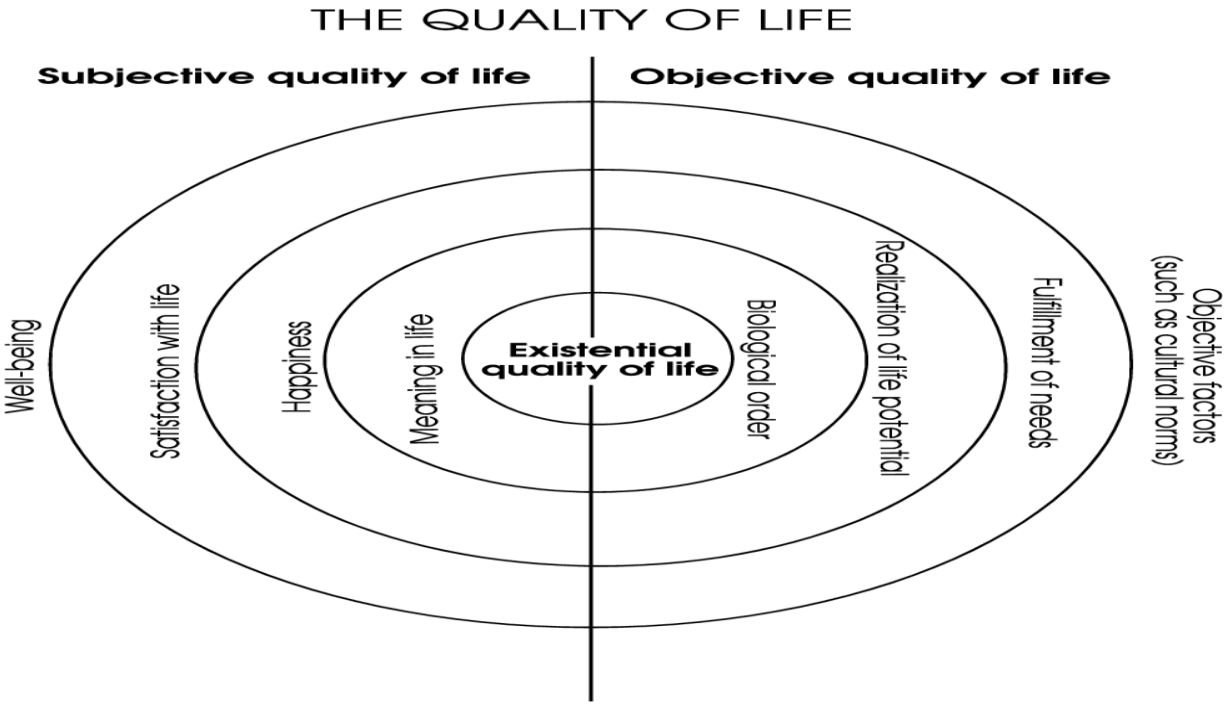
Quality of life has an inverse relation with infertility related stress and pressure (Andrew et al, 1991). Researches shows that infertile women have poorer score on QOL (Namdar A, Naghizadeh MM, Zamani M, Yaghmaei F, Sameni, 2007). The decline in QOL effects the ability of a woman to conceive (Hazavhei SM, et al, 2014).

1.10.1 The Integrative Theory of Quality of Life

Quality of life, means a life that is good and worth living. Different religions and philosophies gave different concept of quality of life. Therefore what is quality of life for you also depends on your culture. People from west include pleasure, achievement of needs and be in work in social context when they see a life of good quality.

This idea is divided into three groups. 1. The first group is subjective quality of life. How good and worthy a person can feel or how good life he has is the subjective quality of life. Each individual have different notion and ideas that what is quality of life for her. But the only thing that can tell the quality of life of a person is whether he is happy or content in his life or not.2.the second group is of existential quality of life. According to existential quality of life a person has deeper nature that should be respected in order to live with harmony and growth. For example the need of growth should be fulfilled in order to be happy. 3. The third one is objective quality of life. How the people from society perceived the quality of life of a person is called objective quality of life. The objective quality of life is culture based.

All these three groups of quality of life merge and overlap to make quality life. The existential group is on the middle as its overlap the other two groups. The existential group also represents the depth of quality of life is being humanity.



2. LITERATURE REVIEW

Extensive research has been carried out on this sensitive issue of infertility and literature indicates that infertility affects all the dimensions of the quality of life.

2.1. Coping strategies and quality of life among young infertile women

Previous researchers showed that inability to conceive is a major threatening remark to quality of life. Brown (2022) proposed that coping abilities, infertility stigma and cognitive distortions are interlinked with each other. Cognitive distortions have a positive relationship with infertility stigma which means that infertility stigmatization cause cognitive distortions among the women dealing with infertility. In contrast adaptive coping abilities are negatively correlated to cognitive distortions. For example as the self-efficacy increased, cognitive distortions will decrease.

In another study Saif, Aqeel and Rohail (2021) tried to figure out how coping strategies, psychological distress and quality of life are related to each other among young infertile women. The findings indicate that positive coping strategies of problem results in less mental health problems. Moreover the quality of life also increases by positive coping strategy. Positive coping strategy helps both in primary and secondary fertility. Positive coping strategy helps in both type of infertility by increasing quality of life and decreasing mental distress.

