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Authors

Shobit Garg¹, Manaswi Gautam², T. S. Sathyanarayana Rao³

Affiliations

¹MBBS, DPM, MD. Professor, Department of Psychiatry, Shri Guru Ram Rai Institute of Medical and Health Sciences, Dehradun, Uttarakhand, India. ORCID: 0000-0001-5913-9021

²MBBS, DPM, MD, Fellowship in Psychosexual Medicine. Associate Professor of Psychiatry, JNUMER, Jaipur; and Senior Consultant Psychiatrist & Director, Gautam Hospital and Research Centre, Jaipur, Rajasthan, India.

³MD (Psychiatry). Professor Emeritus, Department of Psychiatry, JSS Medical College and Hospital, JSS Academy of Higher Education and Research, Mysuru, Karnataka, India.

Corresponding author

Prof. Shobit Garg, Department of Psychiatry, Shri Guru Ram Rai Institute of Medical and Health Sciences, Patel Nagar, Dehradun – 248001, Uttarakhand, India.

Phone: +91 8959534261

Email: shobit.garg@gmail.com

ORCID: 0000-0001-5913-9021

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19 October 2026

To

The Editor

Indian Journal of Psychiatry

Subject: Submission of the Clinical Practice Guideline “Assessment and Management of Sexual Issues in Infertility”

Dear Editor,

On behalf of all the authors, I am pleased to submit the manuscript entitled “Assessment and Management of Sexual Issues in Infertility” for consideration for publication in the Indian Journal of Psychiatry as part of the Indian Psychiatric Society Clinical Practice Guidelines for Psychosexual Health, Dysfunction and Disorders.

Sexual difficulties are a frequent consequence of infertility and, in a real minority of couples, its actual cause, yet they remain the least discussed part of fertility care. Our review of the major international infertility and urological guidelines found that none commits to routine, structured screening of sexual function in the infertile couple. This guideline addresses that gap from a psychiatric perspective and for Indian practice. It sets out a reciprocal model linking infertility, sexual dysfunction and treatment; a structured assessment framework for both partners, including confirmation that penetration and intravaginal ejaculation are occurring; a stepped-care management pathway; and ten graded recommendations. It also addresses the social realities of infertility in India and the counselling mandate of the Assisted Reproductive Technology (Regulation) Act, 2021 and the Surrogacy (Regulation) Act, 2021.

The manuscript has been revised in response to the comments of the Sub-Committee reviewers. It contains an executive summary, 3,096 words of main text, 23 references, five tables and two figures. All references have been verified against PubMed.

We confirm that this manuscript is original, has not been published previously and is not under consideration for publication elsewhere. All authors have read and approved the final manuscript and agree with its submission to the Indian Journal of Psychiatry. The authors declare no conflicts of interest, and the work received no financial support.

Thank you for considering our submission. We look forward to hearing from you.

Yours sincerely,

Prof. Shobit Garg

MBBS, DPM, MD

Professor, Department of Psychiatry

Shri Guru Ram Rai Institute of Medical and Health Sciences

Patel Nagar, Dehradun – 248001, Uttarakhand, India

Phone: +91 8959534261 | Email: shobit.garg@gmail.com

ORCID: 0000-0001-5913-9021

On behalf of the co-authors: Dr Manaswi Gautam and Prof. T. S. Sathyanarayana Rao

Assessment and Management of Sexual Issues in Infertility

EXECUTIVE SUMMARY

There is a reciprocal relationship between sexual dysfunction and infertility. The distress of childlessness, comorbid depression and anxiety, and the demands of fertility treatment all erode sexual function. A sexual problem may be the entire reason that a couple cannot conceive. The most common damage is caused by timed intercourse, which turns sex into a monthly chore that erodes desire and leads to performance failure in both partners. In a real minority of couples, failure to conceive is due to an unconsummated marriage, erectile or ejaculatory failure or vaginismus, and these are usually curable problems once they are named. In India, the burden falls disproportionately on the woman, who bears the blame, the stigma and the threat to the marriage even when the biological factor lies with the man. However, sexual function is rarely addressed in the fertility clinic, and no current infertility guideline commits to routine, structured screening for sexual problems. This guideline recommends that all infertile couples be asked about their sexual functioning, both individually and as a couple; that the clinician confirm that penetration and intravaginal ejaculation are actually occurring; that brief validated instruments supplement rather than replace a sensitive interview; and that couples be helped to decouple sex from the ovulation calendar. Sex therapy and sensate focus are first-line treatments for specific dysfunctions, and cognitive behavioural and mind-body interventions reduce distress. Comorbid depression and anxiety should be treated with fertility-appropriate pharmacotherapy. The psychiatrist should be part of the fertility team, and counselling, a mandatory part of Indian assisted reproduction and surrogacy law, offers a standard point of entry.

