

Coping With Infertility-Related Distress

Understanding the Emotional Burden of Infertility and Protecting Your Mental Health, Relationship and Sexual Wellbeing

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Introduction

When people hear the word **infertility**, they usually think about ovaries, fallopian tubes, sperm count, ovulation, hormones, semen analysis, IVF or other fertility treatment.

But infertility does not affect only the reproductive organs.

It can affect the mind.

It can affect sleep.

It can affect self-confidence.

It can affect sexual intimacy.

It can change the relationship between husband and wife.

It can affect friendships, work, finances and family relationships.

And for some individuals and couples, infertility becomes one of the most emotionally difficult experiences of their lives.

In my clinical practice in **sexual disorders and infertility**, I often meet patients who initially come to me carrying a laboratory report but are actually carrying something much heavier emotionally.

A man may show me an abnormal semen analysis and quietly say:

“Doctor, I feel that I have failed my wife.”

A woman may come after several unsuccessful treatment cycles and say:



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“I cannot stop thinking about pregnancy.”

Another couple may appear physically calm but tell me that they now argue every month when menstruation begins.

Someone else may say:

“Every pregnancy announcement makes me feel terrible, and then I feel guilty because I am not happy for them.”

These are not signs of weakness.

They are understandable human responses to uncertainty, repeated disappointment and an important life goal that feels outside one's control.

Infertility is also much more common than many people realise. The World Health Organization estimates that approximately **one in six people experience infertility during their lifetime.**

In November 2025, WHO published its first comprehensive global guideline for the prevention, diagnosis and treatment of infertility. Importantly, the guideline does not treat infertility only as a biological problem. WHO specifically recognises that infertility can contribute to **depression, anxiety and social isolation** and emphasises ongoing access to psychosocial support for people affected by infertility.

This is an important development.

It tells patients something that I believe strongly:

Emotional care is part of infertility care.

What Is Infertility-Related Distress?

Infertility-related distress is the emotional, psychological, social or relationship burden that develops because of difficulty conceiving, reproductive investigations or fertility treatment.

It is not one single psychiatric diagnosis.

A person may experience sadness without having clinical depression.

Another may experience anxiety primarily before fertility appointments.

Someone else may develop severe depression requiring professional treatment.

A couple may function well individually but experience serious strain in their sexual relationship.

Infertility-related distress can therefore appear as:



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persistent worry,
sadness,
grief,
anger,
frustration,
guilt,
shame,
jealousy,
social withdrawal,
sleep disturbance,
sexual problems,
relationship conflict,
difficulty concentrating,
treatment exhaustion,
financial anxiety,
or fear about the future.
Sometimes several of these occur together.

Why Infertility Can Be So Emotionally Difficult

Infertility contains several characteristics that make it psychologically challenging.

There is uncertainty.

There is often no definite timetable.

There may be repeated investigations.

There may be repeated treatment.

There may be substantial expense.

The couple cannot completely control the outcome.

And every menstrual cycle can bring both hope and disappointment.

For many couples, having a child was not considered an uncertain medical objective.



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They simply assumed:

“When we decide to have children, we will have them.”

When this expectation does not become reality, the couple is forced to reconsider something they previously took for granted.

ASRM's Mental Health Professional Group describes long-term difficulty conceiving as capable of producing a profound sense of loss, and notes that the many medical decisions and uncertainties involved in infertility can create considerable emotional upheaval.

Infertility Can Feel Like Grief

People usually associate grief with the death of someone they love.

But grief can also occur when an expected future becomes uncertain.

A couple may be grieving:

the pregnancy they expected,

the baby they imagined,

the family size they planned,

the age at which they expected to become parents,

the experience of spontaneous conception,

or the belief that reproduction would be simple.

The difficult part is that infertility grief can remain unresolved for a long time.

There may not be one clear beginning and one clear ending.

Instead, there can be repeated cycles of hope and loss.

The Monthly Cycle of Hope and Disappointment

Many infertility patients describe living from one menstrual cycle to the next.

At the beginning of the cycle, hope returns.

Medicines may begin.

Follicles may be monitored.

Ovulation is identified.



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Intercourse may be carefully timed.

Then comes the waiting period.

The woman notices every sensation.

She wonders:

“Is this implantation?”

“Are my breasts different?”

“Why am I feeling tired?”

Then menstruation begins.

Or the pregnancy test is negative.

The emotional process starts again.

Even without IVF, this repeated pattern can become exhausting.

For people undergoing assisted reproduction, the emotional highs and lows may become even more intense because each cycle can involve injections, blood tests, procedures, financial investment and considerable expectation.

Infertility-Related Anxiety and Depression Are Common

The emotional burden of infertility is not simply anecdotal.

Recent research continues to document substantial psychological distress.

A 2025 systematic review and meta-analysis examining infertile women reported pooled estimates of anxiety and depression of approximately **41% and 42% respectively**, although prevalence varied substantially between studies and populations. Longer infertility duration, treatment expense and inadequate information about assisted reproduction were among factors associated with greater distress.

Another systematic review and meta-analysis examining people undergoing assisted reproductive treatment included 40 studies and more than 16,000 participants, again demonstrating that anxiety, depression and stress are important concerns during fertility treatment.

These numbers should not be interpreted to mean that every person with infertility has a psychiatric illness.

They show that psychological distress is common enough that fertility services should actively look for it rather than waiting for patients to reach breaking point.



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Women and Men May Experience Distress Differently

Infertility affects both partners, but it may not affect them in exactly the same way.