Kiani, Simber, Hajian and Zayeri (2020) conducted a research on "Quality of life among infertile women living in a paradox of concerns and dealing strategies: A qualitative study". They tried to investigate the issues that can be the cause of bad quality of life of infertile women and what are the coping strategies they are using to deal with this disease. The results they get comprised of two major themes with four subthemes and categories of issues. The first theme is "infertility concerns" and the issues in this theme are "concerns" and "obscurity about treatment". "Dealing with infertility" is the second theme given by results which involve the issues of "adaptive strategies" and "inhibitors of resolution with perceived infertility". Thus different women deal with different concerns related to infertility. Some got problems due to lack of awareness among their spouses and in laws, some got problems by health care system and some of them got problems due to the common belief system of society. In short all of

these results infertile women to live in a paradox which lessen their will power to deal with disease.

In other study "Infertility and Psychological and Social Health of Iranian Infertile Women: A Systematic Review" Yazdi, Sharbaf, Kareshki, and Amirian (2020) investigated that how infertility can affect the psychological, emotional, social and relational lives of women. They tried to identify the psychological and social health problems in women due to infertility. The results revealed that there are six dimensions that are affected by infertility and leads to poor psychosocial health of infertile women. Quality of life, depression, anxiety, social support, violence, and sexual function are the six dimensions affected by infertility in women. .

Namdar, Naghizadeh, Zamani, Yaghmaei & Sameni (2017) studied the general health and overall quality of life of infertile women and other certain conditions. The results showed that around thirty nine percent of patients are in good health while sixty one percent people showed impairment in health. Another finding stated that the infertile women living in rural areas have bad quality of life than infertile women living in urban areas.

Hasanpoor-Azghdy, Simbar and Vedadhir (2014) gave the hypotheses that inability to conceive cause psychological problems in Iranian women who are seeking treatment. In research 32 semi structure interview were conducted. The study provides four basic domains one is how women cognitively reacts to infertility, second is what their response to therapy process is, third one is what are the emotional effective reactions of infertility and the fourth one is what are the emotional effective reactions of therapy process. The results showed that infertility has very adverse effect on psychological health of women but health care system emphasizes more on biomedical issue of infertility.

In A case- control study (2019) 180 infertile women and 540 fertile women were taken and research was conducted by Bakhtiyar, Beiranvand, Changaee, Almasian, Bastami & Ebrahimzadeh. Analysis of interviews showed that infertile women showed low scores in physical, mental and environmental health domain while shows high score in social domain then fertile women.

Social support and quality of life among infertile women

Another research was conducted on topic "Perceived Social Support and Life Satisfaction in Infertile Women Undergoing Treatment: A Moderated Mediation Model" by Chu, Geng, Zhang, and Guo (2021). Research was conducted on 293 infertile women and the tools used in that study were Multidimensional Scale of Perceived Social Support (MSPSS), The Satisfaction with Life Scale (SWLS) and The Self-Compassion Scale (SCS). The results indicate that social support has a positive correlation with life satisfaction and self-compassion acts as the mediating role in it.

In another study "Coping strategies mediate the association between stigma and fertility quality of life in infertile women undergoing in vitro fertilization-embryo transfer" Jing, Wei Gu, Zhang, Miao, Xu, Wang, Ramachandran & Wenru Wang tried to figure the role of coping strategies and its effect on stigma and fertility quality of life in Chinese women who are currently seeking In Vitro Fertilization Embryo Transfer (IVF-ET) treatment. Results derived from study indicated that meaning- based coping strategy has a positive reconciled role between stigma and fertility quality of life.

Steuber and Andrew (2015) did research on topic "Disclosure strategies, social support, and quality of life in infertile women". In this study they conducted online survey of 301 women who are dealing with infertility. They tried to investigate that how different women reveal infertility related information, how much social support they get from their spouse and relatives and how does it effects their quality of life. They findings showed that infertile women

who find it more comfortable and usually share their infertility problems have more likely good quality of life.

Peterson and Costa (2011) explored that how direct and indirect perceived social support effects on infertility stress . The measurement tools used in this study were Multidimensional Scale of Perceived Social Support, Copenhagen Multi- center Psychosocial Infertility coping scales and Fertility Problem Inventory. The results showed that spouse and social support has a negative relationship with sexual stress. Family support also has negative relationship with social stress.

In order to explore the contribution of of social support and mental health in infertile women, Mousavi, Kalyani,Karimi, Kokabi and Piriaee did research wirh 95 infertile women. Multidimensiioal Scale of Perceived Social Support (MSPSS0, Mental Health Inventory (MHI) and Inventory for Stressful Situations (CISS-21) were used in this study. The aim of study is to assess how social support effects mental health directly and indirectly. The results showed that positive coping strategy acts as a mediator in social support and psychological health of infertile women.