Keywords: Infertility; sexual dysfunction; psychosexual; assisted reproductive techniques; clinical practice guideline; India

Introduction

Infertility is not just a reproductive problem. For the couple who are living it, it is a slow strain on mood, on the marriage and, very often, on their sexual life. It is a familiar story: some one in eight couples of reproductive age seek help to conceive, and around 85% of them have an identifiable cause, with male factors contributing to almost half of cases.^[1] In India the numbers are large in absolute terms and carry a social weight that is hard to overstate, for a marriage without a child is still largely seen as a marriage that has failed.^[2]

All of this has to do with sex, yet it is the least discussed part of the fertility clinic. The couple have come for a baby, the clinician is looking at ovulation and semen parameters, and no one is asking whether they are still able to enjoy sex, or even to have it. This is a mistake, because sexual difficulty is a common consequence of infertility and, in a real minority of couples, its actual cause. What is needed is a guideline that tells the clinician what to ask, how to assess it and what to do.

This is a deliberately narrow chapter. It concerns the sexual problems of the infertile couple — how to identify them, how to evaluate them and how to treat them — and the psychological dimension that accompanies them. The wider psychiatric morbidity of infertility is considered only in terms of its impact on sexual function and the couple's ability to remain in treatment. The intention is to provide a set of clear, graded and usable recommendations for the Indian psychiatrist and the fertility team working together.

The Interaction Between Sexual Function and Infertility

The relationship is reciprocal, and it is worth being clear which way it points in a particular couple, because the treatment differs.

Sex is disturbed by infertility. The diagnosis itself is painful — a man told his semen analysis is abnormal, a woman told her tubes are blocked, each takes it as a verdict on their worth as a partner. Erectile function improves after a child is born, which tells us how much of the dysfunction was the distress of childlessness rather than any fixed organic fault.^[3] Anxiety and low mood, very common in this group, independently worsen desire and arousal in both sexes.^[4]

Sex disrupts fertility. In its most severe form, if a couple cannot complete intercourse they cannot conceive naturally, and the sexual problem is the only cause of their infertility. Short of that, erectile failure on the “right” day, or ejaculatory difficulty, can sabotage conception in a couple who are otherwise fertile.

And the process of treatment further disrupts sex. The worst element is timed intercourse — sex by the calendar, sex without desire, sex as a performance with a deadline. In men with long-standing, known subfertility, rates of erectile dysfunction and premature ejaculation increase with the duration and severity of the problem, and timed intercourse becomes much more frequent.^[5] The pathways are set out in Table 1.

Sexual Dysfunction in the Infertile Couple

Sexual dysfunction is more frequent in infertile couples than in the fertile population, and it affects both partners. Studies using standard instruments have found female sexual dysfunction in a third to a half of infertile women, with desire, arousal, orgasm and satisfaction all affected.^[4,9] The signal is not always uniform — some controlled studies suggest that the excess risk is carried largely by comorbid anxiety and depression rather than infertility as such^[4] — but the clinical burden in the clinic is real and worth screening for.

In men, the most frequent complaints are erectile dysfunction and premature ejaculation, both of which tend to occur in those with long-standing, known impairment of semen quality.^[3,5] In women, low desire and arousal difficulty predominate, with dyspareunia and vaginismus particularly important because they can directly prevent conception.

That last group deserves emphasis. In couples who appear “infertile” but have never consummated the marriage, the problem is sexual, not reproductive. Series of unconsummated marriage show that it is due to male factors (chiefly erectile dysfunction), female factors (vaginismus and dyspareunia) or both, and that couple-oriented sex therapy resolves the majority.^[6] These couples are missed if no one directly asks whether penetrative intercourse is actually occurring. Table 2 maps the common dysfunctions and their relevance to fertility.