A 2025 systematic review and meta-analysis involving more than 10,000 infertile men and women found that women, on average, reported higher levels of anxiety, depression and stress than men, although both sexes can experience substantial psychological burden.

This does not mean women suffer and men do not.

Men may express distress differently.

A woman may cry and openly discuss her fear.

A man may become quiet.

He may work longer hours.

He may avoid discussing the semen report.

He may become irritable.

He may say:

“Don't worry about it.”

while privately feeling deeply ashamed.

If we interpret silence as absence of distress, male infertility-related suffering can easily be missed.

Male Infertility Can Affect a Man's Identity

When a semen analysis shows:

low sperm count,

poor motility,

abnormal morphology,

azoospermia,

or another significant abnormality,

some men interpret the finding as a judgment about masculinity.

I often have to explain:



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Sperm count is not a measure of manhood.

A semen analysis tells us about reproductive biology.

It does not measure:

character,

strength,

sexual worth,

love,

responsibility,

intelligence,

or the quality of a husband.

Likewise, infertility does not automatically mean impotence.

A man can have completely normal erections and severe infertility.

Another man can have excellent semen parameters but erectile dysfunction.

Sexual function and fertility overlap in some situations, but they are not the same thing.

Women Often Carry Additional Social Pressure

In many societies, pregnancy is discussed openly but infertility remains hidden.

A woman may repeatedly hear:

“When are you giving us good news?”

“You have been married for so long.”

“Why haven't you had a baby yet?”

Sometimes people immediately assume the problem belongs to the woman without any medical evidence.

This can create a double burden:

the medical burden of infertility,

and the social burden of being blamed for it.

WHO has highlighted stigma, guilt, emotional strain and high treatment costs among the lived challenges experienced by couples dealing with infertility.

Social stigma is therefore not a minor issue.



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It can influence whether patients seek treatment, whom they tell, whether they remain socially active and how they view themselves.

Infertility Is a Couple's Health Problem—Not a Search for Someone to Blame

One of the most important things I tell couples is:

Do not turn the diagnosis into a courtroom.

The objective of fertility testing is not to identify which spouse is guilty.

It is to identify which biological factors may be preventing conception so that we can decide what can reasonably be done.

A couple may have a male factor.

They may have a female factor.

Both partners may have contributing factors.

Or standard testing may not identify a definite cause.

Whatever the diagnosis, blame usually makes treatment harder.

Instead of saying:

“Your sperm are the problem,”

a couple can say:

“We have identified a male fertility factor that we need to address.”

Instead of:

“Your tubes are blocked,”

say:

“We now understand one reason pregnancy has been difficult for us.”

Language can either divide a couple or remind them that they are facing the situation together.

Do Not Blame Yourself Either

Infertility can create intense self-blame.

A woman may think:

“I waited too long.”



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A man may think:

“My lifestyle caused everything.”

Someone with previous infection may think:

“If only I had done things differently.”

A patient with PCOS may think:

“My body has failed me.”

A man with azoospermia may think:

“I have destroyed my wife's chance of motherhood.”

These thoughts are emotionally powerful but rarely clinically useful.

Once a fertility problem has been identified, our task is not to repeatedly punish the past.

Our task is:

What does the diagnosis mean now, and what are the available options?

“Just Relax and You Will Become Pregnant” Is Not Appropriate Advice

This statement is common and often well-intended.

It can also be extremely harmful.

It implies that the couple is infertile because they are worrying too much.

Then the patient develops another worry:

“Perhaps I am not pregnant because I cannot stop worrying about becoming pregnant.”

The relationship between psychological stress and reproduction is complex.

Some studies identify associations between anxiety, depression and fertility-treatment outcomes. For example, a 2025 meta-analysis found that higher anxiety and depression were associated statistically with somewhat lower pregnancy success after IVF/ICSI.

But an association does not prove that emotional distress **caused** an individual's infertility.

Nor does it mean that becoming calm guarantees conception.



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Psychological support should therefore be offered because patients deserve better mental health and quality of life—not because we want to blame them for failing to “relax enough.”

Treatment Stress Can Be Different From Infertility Stress

There are really two related problems.

The first is distress caused by infertility itself.

The second is distress created by fertility treatment.

Treatment can involve:

frequent appointments,

blood tests,

ultrasound scans,

hormonal injections,

semen collection,

egg retrieval,

embryology reports,

waiting for fertilisation results,

embryo-transfer decisions,

pregnancy testing,

and repeated uncertainty.

Therefore, treatment that offers hope can simultaneously become another source of stress.

This is one reason NICE's fertility quality standard, updated in March 2026, specifically states that people experiencing fertility problems should be offered counselling **before, during and after investigation and treatment** because both infertility and fertility treatment can cause emotional stress.

That is an important standard of care.

Waiting Can Be One of the Hardest Parts

Fertility treatment contains repeated periods when nothing can be done.



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The couple waits for:

laboratory results,
the next menstrual period,
ovulation,
an embryo report,
a pregnancy test,
a consultation,
or another treatment cycle.

Patients often say:

“Doctor, I feel better when I am doing something. Waiting is worse.”

This is understandable.

Action creates a sense of control.

Waiting exposes uncertainty.

One coping strategy is to separate:

what you can control

from:

what you cannot control.

You can attend appointments.

You can take prescribed medication correctly.

You can improve health habits.

You can ask questions.

You can protect your relationship.

You cannot personally control whether every embryo implants or whether every treatment cycle succeeds.

Trying to emotionally control a biological outcome that cannot be completely controlled can create tremendous exhaustion.

Information Can Reduce Some Anxiety

Uncertainty increases fear.