Researches on Infertility in Pakistan

Khalid and Dawood (2020) did research on "Social support, self-efficacy, cognitive coping and psychological distress in infertile women". The idea of this research paper is to find association between social support, self-efficacy, cognitive coping and psychological distress among infertile women of Pakistan. 158 infertile women were taken as a sample from six hospitals of Lahore. Research was conducted by the help of different measurement tools which include demographic questionnaire, multidimensional scale of perceived social support, infertility self-efficacy scale, coping strategies questionnaire and depression anxiety stress scale. By results they concluded that friends and family support reduces stress, depression risk and anxiety prevalence among women dealing with infertility. Moreover Social support, self-efficacy, active-practical coping and active-distractive coping are negatively associated with psychological distress.

Qadir, Khalid & Medhin (2015) also conducted a study with 177 women with primary infertility. They examined relationship between social support, marital adjustment, and sociodemographic factors with psychological distress. They used Self-Reporting Questionnaire, the Multidimensional Scale of Perceived Social Support, and the Locke-Wallace Marital Adjustment Test to study variables. Results showed that social support and marital adjustment are negatively correlated with psychological distress.

Hassan, Siddiqui, Friedman (2019) did research on "Health Status and Quality of Life of Women Seeking Infertility Treatments" in Baluchistan, Pakistan. They aim to find out that how infertility experiences effect on quality of life of infertile women. Study showed that women of different age, education and economic background had the same negative effect on their quality of life. The quality of life lessens due to intimate – partner violence, infertility stigma, fear of divorce and second marriage of husband.

Bibi Nooreen Begum and Hasan did a comparative study on psychosocial problems among women dealing with infertility in Pakistan. In this comparative study they wanted to explore the difference between stress and depression among fertile and infertile women. The sample of infertile women was collected from Liaquat National Hospital, Patel Hospital, Infertility Concept and Zainab Hospital while the sample of fertile women was collected from general population of Karachi. The age limit of women was from 20 to 35 years. By results they proposed that fertile women have less depression and anxiety then infertile women.

2.2. Rationale of study

The motive of this quantitative study is to discover the potential practical relationship between social support, coping strategies and quality of life in young women dealing with primary and secondary infertility. Although there are many researchers conducted on the topic of infertility but we want to study about how much of social support infertile women have in Pakistan and how they cope with this stigma that people usually attach with them. So we aim to study the main problems in quality of life due to lack of social support in infertile women. This study is intended to identify that if the infertile women are treated like this way in future, it may seriously affect the women quality of life. This knowledge will enable young infertile women to seek social support and cope effectively with this stigma which would help them to enhance the quality of life.

2.3. Objectives

1. To explore the relationship among social support, coping strategies and quality of life in women with primary and secondary infertility.
2. To compare the women with primary and secondary infertility in terms of social support, coping strategies and quality of life.
3. To compare the infertile women with high and less social support in terms of quality of life.

2.4. Hypothesis

1) There would be a relationship among social support, coping strategies and quality of life in women with infertility.
2) Infertile women with high social support would be better in terms of social, psychological and environmental domains of quality of life than the infertile women with less social support.
3) Women with primary and secondary infertility would differ in terms of quality of life.
4) Social support and coping strategies would predict the quality of life of infertile women.

3. METHDOLOGY

3.1. Research Design

Purposive sampling technique used in this study to measure Quality of life, coping strategies and social support among young infertile women with primary and secondary infertility.

3.2. Sample

A sample of 50 infertile young women with primary and secondary infertility was taken; age ranges between 23-35 years.

3.3. Inclusion Criteria

Inclusion criteria for present study were infertile women with primary and secondary infertility with age ranges between 25 – 35 years.

3.4. Exclusion Criteria

Exclusion criteria for present study are those women who were not infertile within the age range of 25- 35 years.

3.5. Instruments

3.5.1. Demographics

The demographics information was consisted of age, marriage duration, family type, area of living, type of marriage, previous pregnancy, husband education, husband profession, relationship with husband and husband age.

Table 3.5.1: *Demographic characteristics of participants (N=50)*

Source	*F*	%
Age		
25-30	26	52.0
30-35	24	48.0
Marriage duration		
1-5	13	26.0
5-10	19	38.0
11-15	18	36.0
Family type		
Nuclear	41	82.0
Joint	9	18.0
Type of marriage		
Arranged	33	66.0
Love	17	34.0
Previous pregnancy		
Yes	28	56.0
No	22	44.0
Husband education		
Matric	18	36.0
Intermediate	24	48.0
Bachelors	8	16.0
Husband profession		
Job	17	34.0
Business	33	66.0
Relationship with husband		
Good	25	50.0
Bad	25	50.0
Husband age		
25-30	25	50.0
31-35	25	50.0

3.5.2. WHOQOL-BREF

For the evaluation of quality of life in this research, WHOQOL-BREF was used. This scale was developed by WHO and is a shortened version of WHOQOL-100. WHOQOL-BREF has been developed by WHO tocreate a tool for short assessment for quality of life. The scale consists of 26 items. The scale has four domains (1) physical domain, (2) psychological domain, (3) social domain and (4) environmental domain. The WHOQOL was used in order to measure the physical health of infertile women, psychological health of infertile women, social interaction of infertile women and environmental interaction of infertile women.