Psychiatric Morbidity in Infertility

Depression and anxiety are common in infertility and are relevant here for two reasons: they independently impair sexual function, and they endanger adherence to infertility treatment. The

distress is not trivial low mood but, in many, clinically significant anxiety and depressive symptoms, with grief, self-blame and a sense of failure running through it.^[4,8]

The burden is gendered. Women more often carry the psychological load, the social blame and the treatment, and report higher distress; but men are affected too, often silently, and their sexual symptoms are frequently the only outward sign. Depressed mood and sexual dysfunction reinforce each other; consequently, treating the mood disorder is often the most effective way of restoring sexual function.^[4]

The psychiatrist should be alert to severe presentations — hopelessness, and sometimes suicidal ideation, especially after repeated failed cycles or a lost pregnancy — and assess these directly when the clinical picture warrants, rather than screening indiscriminately.

Sexual and Psychosocial Outcomes of Assisted Reproduction

Assisted reproduction preserves fertility but at a cost to the couple. In vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) cycles repeatedly interrupt the sexual relationship — instructions to abstain, semen production on demand in a clinic room, the emotional exhaustion of the two-week wait, and the crash of a failed cycle.^[1] Each failed cycle adds to cumulative distress, and sexual avoidance can set in as the couple comes to associate sex with disappointment.

Third-party reproduction — donor gametes or surrogacy — carries its own stress, involving secrecy, disclosure and each partner's sense of genetic connection to the child, all of which can play out in the bedroom. It is the clinician's job to anticipate these touch points, not to wait for the couple to mention them. Figure 1 shows the anticipated trajectory of sexual and psychological problems through the assisted reproductive technology (ART) pathway.

The Indian Context

None of this can simply be lifted from Western practice, because the social frame is different. In India, childlessness is seldom a personal matter between two people; it is a family and community issue, and the woman is disproportionately blamed, regardless of where the biological factor lies. Indian clinics show that a large number of women seeking fertility help are in significant psychological distress, compounded by stigma, low reproductive knowledge and prevailing myths.^[7]

- **Marital threat and blame.** The woman is presumed at fault, is under pressure from the marital family and may live under the real threat of a second marriage or desertion. Sexual withdrawal is common in such a marriage and seldom volunteered.
- **Cultural idioms and beliefs.** Beliefs about semen loss and “weakness”, and about the causes of childlessness, shape the couple's understanding of their problem and must be addressed directly rather than dismissed.
- **Male help-seeking and consummation.** Men come forward late and are reluctant to present; unconsummated marriage presenting as “infertility” is seen regularly and is eminently treatable once identified.
- **The legal framework.** Practice is now regulated under the Assisted Reproductive Technology (Regulation) Act, 2021 and the Surrogacy (Regulation) Act, 2021, both of

which mandate counselling of couples — a statutory opening the psychiatrist and the fertility team should use, not merely comply with.

A guideline written for Indian practice must therefore address the couple within their family and social reality, not as an isolated dyad.

Assessment

Assessment begins with asking permission. A short, normalising statement — that sexual problems are common when couples are trying to conceive and that the clinician asks everyone — removes much of the awkwardness. Both partners should be evaluated, and there must be an opportunity to see each one alone as well as together, because information about a non-consummated marriage, or about sexual aversion, often emerges only in private.

A structured sexual and reproductive history should establish whether penetrative intercourse is occurring and, if it is, whether it ends in intravaginal ejaculation, how often and when, and whether there are erectile, ejaculatory, desire, arousal, orgasmic or pain problems in either partner. Brief validated instruments help but do not substitute for the interview: the International Index of Erectile Function (IIEF) for men, the Female Sexual Function Index (FSFI) for women, and a psychotropic-sensitive scale such as the Arizona Sexual Experiences Scale (ASEX) or the Psychotropic-Related Sexual Dysfunction Questionnaire (PRSexDQ-SALSEX) when drug effects are suspected; the ASEX has been used specifically in infertile couples and can identify those needing specialist referral.^[9] Standard tools should be used to screen for comorbid depression and anxiety. The framework is shown in Table 3.