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Patients often suffer more when they do not understand what is happening.

Ask your fertility doctor:

What exactly is our diagnosis?

How certain is it?

Are additional tests required?

What is the purpose of this medicine?

What are our realistic treatment options?

Why is this treatment being recommended?

What is the expected next step if this cycle does not work?

How many cycles are reasonable?

At what point should the treatment strategy change?

Information does not remove every emotional difficulty.

But understanding the plan can reduce the helplessness created by uncertainty.

Protect Yourself From Uncontrolled Internet Searching

The internet can be extremely helpful.

It can also become a source of anxiety.

A patient searches:

“AMH 0.8 pregnancy chances.”

Then reads twenty different opinions.

Another searches:

“IVF failed first cycle.”

She spends four hours reading stories of repeated treatment failure.

A man searches an abnormal semen parameter and becomes convinced he can never father a child before he has even spoken with his doctor.

Online information should support professional care, not replace interpretation of your own clinical situation.

Set boundaries if searching is making you more anxious rather than better informed.



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Social Media Can Intensify Infertility Distress

Pregnancy announcements, newborn photographs and children's milestones can become emotionally difficult during infertility.

A patient may then feel guilty for being upset about somebody else's happiness.

I want patients to understand:

Two emotions can exist together.

You can love someone and still feel sad because their pregnancy reminds you of your own struggle.

You can be pleased for another couple and simultaneously grieve for yourself.

It is acceptable to protect your mental health temporarily.

You may choose not to attend every baby-related event.

You may mute social-media accounts for a period.

That is different from wishing harm to others.

Boundaries can be a form of emotional self-care.

Family Questions Can Become Very Painful

Infertility is often treated socially as public information.

People ask:

“When are you having children?”

The couple may not want to disclose:

a low sperm count,

blocked tubes,

failed IVF,

a miscarriage,

or another private diagnosis.

You have the right to keep your health information private.

A useful response can be:

“We are dealing with this privately and will share news when we are ready.”

You do not need to justify that boundary.



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Couples May Cope in Different Ways

One partner may want to speak about infertility every day.

The other may only want to discuss it around medical appointments.

One may research every treatment.

The other may avoid reading about infertility completely.

One may cry.

The other may become quiet.

Different coping styles do not automatically mean different levels of love or commitment.

Problems arise when each person begins judging the other's coping style.

The wife may think:

“He never talks about it, so he doesn't care.”

The husband may think:

“She talks about infertility constantly and will never be happy.”

Both may be wrong.

Sometimes a helpful conversation is simply:

“When you are stressed about fertility, what kind of support do you need from me?”

Do Not Allow Every Conversation to Become About Infertility

Infertility has a tendency to occupy the entire relationship.

Breakfast becomes:

“Did you take the medicine?”

Lunch becomes:

“When is the scan?”

Evening becomes:

“Did the clinic call?”

Bedtime becomes:



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“We have to have intercourse today because it is the fertile window.”

Gradually the relationship stops feeling like a marriage and begins feeling like a fertility project.

Couples need intentional spaces where infertility is not the subject.

Talk about:

work,

family,

travel,

food,

films,

memories,

future plans not related to pregnancy,

or anything that reminds you why you chose each other before fertility treatment began.

Infertility Can Change Sexual Intimacy

This is an especially important concern within my clinical practice because my work focuses on both **sexual disorders and infertility**.

Sex can become timed around ovulation.

Spontaneity disappears.

The couple begins thinking about sperm deposition instead of pleasure.

The man may feel:

“I have to perform tonight.”

The woman may feel:

“We cannot miss this fertile day.”

If the man then develops erection difficulty, panic increases because the couple believes they are losing their chance for the month.

Research confirms that infertility can affect sexual functioning. A systematic review and meta-analysis found that couples experiencing infertility have increased rates of sexual difficulties, including reduced desire and erectile dysfunction, and emphasised the



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need to consider both the individual and the couple's sexual relationship during fertility care.

A 2024 qualitative meta-synthesis likewise found that infertility frequently changes how people experience sexuality and highlighted unmet needs for sexual-health information and counselling.

Performance Anxiety During the Fertile Window

I see this particularly in male patients.

The man may have perfectly normal erections during spontaneous intimacy.

But when his wife says:

“Today is the ovulation day,”

something changes.

He begins thinking:

“I must get an erection.”

“I must ejaculate.”

“We cannot waste this opportunity.”

Sex suddenly becomes a medical task.

The erection becomes weaker.

Now he becomes even more worried.

The next fertile period carries the memory of the previous difficulty.

This can create a genuine performance-anxiety cycle.

Such patients do not necessarily need stronger sexual medication alone.

They may need sexual counselling, removal of excessive performance pressure and treatment of any physical sexual dysfunction that also exists.

Infertility Can Reduce Sexual Desire

When intercourse becomes scheduled, examined and associated with disappointment, sexual desire may fall.

This can affect either partner.



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A woman may say:

“I no longer feel romantic when we have sex. I am calculating whether I am ovulating.”

A man may say:

“Every time we become intimate I feel that I am being tested.”

The aim should be to preserve some sexual experiences that belong to the relationship rather than to fertility treatment.

Counselling Can Help Couples Protect Intimacy

A 2025 systematic review specifically examined counselling approaches and marital intimacy in women and couples experiencing infertility.

The review concluded that infertility-related stress can adversely affect intimacy and sexual contact, while counselling interventions can help address the psychological and marital consequences of infertility.

This is one reason seeking counselling should not be viewed as:

“Our marriage is failing.”