3.5.3. The Multidimensional Scale Of Perceived Social Support (MSPSS)

In 1988, MSPSS was developed by Zimet, Dalhem, Zimet, & Farley. The purpose to create this scale is to measure social support. MSPSS has 3 dimensions which are friends, family and significant others. The scale comprises of 12 items. The responses of scale are in seven types, likert type format within the range of 7= strongly agree and 1 = strongly disagree. The scoring is done by summing all items and divided by 12. The result can be in between 12-84. The higher the result score, the higher the perceived social support.

3.5.4. The COMPI Coping Strategy Scales (Schimdt et al, 2005)

Schimdt in 1996 developed a questionnaire for the coping strategies. This questionnaire is used in order to find which coping scale is mostly used by infertile women. The scale consists of 19 items with 4 subscales. The first subscale is active avoidance which is measured by item no 1, 2, 3 and 4. The second subscale is active confrontation which is measured by item 5,6,7,8,9,10 and 11. The third subscale is passive avoidance which is measured by item 12, 13, 14. The fourth subscale is meaning based coping which is measure by item 15 to 19. Responses comprises of four point likert scale range between 1= not used at all to 4= mostly used.

3.6. Procedure

The study is quantiative in nature. A sample of 50 infertile women with primary and secondary infertility was taken from the hospitals and private clinics of Lahore. Participants were briefed about the aim of study. Questionnaires were administered to the participants. The participants were assured that the information will be kept confidential. Participants were asked to be honest while responding to the questions Demographic characteristics asked by the participants. Their right to withdraw from the study was kept reserved. The purpose of the study was explained to the participants and their queries were addressed. At the end, participants were thanked for their cooperation.

3.7. Ethical considerations

- First of all, permission and ethical approval were taken from the authors of the scales through mails to use assessment tools for research.
- Informed consent was attached with the questionnaire.
- Participants were assured that their personal information and responses will be kept confidential and the data will be used only for the research purpose.
- No deception was used.
- The purpose of this study and the time required to fill the questionnaire was briefly explained to the participants.

3.8. Statistical Analysis:

For the data analysis, SPSS 21(statistical package for the social sciences) was used. Both descriptive and inferential statistics were used to analyze the data. Pearson Product Moment Correlation (PPMC) was used to find out the relationship between all variables of study.

4. RESULTS

For the analysis of data collected in order to do this research we used IBM SPSS version 23 . Multiple Statistical Analysis was applied in order to find out the results.

Pearson correlation was used to investigate that how Quality of life and its domains (physical, psychological, social and environmental), Perceived Social support and coping strategies are correlated. Results are shown in table 4.2. in order to find significance difference among women with primary and secondary infertility in terms of — Quality of life and its domains (physical, psychological, social and environmental), Perceived Social support and coping strategies T-test was used. Results are shown in table 4.3

To explore the significance difference in terms of love and arranged marriage with respect to Quality of life and its domains (physical, psychological, social and environmental), Perceived Social support and coping strategies T-test was used.. Results are shown in table 4.4. Multivariate ANOVA was used to explore the significance relationship among previous pregnancy and relationship with husband. Results are shown in table 4.5.

Table 4.1: *Reliability of Quality of life, Coping strategies and Social support Scales.*

Variables	K	M	*SD*	*α*
Quality of life	26	65.3200	7.47633	0.621
Coping strategies	19	44.4800	6.39273	0.730
Social support	12	29.6800	10.80333	0.889

Reliability analyses revealed that internal consistency of all the scales were acceptable such as alpha coefficient value of Quality of life is moderate i.e 0.62. Further analysis revealed that coping strategy scale holds the alpha coefficient value of 0.730 which is good. The last scale detects social support which holds the alpha coefficient value of 0.889 which is very high.

Table 4.2: *Pearson correlation showing relationship between Quality of life, COMPI scale and MSPSS Scale for infertile women.*

Variable	1	2	3	4	5	6	7
Physical health	-	.134	.353*	-.187	-.166	.164	-.014
Psychological Health domain	.134	-	.092	.158	-.094	.117	-.073
Social domain	.353*	.092	-	-.044	.006	.248	-0.86
Environmental domain	-.187	.158	-.044	-	-.158	.685**	.215
Social support	-.166	-.094	.006	-1.58	-	-.096	.019
Quality of life	.164	.117	.248	.685**	-.096	-	.034
Coping strategies	-.014	-.073	-.086	.215	.019	.034	-

*Note: *P< .05, **P< .01*

There was a significant positive correlation between physical health and social health of infertile women (r=-.353*) and significant positive correlation between environmental health and quality of life (r=.685**).