Warning signs for referral to a psychiatrist

- Unconsummated marriage or complete sexual aversion
- Erectile or ejaculatory dysfunction that prevents conception
- Penetration without intravaginal ejaculation (anejaculation, delayed or retrograde ejaculation)
- Vaginismus or severe dyspareunia
- Severe depression, hopelessness or any suicidal ideation
- Sexual dysfunction after starting a psychotropic

Particular consideration should be given to sexual aversion. It is different from mere low desire and is readily overlooked when a couple only presents as "infertile." It is a chronic, phobic avoidance of sexual contact, characterized by anxiety, disgust, or even panic at the idea of intimacy. Its relevance is straightforward: an unconsummated marriage is often caused by aversion to penetrative sex, which is a barrier to conception in and of itself.^[6] Because couples rarely offer it, it typically only manifests when each partner is viewed alone. It may be primary or secondary to the constant strain of scheduled sex and repetitive procedures.^[4] A suspected aversion should lead to an early referral rather than another cycle of timed attempts because it is treatable by graded exposure, sensate attention, and therapy of the underlying fear, which allows most couples to resume sexual activity.

Management

Management is couple-centred, stepwise and delivered in partnership with the fertility team. The intervention focuses on the couple rather than the individual, and its intensity is tailored to the severity of the problem.

Non-pharmacological

Psychoeducation comes first and goes a long way: dispelling myths, explaining that timed intercourse is one means and not the whole of their sexual life, and giving permission to have sex that is not aimed at conception. Sensate-focus and sex therapy are the treatments of choice for specific dysfunctions (vaginismus, erectile difficulty, unconsummated marriage), and couple-oriented therapy resolves most cases of non-consummation.^[6] Cognitive behavioural therapy (CBT) reduces depression, anxiety and infertility-specific stress and improves quality of life in this population,^[10] and psychological and mind-body interventions are associated with reduced distress and, in some analyses, modestly higher pregnancy rates.^[8,11]

Pharmacological

Where a depressive or anxiety disorder is present, it should be treated, because it is a source of suffering and a drag on sexual function and adherence. Drug choice should weigh fertility and the periconception window; agents with a lower burden of sexual side effects are preferred where possible, and teratogenic risk must be considered for any woman of child-bearing potential. Treatment-emergent sexual dysfunction should be anticipated and managed (dose adjustment, timing, or switching to a lower-liability agent) rather than allowed to compound the couple's difficulties. Phosphodiesterase-5 (PDE-5) inhibitors have a definite role in erectile dysfunction that is interfering with conception.

Sexual dysfunction impeding conception

Where the sexual problem is the barrier to conception, it takes precedence and is usually curable. Erectile and ejaculatory failure on demand are treated with PDE-5 inhibitors, reduction of performance pressure and, when necessary, methods for obtaining semen; vaginismus is treated with graded exposure and sensate focus; unconsummated marriage is treated with couple therapy. Table 4 maps the problems to management.

Penetration without ejaculation. The confirmation of penetration does not end the enquiry. A couple in whom penetration occurs without intravaginal ejaculation is, in effect, just as incapable of conception as a couple whose marriage is unconsummated, and the reason must be sought. The most common pattern in the fertility clinic is situational delayed ejaculation or anejaculation. Ejaculation occurs with masturbation or as nocturnal emission but fails during intercourse, often only on scheduled days and under the burden of performance pressure. This diagnosis should be accepted only after organic causes have been excluded: retrograde ejaculation, confirmed by sperm in a post-ejaculate urine sample; diabetic or other autonomic neuropathy; spinal cord injury; pelvic or retroperitoneal surgery; and drugs, particularly serotonergic antidepressants, antipsychotics and alpha-blockers.^[12–14] Management depends on the cause. Psychogenic delayed ejaculation responds to sex therapy, reduction of performance pressure and review of any offending medication; retrograde ejaculation may respond to sympathomimetic agents, or sperm can be recovered from

post-ejaculate urine for assisted conception. If these measures fail, penile vibratory stimulation or electroejaculation with intrauterine insemination or assisted reproduction, or surgical sperm retrieval with in vitro fertilisation and intracytoplasmic sperm injection, allows conception while the sexual problem is treated in parallel.^[13,14]

Stepped-care pathway

Care is stratified by severity: all couples are queried regarding sexual function and provided with psychoeducation, specific dysfunctions are managed with sex therapy, sensate focus or cognitive behavioral therapy, co-morbid depression and anxiety are managed with fertility-safe pharmacotherapy and psychotherapy, and intractable or complex problems are referred for specialist psychosexual or psychiatric care. The pathway is summarised in Figure 2.