Sometimes counselling is exactly what helps prevent treatment stress from damaging an otherwise healthy relationship.

Financial Stress Is Real

Fertility treatment can be expensive.

The couple may be paying for:

consultations,

blood tests,

ultrasound,

medicines,

procedures,

travel,

IUI,

IVF,



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ICSI,

embryo freezing,

storage,

or repeated treatment cycles.

A WHO-linked systematic review of assisted-reproduction costs in low- and middle-income countries found that out-of-pocket ART treatment can be extremely expensive relative to average income and can expose families to catastrophic expenditure.

More recent 2026 research has also described how the financial burden of infertility treatment can maintain anxiety even while treatment itself is being used as a way of coping with infertility.

Financial anxiety therefore deserves to be discussed honestly.

It is not a sign that the couple cares less about having a child.

Before continuing repeated expensive treatment, ask the treating team to explain the realistic benefit, alternatives and likely total cost.

It Is Acceptable to Take a Treatment Break

Patients sometimes believe:

“If we stop treatment for one month, we are giving up.”

That is not necessarily true.

A short treatment break can sometimes allow a couple to recover emotionally, physically or financially.

Whether delaying treatment is medically reasonable depends upon factors such as:

female age,

ovarian reserve,

specific diagnosis,

cancer-related fertility issues,

duration of infertility,

and the proposed treatment.

Therefore, the decision should be discussed with the treating fertility specialist.

But emotionally, a pause and a permanent decision to stop are not the same thing.



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Failed Treatment Can Feel Like Another Loss

A failed fertility cycle is not merely:

“The test was negative.”

The couple may have invested weeks of medication, procedures, money, hope and emotional energy.

When the result is negative, grief can be intense.

Allow yourself time to react.

Do not immediately conclude:

“Nothing will ever work.”

At the follow-up appointment, ask what was learned from the cycle.

Did ovarian response match expectations?

Did fertilisation occur?

Was embryo development as expected?

Did the diagnosis change?

Should the same strategy be repeated?

Should something different be considered?

A failed cycle may provide clinical information even when it does not produce pregnancy.

Pregnancy Loss During Fertility Treatment

Pregnancy after infertility can carry enormous emotional meaning.

If that pregnancy is subsequently lost, patients may experience both pregnancy-loss grief and the return of infertility-related fear.

A patient may think:

“We finally became pregnant, and now we are back at the beginning.”

Psychological support may be especially valuable in this situation.

The couple should not be expected to immediately begin another treatment cycle simply because a fertility clinic can technically start one.



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Emotional readiness matters too.

When to Consider Professional Counselling

I strongly encourage patients to consider infertility-focused counselling when emotional distress is becoming persistent or is interfering with normal life.

ASRM's Mental Health Professional Group suggests professional help when symptoms continue over time, including persistent depression, loss of interest in usual activities, strained relationships or difficulty thinking about anything other than infertility.

Counselling is also appropriate before severe symptoms develop.

You do not need to wait until you are completely overwhelmed.

NICE specifically recommends access to counselling **before, during and after** fertility investigation and treatment.

ESHRE likewise treats psychosocial care as an important part of infertility and medically assisted reproduction, recognising that patient needs change at different stages of the treatment pathway.

Psychological Therapy Is Evidence-Based Care

Counselling is not merely someone telling you:

“Try to think positively.”

Proper psychological treatment uses structured approaches to help patients manage distress.

A major 2025 systematic review and meta-analysis evaluated 69 studies involving 5,935 women with infertility.

Although the combined effect across every psychological outcome was not statistically significant, targeted analyses found significant improvements in **anxiety, depression and psychological wellbeing**, with approaches such as cognitive-behavioural therapy and counselling among the more effective interventions.

This is important evidence.

Psychological treatment should be used because emotional wellbeing matters in its own right.

It should not be sold as a guaranteed method for becoming pregnant.



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Cognitive-Behavioural Therapy

One commonly used psychological approach is **cognitive-behavioural therapy**, usually called CBT.

CBT helps patients identify patterns such as:

“I will never become a parent.”

“Everyone else is succeeding except me.”

“If IVF fails, my life is over.”

“My husband deserves someone fertile.”

“My semen report proves I am not a man.”

The aim is not to replace difficult reality with unrealistic positive thinking.

It is to identify thoughts that are unnecessarily absolute, catastrophic or self-punishing and replace them with more balanced interpretations.

For example:

Instead of:

“This treatment failed, so nothing will ever work,”

the more accurate thought might be:

“This cycle did not result in pregnancy. I am disappointed, and I need to discuss what this result means for the next decision.”

That small change can reduce unnecessary psychological suffering without denying reality.

Mindfulness and Relaxation

Some patients benefit from mindfulness, breathing exercises, relaxation techniques or structured stress-management practices.

These approaches can help reduce:

rumination,

physical tension,

sleep difficulty,

and emotional overactivation.



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Again, they should not be advertised as fertility cures.

Use them to support the patient—not to make the patient responsible for the pregnancy outcome.

Exercise Can Support Mental and Physical Health

Regular physical activity can support:

mood,

sleep,

metabolic health,

cardiovascular health,

and general wellbeing.

WHO's 2025 infertility guideline recommends healthy diet, physical activity and tobacco cessation as part of fertility-health promotion.

But exercise should not become another source of obsession.

After an infertility diagnosis, some patients try to control every aspect of life perfectly.

They believe:

“If I exercise exactly enough, eat perfectly and eliminate every possible unhealthy food, pregnancy must happen.”

Human fertility is more complicated than that.

Healthy lifestyle supports health.