Table no 4.3: *Independent Sample t-test analysis showing significant differences among environmental domain, and quality of life among infertile women with primary and secondary infertility (N=50)*

Variables	Primary infertility	Secondary infertility	t	p	Confidence interval		Cohen's d
	M(SD)	M(SD)			LL	UL	
Physical domain	15.8214(3.4539)	15.7273(2.93066)	.102	.919	-1.75922	1.94753	0.029
Psychological domain	16.7500(7.71062)	16.1818(2.06182)	.336	.739	-2.83536	3.97172	0.100
Social domain	5.1071(1.72861)	4.9091(1.74326)	.401	.690	-.79583	1.19194	0.114
Environmental domain	22.1429(3.60775)	24.6364(4.42445)	-2.19	.033	-4.77665	-21037	-0.61
Social support	31.2500(11.3647)	27.7727(10.18838)	1.123	.267	-2.74699	9.70154	0.322
Quality of life	65.5000(7.33081)	69.9091(7.35436)	-2.10	.040	-8.61432	-20386	-0.60
Coping strategies	51.5357(9.14283)	52.0909(8.90109)	-.216	.830	-5.73238	4.62199	-0.06

Results indicated that there was a significant difference between environmental domain of primary and secondary infertile women with (t (50) = -2.19, p< .005). Thus, primary infertile women (M= 22.1429, SD=3.60775) had lower environmental health than secondary infertile women (M=24.6364 , SD=4.42445).

Figure 4.2:

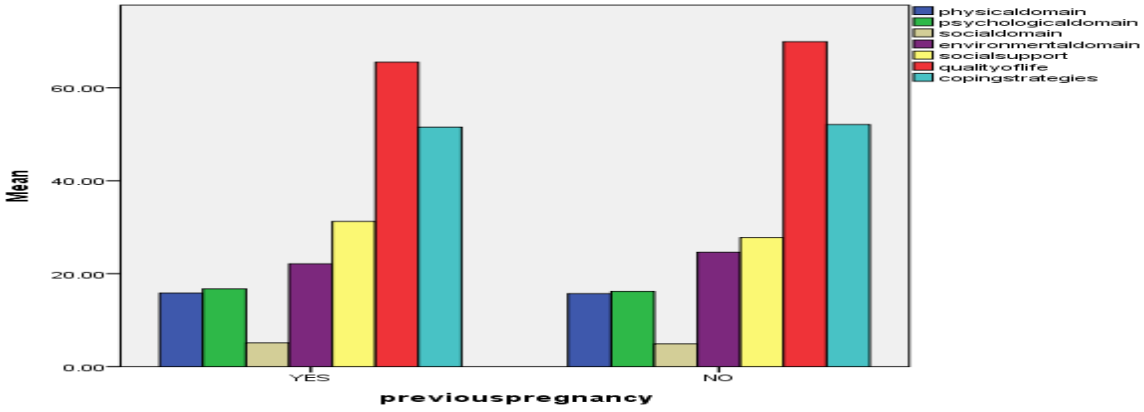


Table no 4.4: *Independent Sample t-test analysis showing significant differences among Psychological domain among infertile women with love and arrange marriage(N=50)*

Variables	Arrange Marriage	Love Marriage	t	p	Confidence interval		Cohen's d
	M(SD)	M(SD)			LL	UL	
Physical domain	15.6970(3.23540)	15.9412(3.23014)	-.253	.929	-2.18522	1.69681	-0.07
Psychological domain	15.8788(1.76348)	17.7059(9.87905)	-1.04	.049	-5.35817	1.70398	-0.25
Social domain	4.7879(1.76348)	5.4706(1.58578)	-1.34	.077	-1.70693	.34151	-0.40
Environmental domain	22.6364(4.24866)	24.4118(3.75930)	-1.45	.367	-4.23168	.68088	-0.44
Social support	28.7576(10.44937)	31.5882(11.81132)	-.868	.314	-9.38680	3.72549	-0.25
Quality of life	66.5455(7.37009)	69.1765(7.94698)	-1.16	.615	-7.17332	1.91129	-0.34
Coping strategies	50.4848(9.52996)	54.2941(7.31236)	-1.44	.249	-9.12316	1.50462	-0.44

Results indicated that there was a significant difference between psychological health of infertile women with arrange and love marriage with (t (50) = -1.04, p< .005). Thus, infertile women with love marriage (M= 17.7059, SD= 9.87905) had higher psychological health than infertile women with arrange marriage (M= 15.8788, SD=1.76348).

Figure 4.3:

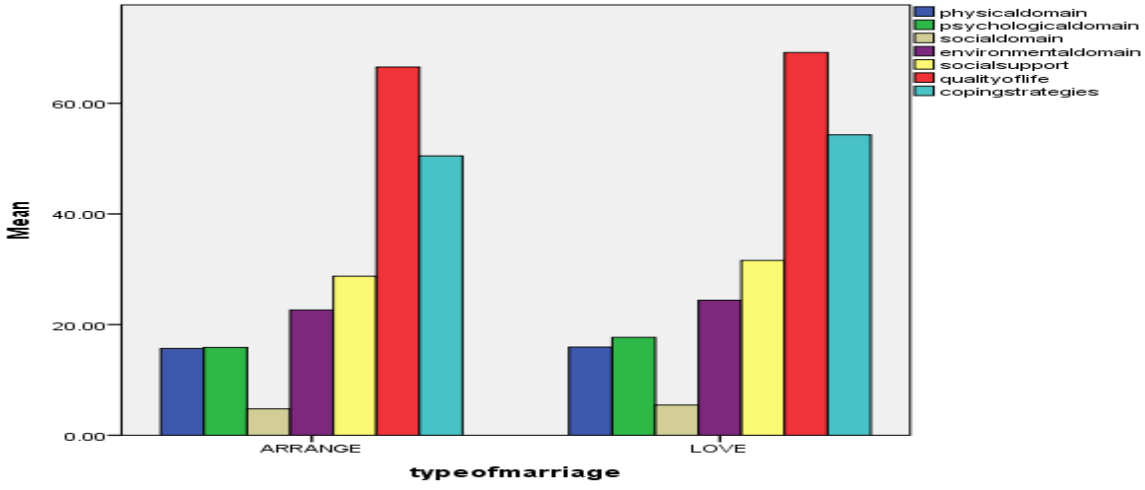


Table no 4.5: *Multivariate ANOVA analysis to find effect of Previous pregnancy and relationship with husband among infertile women.*

Source of variable	DV	df	MS	F	p	Partial n^2	Observed power
Previous pregnancy	Physical health domain	1	.109	0.010	.920	0.000	0.051
	Psychological health domain	1	3.977	.111	.741	0.002	0.062
	Social domain	1	.483	.166	.685	0.004	0.068
	Environmental domain	1	76.601	4.684	.036	0.092	0.563
	Social support	1	148.966	1.210	.277	0.026	0.190
	Quality of life	1	239.502	4.788	.034	0.094	0.572
	Coping strategies	1	3.798	.406	.830	0.001	0.055
Relationship with husband	Physical health domain	1	5.143	.477	.493	0.010	.104
	Psychological health domain	1	22.800	.634	.430	0.014	.122
	Social domain	1	9.679	3.327	.075	0.067	.431
	Environmental domain	1	2.195	.134	.716	0.003	0.065
	Social support	1	2.582	.021	.885	0.000	0.052
	Quality of life	1	25.833	.516	.476	0.011	0.108
	Coping strategies	1	122.952	1.504	.226	0.032	0.225
Previous pregnancy * relationship with husband	Physical health domain	1	.983	.091	.764	0.002	0.060
	Psychological health domain	1	12.240	.340	.563	0.007	0.088
	Social domain	1	1.839	.632	.431	0.014	0.122

	Environmental domain	1	8.915	.545	.464	0.012	0.112
	Social support	1	.422	.003	.954	0.000	0.050
	Quality of life	1	276.073	5.519	.023	0.107	0.633
	Coping strategies	1	22.152	.271	.605	0.006	0.080
error	Physical health domain	46	10.776				
	Psychological health domain	46	35.976				
	Social domain	46	2.910				
	Environmental domain	46	16.335				
	Social support	46	123.126				
	Quality of life	46	50.023				
	Coping strategies	46	81.758				
Total	Physical health domain	50					
	Psychological health domain	50					
	Social domain	50					
	Environmental domain	50					
	Social support	50					
	Quality of life	50					
	Coping strategies	50					

Previous pregnancy had highly significant effect on the environmental domain of quality of life (F (=.166 p<.05) and overall quality of life of infertile women (F =4.788 p<.05) but not significantly effect on other social support and coping strategies (p>.05). Relationship with husband had highly significant effect on social domain of quality of life (F (1,200) =6.493 p<.01). Moreover previous pregnancy ^{x} relationship with husband also have significant effect on quality of life of infertile women.

5. Discussion

The study was carried out to investigate the impact of primary and secondary infertility of young women and their quality of life, social support and coping strategies.

The correlation analysis has indicated that physical health has a significant positive relationship with how good can be social quality of life of an infertile women. .previous researches also indicated that physical health and social health are correlated. Research on topic "An investigation of the effects of infertility on Women's quality of life: a case-control study" showed that infertility directly effects the physical, social interaction and mental health of infertile women (Katayoun Bakhtiyar and all). This clearly means that these three domains of quality of life are correlated. Environmental domain has a positive relationship with the quality of life. However, no significance relationship was found among quality of life, social support and coping strategies.

The positive relationship between the physical and social domain of quality of life indicates that they strengthen each other. This means that women with good social interaction and support have a better quality of life. Xiying Chu, Yaoguo Geng, Ruiping Zhang, and Wenjing Guo did a reseach on topic "Perceived Social Support and Life Satisfaction in Infertile Women Undergoing Treatment: A Moderated Mediation Model" which shows the results that perceived social support results in higher self-compassio which leads to higher life satisfaction. (Xiying Chu and all). .

The comparison of women with primary and secondary infertility indicates that women with primary infertility have better environmental well-being than the women with secindary infertility. However, there is no significant difference between women with primary and secondary infertility and their domains of quality of life. In a previous research "Quality of life and associated factors among infertile women attending infertility clinic at Mnazi Mmoja Hospital, Zanzibar" Suleiman, August, Nanyaro, Wangwe, Kikula, Balandya, Ngarina & Projestine Muganyizi concluded that the average quality of life of women with primary infertility is less than the women with secondary infertility. This clearly means that primary infertile women have better quality of life in physical, psychological, social and environmental domains.