What the Guidelines Say About Screening for Sexual Issues in Infertility

The dedicated evidence here comes mainly from reproductive medicine, not psychiatry. The anchor document is the European Society of Human Reproduction and Embryology (ESHRE) guideline on routine psychosocial care in infertility: built on structured methodology, it directs all fertility staff to address patients' emotional, relational and behavioural needs throughout the treatment pathway, and clearly identifies the couple's relationship — sexual life included — as a domain to be supported before, during and after treatment.^[15] It is frank that much of the evidence base is of modest quality, with many recommendations resting on good-practice consensus.

Against that anchor, it is worth stating plainly where the major infertility and related guidelines stand on the specific question of screening for sexual problems, and whether any of them says how such screening should be done and how the problems should be approached. The honest summary is that most do not commit. The first global World Health Organization (WHO) infertility guideline makes 40 recommendations and six good-practice statements, one of which is to listen to individuals and couples, but it makes no specific recommendation on screening for sexual dysfunction and gives no direction on how to do so.^[16,17] The urological guidelines are the firmest on the sexual history, because taking one is intrinsic to the andrological work-up, and the European Association of Urology (EAU) male sexual-dysfunction guideline offers full diagnostic and treatment algorithms that apply directly to the infertile man; but none frames sexual-dysfunction screening as a routine step for every infertile couple.^[12–14] The condition-specific guidelines commit where the condition demands it: the endometriosis guideline assesses dyspareunia and sexual function, and the unexplained-infertility guideline, by defining the diagnosis against adequate intercourse, forces at least a check that effective coitus is occurring.^[18,19] Table 5 sets out the position of each, and marks plainly where a document makes no commitment.

Two conclusions follow. First, no guideline yet commits to routine, structured screening of sexual function for every infertile couple with a validated tool: the fertility guidelines touch sexual function only in passing or by implication, the urological guidelines assess it within the andrological history, and only condition-specific documents commit where their condition forces it.^[13–15,19] Second, general psychiatric guidelines address sexual dysfunction without reference to the infertile couple at all. The gap is therefore twofold, and an India-specific, psychiatry-led guideline that places routine sexual

enquiry inside the fertility pathway, and accounts for Indian social and legal realities, fills a space that no existing document occupies.

Recommendations

1. Ask about sexual function, with each partner individually and together, as part of the routine assessment of every infertile couple. (*Good practice point.*)
2. Establish whether penetration is actually occurring and whether it ends in intravaginal ejaculation; do not assume either. Unconsummated marriage, and penetration without ejaculation, presenting as infertility are treatable. (*Good practice point.*)
3. Use brief validated instruments (IIEF, FSFI; ASEX or PRSexDQ-SALSEX where drug effects are suspected) to support, not replace, a sensitive interview. (*Recommendation, low-to-moderate evidence.*)
4. To counter the harm of timed intercourse, advise all couples to decouple sex from the ovulation calendar and to maintain non-coital intimacy. (*Recommendation, low-to-moderate evidence.*)
5. Offer sex therapy and sensate focus as first-line treatment for specific dysfunctions such as vaginismus and unconsummated marriage. (*Recommendation, moderate evidence.*)
6. Offer CBT or mind-body treatments to reduce infertility-related distress and to support sexual function and quality of life. (*Recommendation, moderate evidence.*)
7. Treat comorbid depression and anxiety with fertility-appropriate pharmacotherapy, weighing sexual side effects and periconception teratogenic risk. (*Recommendation, moderate evidence.*)
8. Treat sexual dysfunction that is a barrier to conception first; PDE-5 inhibitors are indicated for erectile dysfunction that obstructs conception. (*Recommendation, moderate evidence.*)
9. Integrate psychosexual care within the fertility team, using the counselling mandate of the ART and Surrogacy Acts as a routine entry point. (*Good practice point.*)
10. Be alert to the blame, stigma and marital threat falling on the woman, and respond to the couple within their family and social context. (*Good practice point.*)

The Future

- **Routine screening integrated into fertility clinics.** Brief, validated, culturally adapted sexual-function screening should be a standard step at intake and throughout the cycle, not an afterthought.
- **Tele-counselling.** Remote psychosexual counselling can bring scarce expertise to couples living far from tertiary centres, with attention to privacy and the couple's ability to attend together.
- **Fertility-preservation populations.** Fertility preservation is an emerging field that will need to meet the particular sexual and psychological needs of cancer survivors and others who seek it.
- **Indian evidence.** Good Indian data on the prevalence and management of sexual dysfunction in infertile couples remain scarce; generating them is a priority so that future editions rest on local evidence.