It does not guarantee reproductive outcomes.

Protect Your Sleep

Infertility anxiety often becomes strongest at night.

The mind begins calculating:

fertile days,

ages,

treatment costs,

IVF probabilities,



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previous results,

future possibilities.

Then sleep deteriorates.

The next day, emotional resilience is lower.

Try to keep a regular sleep routine.

Avoid spending hours in bed reading frightening infertility forums.

If insomnia becomes persistent or severe, discuss it with a healthcare professional.

Protect Your Identity Outside Infertility

A patient can gradually begin describing themselves only as:

“an infertile woman”

or:

“a man with low sperm count.”

But infertility is something you are experiencing.

It is not your complete identity.

You are also:

a spouse,

a professional,

a friend,

a family member,

a person with interests,

a person with skills,

a person whose life has value independently of reproductive status.

Maintaining activities outside fertility treatment can protect mental wellbeing.

Choose Your Support Network Carefully

Not everybody who asks about your fertility journey deserves access to it.

Choose people who make you feel safer rather than more pressured.



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Useful support sounds like:

“I am available if you want to talk.”

Less useful support sounds like:

“Why haven't you tried IVF?”

“Just adopt.”

“You are thinking too much.”

“My friend's cousin took this medicine and immediately became pregnant.”

A supportive person listens before offering solutions.

Support Groups Can Help Some Patients

Meeting others who understand infertility can reduce isolation.

A support group can provide a place where someone does not have to explain why another negative pregnancy test feels so painful.

However, not every group is helpful for every person.

If an online group leaves you more frightened, competitive or hopeless after every visit, it may not currently be the right support environment for you.

Support should reduce isolation—not multiply anxiety.

When Social Withdrawal Becomes a Problem

Temporarily avoiding a baby shower because it feels emotionally overwhelming can be understandable.

Withdrawing from almost everyone for months is different.

If infertility is causing you to stop:

seeing friends,

attending work,

participating in normal activities,

or communicating with your partner,

professional psychological support becomes increasingly important.

Isolation usually makes distress harder to manage.



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When Anxiety Becomes More Than Normal Worry

Some worry during fertility treatment is expected.

But anxiety may require professional assessment when it becomes persistent, excessive or physically overwhelming.

For example, a patient may experience:

panic attacks,

continuous racing thoughts,

severe sleep disturbance,

constant checking behaviours,

inability to concentrate,

or extreme fear before every appointment.

Treatment is available.

You do not need to wait until treatment is finished before taking care of your mental health.

Depression Should Not Be Dismissed as “Fertility Stress”

A person experiencing infertility may develop clinical depression.

Warning signs may include prolonged:

sadness,

hopelessness,

loss of interest or pleasure,

social withdrawal,

difficulty functioning,

severe guilt,

poor concentration,

sleep or appetite disturbance.

Mental-health assessment is particularly important when these symptoms persist or intensify.



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The presence of infertility does not mean every emotional symptom should automatically be explained away as:

“Of course you are stressed.”

Sometimes specific treatment for depression is needed.

Suicidal Thoughts Require Urgent Help

There is one situation in which the message must be completely clear.

If infertility-related distress leads to thoughts such as:

“I do not want to live.”

“There is no point continuing.”

or thoughts of self-harm, suicide or harming another person, please seek urgent professional help.

This is no longer something to manage alone.

In India, the Government's **Tele-MANAS** mental-health service can be accessed through **14416** or **1800-89-14416**.

For an immediate emergency or imminent danger, India's integrated emergency number is **112**.

A person in immediate danger should not be left alone while appropriate emergency help is being arranged.

Infertility Does Not Mean Your Relationship Is Failing

Couples often interpret fertility-related arguments as evidence that something is fundamentally wrong with their marriage.

Sometimes the relationship is actually reacting to an unusually demanding situation.

This distinction matters.

Two people may love one another deeply and still:

cope differently,

communicate badly under stress,

disagree about treatment,

or become sexually distant.



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These patterns can often improve.

A 2025 systematic review examining infertility counselling and marital intimacy supports counselling approaches as a useful way of addressing relationship and intimacy difficulties in couples experiencing infertility.

Make Fertility Decisions Together

Major decisions should ideally be discussed openly.

For example:

How long do we want to continue treatment?

How much financial burden can we reasonably accept?

How do we feel about IUI or IVF?

How many cycles feel manageable?

Do we agree about fertility preservation?

What are our boundaries around telling family?

Would we consider donor treatment where legally and personally appropriate?

Do we need a temporary break?

When one partner makes every decision and the other silently follows, resentment can build.

The goal is not necessarily for both partners to feel identical.

The goal is for both voices to be heard.

When One Partner Wants to Stop and the Other Wants to Continue

This is one of the most difficult situations.

One partner may say:

“I cannot go through another treatment cycle.”

The other may say:

“I cannot stop while there is still a chance.”

Neither position is automatically selfish.

One person may be exhausted.



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The other may be terrified that stopping will close the door permanently.

This is exactly the kind of situation where fertility-focused counselling can help.

The therapist does not make the reproductive decision.

The therapist helps the couple understand what each decision means emotionally and communicate without destroying the relationship.

Do Not Make Every Fertility Decision During an Emotional Crisis

Immediately after:

a negative pregnancy test,

a failed IVF cycle,

a miscarriage,

or a difficult diagnosis,

emotions may be intense.

Unless a genuinely urgent medical reason exists, it can sometimes be helpful to allow a little emotional recovery before making major long-term decisions.

Then return to the conversation with clearer questions.