The comparisons of women with arrange and love marriage showed that women with love marriage have better psychological health than infertile women with arrange marriage. A research on " The Role of Perceived Social Support and Coping Styles in Predicting Adolescents' Positivity" by Çevik, Yıldız showed that people married for love are involuntary childless but according to them they had a good quality time with their husbands and are in good psychological health. However there is no significant difference between women with love and arrange marriage in coping strategies and other domains of quality of life.

The results of MNOVA indicated that previous pregnancy has significant effect on environmental domain of quality of life. And relationship with husband also has a significant effect on social domain of quality of life. Results by MNOVA also showed that previous

pregnancy and relationship with husband results in good quality of life of infertile women. Previous literature on topic "Correlation between Marital Satisfaction and Mental Health in Infertile Couples referred to Kosar Infertility Clinic in Urmia: A Cross-Sectional Study" also showed that bad marital relationship has an adverse effect on mental health of infertile women (Hamideh Mohaddesi and all). This indicated that infertile women are affected by their bad marital relationship and had a devastating effect on overall quality of life. .

5.1. Limitations:

The study was totally quantitative in nature however; the study should also be investigated by the help of qualitative techniques.. Secondly, the sample of this study are only women, but in my opinion the study also conducted on men.

5.2. Suggestions:

Despite of above mentioned limitations, the current study provides in-depth information related to infertility, how social support helps in the quality of life women and spread awareness to proper address about how important are the coping strategies for better well-being of infertile women in Pakistan culture.

6. Conclusion

The study's empirical findings illuminate critical interdependencies shaping infertile women's quality of life (QoL), with a significant positive correlation between the social domain and physical health underscoring their symbiotic reinforcement. Robust social networks encompassing familial affirmation, peer companionship, and communal integration directly bolster physical well-being by mitigating stress-induced physiological burdens such as hypertension, immune suppression, and sleep disturbances commonly exacerbated by infertility stigma. This bidirectional linkage aligns with biopsychosocial models, where perceived belongingness activates neuroendocrine pathways (e.g., oxytocin release) that enhance somatic resilience, while physical vitality enables sustained social engagement. Similarly, the pronounced positive association between overall QoL and environmental factors highlights how access to supportive infrastructures reliable healthcare, economic stability, safe habitats amplifies life satisfaction. Women navigating infertility in resource-rich environments report heightened agency in treatment pursuit and stigma negotiation, contrasting sharply with those in deprived settings where logistical barriers compound psychological strain. Notably, absent significant ties with social support or coping strategies suggest contextual nuances; in Pakistan's collectivist milieu, external support may be culturally mandated yet superficial, failing to penetrate core distress unless internalized through adaptive mechanisms.

Comparative analyses further reveal relational and diagnostic moderators of QoL. Infertile women in love marriages exhibit superior psychological health, attributable to volitional partner selection fostering emotional intimacy, mutual empathy, and collaborative coping dynamics often attenuated in arranged unions where familial pressures predominate. Concomitantly, harmonious spousal relationships emerge as a cornerstone of elevated QoL, buffering against abandonment fears and second-marriage threats that plague discordant pairings. Intriguingly, primary infertility confers more favorable outcomes than secondary, with affected women demonstrating higher environmental QoL; those without prior pregnancies may harbor optimistic treatment narratives and lesser grief accumulation compared to secondary cases marked by recurrent loss trauma. These differentials challenge monolithic infertility narratives, advocating tailored interventions enhancing spousal dialogue in arranged contexts, environmental resource allocation, and primary-focused psychosocial support to optimize QoL trajectories in Pakistan's infertility landscape.

Refrences

Arbağ, E., Tokat, M. A., & Fata, S. (2023). Emotions, thoughts, and coping strategies of women with infertility problems on changes in treatment during Covid-19 pandemic: A qualitative study. *Womens Studies International Forum*, *98*, 102735. https://doi.org/10.1016/j.wsif.2023.102735

Çevik, G. B., & Yildiz, M. A. (2017). The role of perceived social support and coping styles in predicting adolescents' positivity. *Universal Journal of Educational Research*, *5*(5), 723–732. https://doi.org/10.13189/ujer.2017.050504

Chu, X., Geng, Y., Zhang, R., & Guo, W. (2021a). Perceived social support and life satisfaction in infertile women undergoing treatment: a moderated mediation model. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.651612

Chu, X., Geng, Y., Zhang, R., & Guo, W. (2021b). Perceived social support and life satisfaction in infertile women undergoing treatment: a moderated mediation model. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.651612

Dovom, M. R., Tehrani, F. R., Abedini, M., Amirshekari, G., Hashemi, S., & Noroozzadeh, M. (2014). A population-based study on infertility and its influencing factors in four selected provinces in Iran (2008-2010). *PubMed*, *12*(8), 561–566. https://pubmed.ncbi.nlm.nih.gov/25408706

Dube, L., Nkosi-Mafutha, N. G., Balsom, A. A., & Gordon, J. L. (2021). Infertility-related distress and clinical targets for psychotherapy: a qualitative study. *BMJ Open*, *11*(11), e050373. https://doi.org/10.1136/bmjopen-2021-050373