271 This has a natural opening. Psychological evaluation, counseling, and support are already required by
272 the fertility specialty's own treatment protocols at multiple stages of the assisted-reproduction
273 pathway.^[15] As a result, the psychiatrist is a legitimate stakeholder in the assisted-reproduction
274 pathway and should be included in the protocol rather than being called upon only in an emergency.
275 The destination is a fertility clinic where the couple's sexual life is addressed as a legitimate part of
276 their care — asked about without embarrassment, assessed properly and treated competently —
277 rather than left as a private matter for the couple to raise. This chapter is a step in that direction.

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335 **Table 1:** *Infertility, sexual dysfunction and treatment: a three-way relationship. Knowing which*
 336 *pathway dominates in a couple tells us where to intervene first.*

Infertility → sexual dysfunction	Sexual dysfunction → infertility	Treatment → sexual dysfunction
The diagnosis hurts self-worth and gender identity ^[3]	Unconsummated marriage makes conception impossible ^[6]	Timed intercourse takes away desire and spontaneity ^[5]
Comorbid depression and anxiety reduce desire and arousal ^[4]	Erectile or ejaculatory failure defeats a fertile couple ^[3]	Performance pressure on ovulation days causes failure ^[5]
Blame and marital conflict destroy intimacy ^[7]	Vaginismus and dyspareunia block penetration ^[6]	Repeated, failed cycles increase distress and avoidance ^[8]

337 **Table 2:** *Common sexual dysfunctions by partner and their importance to fertility. Whether*
 338 *penetrative intercourse is occurring at all is an essential question and is often omitted.*

Partner	Common sexual dysfunctions	Relevance to fertility
Male	Erectile dysfunction; premature or delayed ejaculation; anejaculation; low desire; performance anxiety ^[3,5]	Erectile/ejaculatory failure on ovulation days prevents conception; may signal endocrine disease ^[3]
Female	Desire and arousal disorders; anorgasmia; dyspareunia; vaginismus ^[4]	Vaginismus and dyspareunia may be the direct cause of non-conception ^[6]
Couple	Unconsummated marriage; loss of spontaneity from timed intercourse ^[6]	Sexual problem is the whole of the infertility; fully treatable once named ^[6]

Table 3: *A proposed approach to the assessment of sexual problems in the infertile couple. Instruments facilitate a delicate interview; they do not supplant it.*

Domain	What to determine	Tools / instruments
Intercourse and consummation	Is penetration occurring? Does it end in intravaginal ejaculation? Timing, frequency, avoidance	Clinical interview (individually and together)
Male sexual function	Erectile function, ejaculation, libido, performance anxiety	IIEF / IIEF-5; PEDT
Female sexual function	Desire, arousal, lubrication, orgasm, dyspareunia, vaginismus	FSFI
Treatment-emergent effects	Sexual change on antidepressants or other drugs	ASEX; PRSexDQ-SALSEX ^[9]
Psychiatric morbidity	Depression, anxiety, grief; risk where indicated	PHQ-9, GAD-7; FertiQoL for quality of life

Abbreviations: ASEX, Arizona Sexual Experiences Scale; FertiQoL, Fertility Quality of Life tool; FSFI, Female Sexual Function Index; GAD-7, Generalized Anxiety Disorder 7-item scale; IIEF, International Index of Erectile Function; IIEF-5, five-item version of the International Index of Erectile Function; PEDT, Premature Ejaculation Diagnostic Tool; PHQ-9, Patient Health Questionnaire 9-item; PRSexDQ-SALSEX, Psychotropic-Related Sexual Dysfunction Questionnaire.