Infertility Distress Can Continue Even After Pregnancy

This is another point patients are rarely warned about.

Pregnancy after infertility does not always make anxiety disappear.

Some patients remain frightened:

“What if we lose the pregnancy?”

They may check symptoms constantly.

Ultrasound appointments can become intensely stressful.

Therefore, psychological support may continue to be useful after successful conception.

This is one reason good fertility care should not treat a positive pregnancy test as the moment all psychological support suddenly becomes unnecessary.



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What About Unexplained Infertility?

Unexplained infertility can be psychologically difficult because patients often want a clear explanation.

They ask:

“If all our tests are normal, why are we not becoming pregnant?”

The term does not mean that the difficulty is imaginary.

It means currently available standard investigations have not identified a definite explanation.

Do not let anyone tell you:

“Everything is normal, so the problem must be in your mind.”

That is not an appropriate interpretation.

The absence of an identified biological cause is not proof of a psychological cause.

The Unani Perspective on Infertility-Related Distress

As a physician trained in the **Unani system of medicine**, I consider one of its useful features to be its traditional whole-person approach.

Unani health principles do not separate emotional state completely from physical health.

The system gives importance to the **Asbab-e-Sitta Zarooriya**, or six essential factors associated with preservation of health.

These traditionally include environmental air; food and drink; physical activity and rest; psychological or mental activity and rest; sleep and wakefulness; and appropriate retention and elimination. The Ministry of Ayush describes these factors as central preventive and health-promoting principles within Unani medicine.

For a patient undergoing infertility treatment, several of these areas can become disturbed simultaneously:

sleep becomes poor,

diet becomes irregular,

exercise decreases,

the mind remains continuously preoccupied,

sexual activity becomes stressful,



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and daily routines become dominated by treatment.

A whole-person approach is therefore particularly relevant.

How I Use Unani Principles in Patients With Infertility-Related Distress

At **Saira Health Care**, my approach is not:

“Infertility distress needs one calming herbal medicine.”

That would be too simplistic.

I want to understand the complete patient.

I consider:

the infertility diagnosis,

duration of infertility,

previous treatment,

sexual function,

sleep,

nutrition,

physical activity,

digestive health,

general vitality,

emotional distress,

relationship circumstances,

financial pressure,

and existing medical conditions.

When clinically appropriate, individualized Unani supportive management may be used to address general wellbeing, sleep, lifestyle regulation, nutrition and accompanying functional complaints.

But if the patient has major depression, significant anxiety, trauma, severe relationship breakdown or suicidal thinking, Unani supportive care should **not replace appropriate mental-health treatment**.

That distinction is essential.



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Unani Medicine and Fertility Treatment Should Not Be Used to Create False Hope

Traditional Unani medicine has a long history of treating reproductive and sexual-health problems.

There is also some clinical research examining specific Unani formulations in male infertility.

For example, CCRUM-linked literature has reported observational and comparative studies of Unani formulations in men with oligospermia, including changes in semen parameters.

Such research supports continued scientific study.

But these studies do not justify telling every distressed infertile couple:

“Take this medicine and pregnancy is guaranteed.”

No ethical fertility treatment—Unani, conventional, surgical, IVF or otherwise—can guarantee the same result for every patient.

At Saira Health Care, I believe hope should be based upon realistic clinical understanding rather than exaggerated promises.

Traditional Treatment and Psychological Therapy Can Work Together

There is no reason to create a false choice:

“Either Unani medicine or counselling.”

They address different needs.

A woman undergoing infertility treatment may receive appropriate reproductive treatment and individualized Unani supportive care while also seeing a psychologist for severe treatment anxiety.

A man receiving treatment for male-factor infertility may also require sex therapy because timed intercourse has caused erectile performance anxiety.

A couple may require fertility counselling because repeated treatment has damaged communication.

That is not contradictory care.

That is individualized care.



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Stress Management Should Never Become Another Burden

Some patients receive so much advice about reducing stress that stress reduction itself becomes stressful.

They begin thinking:

“I must meditate.”

“I must remain positive.”

“I must never cry.”

“Negative thoughts will reduce my chances.”

This is not healthy.

Emotional wellbeing does not require pretending to be happy.

You are allowed to be disappointed.

You are allowed to grieve.

You are allowed to have difficult days.

Coping means learning how to carry difficult emotions without allowing them to completely control your life.

It does not mean eliminating every negative feeling.

A Practical Way to Think About Coping

When I speak with patients, I often encourage them to separate their fertility journey into three areas.

The first is **medical responsibility**: attend appropriate appointments, complete necessary tests, follow prescribed treatment and understand the diagnosis.

The second is **personal health responsibility**: sleep, nutrition, physical activity, avoiding tobacco, taking medicines appropriately and managing chronic conditions.

The third is **emotional protection**: maintain communication, create social boundaries, seek counselling when needed and protect life outside fertility treatment.

Pregnancy outcome itself cannot be completely controlled.

These areas can.

What Not to Say to Someone Experiencing Infertility



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Even well-meaning friends and relatives can unintentionally cause pain.

Statements such as:

“Just relax.”

“At least you can enjoy your freedom.”

“Why don't you simply adopt?”

“Everything happens for a reason.”

or:

“Maybe you were not meant to have children.”

can feel deeply dismissive.

A more supportive response is:

“I am sorry you are going through this. I am here if you want to talk.”

Sometimes listening is more useful than advice.

When Should Couples Seek Sex-Therapy Support?

Consider psychosexual support when infertility has led to:

persistent erection difficulty during timed intercourse,

premature or delayed ejaculation caused partly by treatment pressure,

loss of sexual desire,

complete avoidance of intimacy,

resentment about scheduled intercourse,

or repeated arguments about sex.