Hasanpoor-Azghdy, S. B., Simbar, M., & Vedadhir, A. (2014). The emotional-psychological consequences of infertility among infertile women seeking treatment: Results of a qualitative study. *PubMed*. https://pubmed.ncbi.nlm.nih.gov/24799871

Hassan, S., Siddiqui, S., & Friedman, B. D. (2019). Health status and quality of life of women seeking infertility treatments in Baluchistan, Pakistan. *British Journal of Social Work*, *50*(5), 1401–1418. https://doi.org/10.1093/bjsw/bcz130

Iordăchescu, D., Paica, C. I., Boca, A. E., Gică, C., Panaitescu, A. M., Peltecu, G., Veduta, A., & Gică, N. (2021). Anxiety, difficulties, and coping of infertile women. *Healthcare*, *9*(4), 466. https://doi.org/10.3390/healthcare9040466

Jing, X., Gu, W., Zhang, L., Miao, R., Xu, X., Wang, M., Ramachandran, H. J., & Wang, W. (2021a). Coping strategies mediate the association between stigma and fertility quality of life in infertile women undergoing in vitro fertilization-embryo transfer. *BMC Women's Health*, *21*(1). https://doi.org/10.1186/s12905-021-01525-9

Jing, X., Gu, W., Zhang, L., Miao, R., Xu, X., Wang, M., Ramachandran, H. J., & Wang, W. (2021b). Coping strategies mediate the association between stigma and fertility quality of life in infertile women undergoing in vitro fertilization-embryo transfer. *BMC Women's Health*, *21*(1). https://doi.org/10.1186/s12905-021-01525-9

Khalid, A., & Dawood, S. (2020). Social support, self-efficacy, cognitive coping and psychological distress in infertile women. *Archives of Gynecology and Obstetrics*, *302*(2), 423–430. https://doi.org/10.1007/s00404-020-05614-2

Kiani, Z., Simbar, M., Hajian, S., & Zayeri, F. (2020). Quality of life among infertile women living in a paradox of concerns and dealing strategies: A qualitative study. *Nursing Open*, *8*(1), 251–261. https://doi.org/10.1002/nop2.624

Mohaddesi, H., Khalkhali, H. R., Behrozi-Lak, T., Rasouli, J., Nemoon, R. E., & Ghasemzadeh, S. (2022). Correlation Between Marital Satisfaction and Mental Health in Infertile Couples referred to Kosar Infertility Clinic in Urmia: A Cross-Sectional Study. *Journal of Obstetrics, Gynecology and Cancer Research*, *7*(4), 341–347. https://doi.org/10.30699/jogcr.7.4.341

Mohammadi, M., Samani, R. O., Navid, B., Maroufizadeh, S., & Sabeti, S. (2018). Coping strategy in infertile couples undergoing assisted reproduction treatment. *Middle East Fertility Society Journal*, *23*(4), 482–485. https://doi.org/10.1016/j.mefs.2018.07.004

Monticone, M., Ferrante, S., Giorgi, I., Galandra, C., Rocca, B., & Foti, C. (2014). The 27-Item Coping Strategies Questionnaire — Revised: Confirmatory Factor Analysis, Reliability and Validity in Italian-Speaking Subjects with Chronic Pain. *Pain Research & Management*, *19*(3), 153–158. https://doi.org/10.1155/2014/956828

Namdar, A., Naghizadeh, M. M., Zamani, M., Yaghmaei, F., & Sameni, M. H. (2017). Quality of life and general health of infertile women. *Health and Quality of Life Outcomes*, *15*(1). https://doi.org/10.1186/s12955-017-0712-y

Qadir, F., Khalid, A., & Medhin, G. (2015). Social support, marital adjustment, and psychological distress among women with primary infertility in Pakistan. *Women & Health*, *55*(4), 432–446. https://doi.org/10.1080/03630242.2015.1022687

Saif, J., Rohail, I., & Aqeel, M. (2021). Quality of Life, Coping Strategies, and Psychological Distress in Women with Primary and Secondary Infertility; A Mediating Model. *Research Gate*, *1*(1), 8–17. https://doi.org/10.53107/nnjp.v1i1.6

Simon, A., & Laufer, N. (2012). Repeated implantation failure: clinical approach. *Fertility and Sterility*, *97*(5), 1039–1043. https://doi.org/10.1016/j.fertnstert.2012.03.010

Steuber, K. R., & High, A. C. (2015). Disclosure strategies, social support, and quality of life in infertile women. *Human Reproduction*, *30*(7), 1635–1642. https://doi.org/10.1093/humrep/dev093

Tang, N., Jia, Y., Zhao, Q., Liu, H., Li, J., Zhang, H., Lin, H. C., & Huangfu, C. (2022). Influencing factors of dyadic coping among Infertile women: a Path analysis. *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.830039

Yazdi, H. Z. G., Sharbaf, H. A., Kareshki, H., & Amirian, M. (2020). Infertility and Psychological and Social health of Iranian infertile women: a systematic review. *Iranian Journal of Psychiatry*. https://doi.org/10.18502/ijps.v15i1.2441

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment*, *52*(1), 30–41. https://doi.org/10.1207/s15327752jpa5201_2