345 **Table 4:** *Management options related to the presenting issue. Where a sexual dysfunction is the*
 346 *barrier to conception, it is treated first and is usually curable.*

Problem	Management options
Loss of desire / spontaneity from timed intercourse	Psychoeducation; decouple sex from the calendar; scheduled non-coital intimacy; reduce monitoring pressure ^[5]
Erectile dysfunction preventing conception	PDE-5 inhibitor; reduce performance pressure; treat comorbid anxiety/depression; sperm retrieval if needed ^[1]
Premature / delayed ejaculation; anejaculation	Behavioural techniques; pharmacotherapy as indicated; address anxiety; review offending drugs; post-ejaculate urinalysis for retrograde ejaculation; sperm recovery with assisted conception if needed ^[13,14]
Vaginismus / dyspareunia	Graded exposure and dilators; sensate focus; pelvic-floor work; treat pain cause ^[6]
Unconsummated marriage	Couple-oriented sex therapy assessing both partners; sex education; myth correction ^[6]
Comorbid depression / anxiety	CBT and couple therapy; fertility-safe pharmacotherapy with attention to sexual side effects and teratogenicity ^[8,10]

347 **Abbreviations:** CBT, cognitive behavioural therapy; PDE-5, phosphodiesterase type 5.

348 **Table 5:** *Where the major infertility and related guidelines stand on screening and managing sexual*
349 *issues in the infertile couple. “No” denotes that the document makes no specific commitment on this*
350 *point. Superscripts are reference numbers.*

Guideline (year)	Commitment to screening sexual issues	Direction on how to screen	Approach to management
WHO infertility guideline (2025) ^[16,17]	No specific commitment; nearest is a good-practice statement on listening to couples	None given for sexual issues	None specific; patient-centred communication and STI prevention only
ESHRE routine psychosocial care (2015) ^[15]	Yes — strongest; names the couple's relationship and sexual life as a need for all staff to address	Partial — detect and address needs across the pathway; no single mandated instrument	Yes — staff address needs; refer for specialist psychosexual therapy
AUA/ASRM male infertility (2020; 2024) ^[12,20]	Partial — sexual and ejaculatory history part of male evaluation; both partners assessed together	Partial — history-based (erectile, ejaculatory, timing); no standalone psychosexual screen	Addresses ejaculatory and erectile contributors; 2024 update technical, silent on sexual screening
EAU male infertility (2025) ^[13]	Partial — andrological assessment includes sexual history; parallel female evaluation	Partial — clinician history; no dedicated screening tool for the infertile couple	Manage male-factor contributors; cross-refers to EAU sexual-dysfunction guidance
ASRM fertility evaluation of women (2021) ^[21]	No — focuses on ovulatory, tubal and uterine work-up	None given for sexual issues	None specific
ESHRE unexplained infertility (2023) ^[18]	Partial and implicit — diagnosis requires confirming adequate, effective intercourse	Implicit — assess coital frequency and adequacy; no structured sexual screen	Does not address management of sexual dysfunction as such
International PCOS guideline (2023) ^[22]	Partial — screen psychological wellbeing and quality of life; psychosexual aspects acknowledged	Partial — screen emotional wellbeing; no infertility-specific sexual screen	Psychological support within multidisciplinary care
ESHRE endometriosis (2022) ^[19]	Yes (condition-specific) — assess dyspareunia and impact on sexual function	Partial — symptom-based assessment of dyspareunia and sexual quality of life	Yes — address dyspareunia; counsel on sexual function before and after surgery
ASRM definitions of infertility and RPL (2020) ^[23]	No — a definitions document; anchors infertility to regular unprotected intercourse	None given	None; useful only for anchoring definitions
EAU male sexual dysfunction (2021) ^[14]	Yes for male sexual dysfunction — ED, ejaculatory disorders, low desire, hypogonadism; applies to the infertile man	Yes — validated diagnostic algorithms and tools (e.g. IIEF)	Yes — detailed management (PDE-5 inhibitors, PE pharmacotherapy,

Guideline (year)	Commitment to screening sexual issues	Direction on how to screen	Approach to management
			testosterone where indicated)

Abbreviations: ASRM, American Society for Reproductive Medicine; AUA, American Urological Association; EAU, European Association of Urology; ED, erectile dysfunction; ESHRE, European Society of Human Reproduction and Embryology; IIEF, International Index of Erectile Function; PCOS, polycystic ovary syndrome; PDE-5, phosphodiesterase type 5; PE, premature ejaculation; RPL, recurrent pregnancy loss; STI, sexually transmitted infection; WHO, World Health Organization.