The objective is not simply to increase intercourse frequency.

It is to help the couple recover a sexual relationship that contains intimacy, communication and pleasure rather than functioning only as a reproductive procedure.

When Should Couples Seek Relationship Counselling?

Couples therapy may be useful when:

every fertility discussion becomes an argument,



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one partner feels unsupported,
one partner wants to continue treatment while the other wants to stop,
family pressure is dividing the couple,
sexual intimacy has disappeared,
or the relationship has become entirely organised around infertility.
Seeking help at this stage is not evidence that the relationship has failed.
It can be a way of protecting it.

When Should a Psychiatrist Be Involved?

A psychiatrist may be particularly appropriate when there is:

significant clinical depression,
severe anxiety,
panic disorder,
obsessive symptoms,
serious sleep disturbance linked to mental illness,
or suicidal thinking.

Some patients worry that psychiatric medication will automatically prevent fertility treatment.

That is not always the case.

Medication decisions can be individualized in coordination with fertility and mental-health professionals.

Do not stop psychiatric medicines suddenly because you are trying to conceive.

The risks of untreated psychiatric illness also matter.

Psychological Screening Should Become Normal in Fertility Care

My hope is that in the future asking:

“How are you coping emotionally?”

will become as normal in fertility care as asking:

“When was your last menstrual period?”



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or:

“What is your sperm count?”

ESHRE's psychosocial-care guidance has long emphasised that fertility clinics should identify psychological needs throughout the treatment pathway rather than treating mental wellbeing as an unrelated issue. An update to its psychosocial guidance is currently under development, reflecting the continuing importance of this area in reproductive medicine.

Saira Health Care's Approach to Infertility-Related Distress

At **Saira Health Care**, my focused work in sexual disorders and infertility has taught me that a fertility report never tells the complete story.

When I evaluate a patient or couple, I want to understand both:

the reproductive problem

and

the way that problem is affecting their life.

I consider whether there is male-factor infertility, female-factor infertility, combined or unexplained infertility.

I also consider whether the couple is developing:

anxiety,

depression,

sexual dysfunction,

relationship stress,

treatment fatigue,

sleep disturbance,

social isolation,

or excessive pressure from family.

Where appropriate, my role includes individualized Unani supportive management, sexual-health treatment and fertility care within my scope of practice.

Where specialist reproductive medicine, gynaecology, urology, genetics, IVF, psychology, psychiatry or counselling is needed, responsible referral or collaboration is part of good clinical care.



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Why My Focus on Sexual Disorders and Infertility Matters

Infertility is one of the clearest examples of how sexual and reproductive health overlap.

A patient may initially present because pregnancy is not occurring.

Further discussion may reveal:

erectile dysfunction,

premature ejaculation,

low libido,

difficulty ejaculating during timed intercourse,

painful sex,

or complete loss of spontaneous intimacy.

Treating fertility while ignoring sexual function can therefore leave an important part of the problem untouched.

My clinical focus allows these concerns to be discussed openly and professionally.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician – Saira Health Care

Focused Practice in Sexual Disorders & Infertility

My professional qualifications and training include **BUMS from Hamdard University, Delhi; MD; CGO; Certificate in Infertility from MGBIMS, Delhi; Certificate in Urology – London, UK; Masters in Male Infertility from MasterHealthPro (HealthPro); and Integrated Sexual and Reproductive Health training through ISRH, UNFPA.**

My focused clinical work involves male sexual disorders, male reproductive health, infertility and related couple concerns.

Through Saira Health Care, my aim is not only to address reproductive laboratory findings but to help patients understand how fertility, sexual function, general health, lifestyle and psychological wellbeing interact.

Frequently Asked Questions

Is infertility-related stress normal?



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Some emotional distress is very common.

Infertility involves uncertainty, repeated disappointment and major personal decisions.

However, persistent anxiety, depression, severe relationship conflict or inability to function normally deserves professional assessment. WHO's current infertility guideline explicitly recognises the need for psychosocial support.

Can stress cause infertility?

The relationship is complex.

Stress can affect health, sexual activity and some reproductive processes, and studies have found associations between psychological distress and some fertility-treatment outcomes.

However, it is not scientifically appropriate to tell an individual that infertility occurred because they were stressed.

Infertility has many biological causes.

Will reducing stress guarantee pregnancy?

No.

Psychological treatment can significantly improve anxiety, depression and wellbeing in people experiencing infertility, but it should not be advertised as a guaranteed fertility treatment.

Does counselling actually help?

Yes, it can.

Modern evidence supports psychological interventions, including counselling and CBT, for important areas of infertility-related psychological distress.

NICE recommends counselling access before, during and after fertility investigation and treatment.

Does counselling mean I have a mental illness?

No.



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Fertility counselling can help people cope with a highly demanding health situation even when they do not have a psychiatric disorder.

My husband never talks about infertility. Does that mean he does not care?

Not necessarily.

People cope differently.

Men may sometimes express distress through silence, withdrawal, irritability or concentrating on practical issues rather than discussing emotions openly.

Is it normal to feel jealous when someone becomes pregnant?

Such feelings are common during infertility.

You may simultaneously care about the other person and feel sad about your own situation.

If jealousy or sadness is becoming overwhelming or leading to major social withdrawal, counselling may help.

Can infertility cause sexual problems?

Yes.

Research shows increased sexual difficulties among couples experiencing infertility, including reduced desire and erectile dysfunction. Timed intercourse and performance pressure can also interfere with sexual function.

Can I take a break from fertility treatment?

Sometimes.

Whether a break is medically sensible depends upon age, diagnosis and treatment urgency.

Discuss the timing with your fertility specialist rather than assuming that any delay is either completely harmless or automatically dangerous.

Should we tell our family about infertility?

That is your decision.

You have the right to keep medical information private.

Choose people who genuinely support you rather than people whose involvement increases pressure.

Can Unani medicine help with infertility-related distress?

Individualized Unani care may provide useful supportive management through attention to sleep, nutrition, lifestyle, psychological balance, general health and relevant reproductive-health conditions.

However, significant depression, severe anxiety, major relationship problems or suicidal thoughts require appropriate mental-health treatment.

Unani care should complement—not replace—necessary psychological or psychiatric care.

Can Unani medicine treat infertility itself?

The answer depends entirely on the underlying fertility condition.

Some traditional Unani therapies have been studied for selected male fertility conditions such as oligospermia, but available evidence is not sufficient to claim that Unani treatment can cure every type of infertility or guarantee pregnancy.

Correct diagnosis comes first.

What if I cannot think about anything except fertility?

That is one of the situations in which professional counselling can be especially valuable.

ASRM specifically identifies persistent preoccupation with infertility, along with continuing depression and strained relationships, as reasons to consider mental-health support.

My Message to Men Experiencing Infertility

If your semen report is abnormal, please do not use that report to judge your worth.

You are not a sperm count.



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You are not a motility percentage.

You are not defined by whether sperm are present or absent in one sample.

Understand the diagnosis.

Repeat testing when medically appropriate.

Investigate the cause.

Discuss treatment.

And if the diagnosis is affecting your confidence, sexual function or mental health, say so.

Remaining silent does not make the burden smaller.

My Message to Women Experiencing Infertility

If you are undergoing repeated scans, medicines, injections and pregnancy tests, it is understandable to feel emotionally tired.

You do not have to remain positive every day.

You do not need to smile at every pregnancy announcement.

You do not need to explain your fertility history to every relative.

And you should not carry responsibility for a couple's infertility without proper evaluation of both partners.

Your fertility diagnosis is part of your medical history.

It is not your value as a woman.

My Message to Couples

Remember why you became partners before infertility entered your relationship.

Protect that relationship.

Talk to each other.

But also allow conversations that have nothing to do with fertility.

Be honest when you are tired.

Do not turn sex into an examination.

Do not blame.



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Do not assume that your partner's coping style is proof that they care less.

Ask for professional support before communication completely breaks down.

The purpose of fertility treatment is to help build a family.

The treatment process should not be allowed to destroy the relationship at the centre of that family.

Final Words From Dr. Nizamuddin Qasmi

When a couple visits me for infertility, it is easy to focus on numbers.

Sperm count.

Motility.

AMH.

Follicle size.

Hormone levels.

Duration of infertility.

Treatment cycles.

These numbers matter clinically.

But the people behind those numbers matter more.

The man may be frightened that his wife will leave him because of azoospermia.

The woman may secretly cry whenever menstruation begins.

Both may be exhausted from answering family questions.

Their sexual relationship may have become mechanical.

Their savings may be disappearing into treatment.

And neither person may have told the doctor because they believe:

“The doctor only needs to know the medical part.”

I do not believe that is enough.

The World Health Organization's current infertility guideline recognises that effective fertility care must address the emotional and social burden of infertility as well as biological treatment.

Modern psychological research shows that structured psychological care can improve anxiety, depression and wellbeing.

Modern fertility standards recommend counselling before, during and after treatment.

And the traditional Unani approach reminds us that sleep, mental balance, nutrition, activity, rest and general health form parts of one person's overall wellbeing.

These ideas do not need to compete.

At **Saira Health Care**, my aim is to combine responsible reproductive evaluation with compassionate sexual-health care and individualized Unani supportive management where appropriate.

Some patients will need fertility medicine.

Some will need reproductive procedures.

Some will require specialist referral.

Some will need sexual-health treatment.

Some will benefit greatly from counselling.

And some will need several of these approaches together.

The most important message I want patients to remember is this:

Infertility is a diagnosis. It is not your identity.

A negative pregnancy test does not measure your worth.

An abnormal semen analysis does not measure masculinity.

A low ovarian reserve does not measure femininity.

A failed IVF cycle does not mean that you have failed as a person.

And asking for psychological support does not mean that you are weak.

It means you are taking care of another important part of your health.

So if infertility is beginning to control your thoughts, your sleep, your sexual relationship, your marriage or your ability to enjoy life, please speak about it.

The goal of infertility care should not only be to pursue pregnancy.

It should also be to help patients move through the fertility journey with as much **health, dignity, understanding, emotional stability and relationship support** as possible.



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Important Medical and Mental-Health Disclaimer

This article is intended for general patient education and awareness. It does not replace individualized fertility, medical, psychological or psychiatric assessment.

Infertility-related distress can range from normal temporary sadness to significant anxiety or clinical depression. Persistent or severe symptoms should be assessed by an appropriately qualified mental-health professional.

Psychological stress should not be assumed to be the cause of an individual's infertility, and patients should never be blamed for failing to conceive because they have not “relaxed enough.”

Unani medicine can form part of individualized supportive and integrative care where appropriate, but it should not replace medically necessary infertility investigations, assisted reproductive treatment, psychotherapy, psychiatric care or emergency mental-health treatment.

Never discontinue prescribed fertility, psychiatric or other medicines without discussing the change with the treating clinician.



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