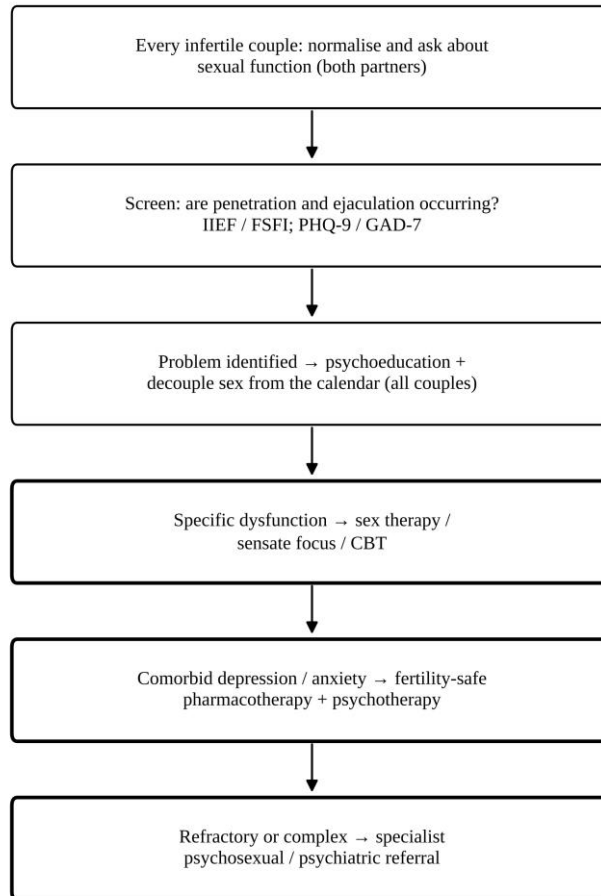
355 **Figure Legends**

356 **Figure 1:** *Sexual and psychological touch points on the assisted-reproduction pathway. Each is a point*
357 *at which short, anticipatory counselling can be offered.*

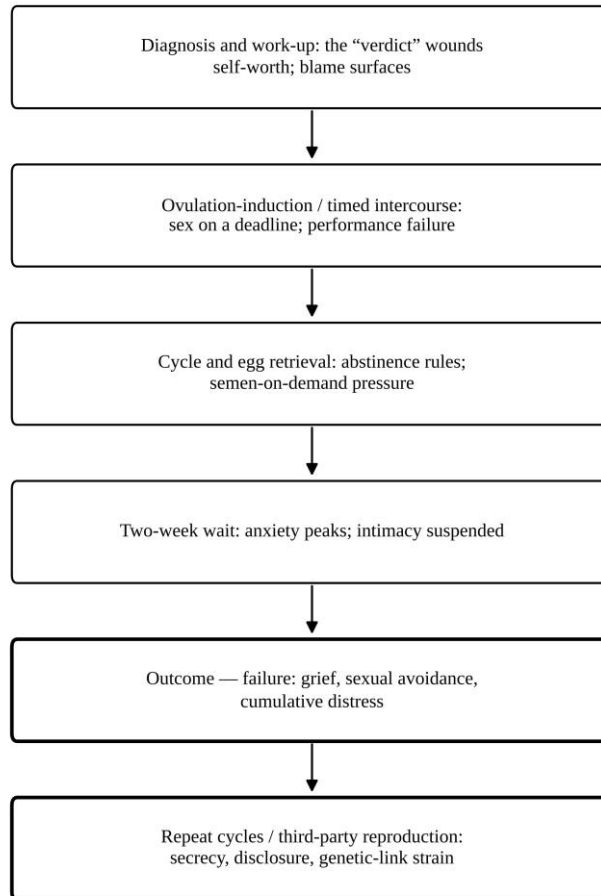
358 **Figure 2:** *Stepped-care pathway for sexual and psychological problems in the infertile couple, from*
359 *universal enquiry to specialist referral.*

360 **Abbreviations:** CBT, cognitive behavioural therapy; FSFI, Female Sexual Function Index; GAD-7, Generalized Anxiety
361 Disorder 7-item scale; IIEF, International Index of Erectile Function; PHQ-9, Patient Health Questionnaire 9-item.

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