TOPIC 7 · THE PSYCHOLOGICAL BURDEN OF INFERTILITY & IVF

What we know about anxiety, depression, quality of life, stigma, relationships, treatment burden and treatment discontinuation.

Why 8 core sources?

Eight is the ideal number here. This topic is much broader than stress alone and needs to capture distinct dimensions of the experience: depression and anxiety, quality of life, stigma, identity and relationships, treatment burden, treatment discontinuation, formal clinical guidance, and whether psychological interventions can meaningfully help.

The evidence in context

Infertility is not only a biomedical diagnosis. For many women and couples it can affect identity, body confidence, sexuality, the couple relationship, social life, work, finances and sense of control. IVF adds repeated tests, medication, waiting, uncertainty and the possibility of failure. The literature documents substantial anxiety, depressive symptoms and impaired quality of life, while physical and psychological burden are important reasons for discontinuing treatment. ESHRE also recognises psychosocial care as part of quality fertility care. The central point is that psychological support has value for women and couples in its own right - not because they must 'think positively' in order for treatment to succeed.

1. Braverman et al. (2024)

Depression, anxiety, quality of life, and infertility: a global review of the literature

Original source

What it studied → A review of the global literature from the preceding decade on depression, anxiety, stress and quality of life in people experiencing infertility and assisted reproduction.

What it found → Infertility is repeatedly associated with greater psychological distress and lower quality of life. The intensity and form of that burden vary by sex, treatment stage, social context and measurement tool.

What it means in practice → Psychological burden is not peripheral to infertility; it is a central part of the experience and should be routinely recognised within fertility care.

Limitations → A broad review of heterogeneous studies using different assessment tools. It does not support one universal prevalence estimate or a single causal conclusion across all populations.

2. Salari et al. (2024)

Global prevalence of major depressive disorder, general anxiety, stress, and depression in infertile women: a systematic review and meta-analysis

Original source

What it studied → A systematic review and meta-analysis of global evidence on major depression, general anxiety, stress and depressive symptoms among infertile women.

What it found → The analysis documented a high psychological burden among women with infertility, confirming that anxiety, depression and stress are common in this population.

What it means in practice → It supports active recognition and assessment of mental-health burden rather than treating distress as an expected inconvenience women are simply supposed to endure.

Limitations → Substantial heterogeneity across countries, cultures, screening tools and clinical definitions. Screening scores do not always equal a formal psychiatric diagnosis.

3. Shen et al. (2025)

Worldwide prevalence of discontinuation in fertility treatment: a systematic review and meta-analysis

Original source

What it studied → A systematic review and meta-analysis examining how often patients discontinue fertility treatment before completing the proposed treatment pathway.

What it found → The review concluded that treatment discontinuation occurs in approximately one in three fertility patients.

What it means in practice → Treatment success is not only about the biological protocol. Whether patients are psychologically, practically and financially able to continue is also a critical component of fertility care.

Limitations → Reasons for discontinuation vary substantially across healthcare systems and countries, and definitions of discontinuation were not uniform across studies.

4. Gameiro et al. (2012)

Why do patients discontinue fertility treatment? A systematic review of reasons and predictors of discontinuation in fertility treatment

Original source

What it studied → A systematic review of 22 studies involving 21,453 patients across eight countries, examining reasons for discontinuing fertility treatment.

What it found → Physical and psychological burden were among the most frequently reported reasons for discontinuation, alongside personal/relationship, organisational and treatment-related factors.

What it means in practice → Psychosocial care may matter not because it 'makes IVF work', but because it can reduce part of the burden that leads people to stop treatment they might otherwise wish to continue.

Limitations → An older review, with substantial variation in funding systems and clinical pathways, and often overlapping or inconsistently defined categories of discontinuation.

5. Xie et al. (2023)

The impact of stigma on mental health and quality of life of infertile women: a systematic review

Original source

What it studied → A systematic review of 28 studies examining infertility stigma and its relationship with mental health and quality of life in women.

What it found → Stigma was associated with substantial psychological pressure, poorer quality of life and adverse social consequences. Social support, environment, education and fertility beliefs influenced its severity.

What it means in practice → Women experience more than tests and procedures. Shame, social isolation, a sense of failure or pressure from family and society can be real components of the fertility experience.

Limitations → Most included studies were cross-sectional or qualitative and therefore cannot establish causal direction. Cultural differences are also substantial.

6. Woods et al. (2022)

Infertility-related stress: A concept analysis

Original source

What it studied → A concept analysis synthesising literature on infertility-related stress, including its defining attributes, antecedents and consequences.

What it found → Key attributes included identity crisis, social isolation and stigma, sexual stress and financial strain. Consequences included treatment dropout and marital strain, with anxiety, depression and poorer quality of life closely intertwined.

What it means in practice → Fertility distress is multidimensional. It is not merely 'worrying whether treatment will work'; it can affect identity, relationships, sexuality, finances, social life and sense of control.

Limitations → A concept analysis rather than a quantitative meta-analysis or RCT. It maps the phenomenon but does not estimate effect sizes or treatment efficacy.

7. Gameiro et al. / ESHRE (2015)

ESHRE guideline: routine psychosocial care in infertility and medically assisted reproduction - a guide for fertility staff

Original source

What it studied → An evidence-based European guideline addressing psychosocial needs throughout infertility and medically assisted reproduction.

What it found → ESHRE concludes that routine psychosocial care should be incorporated into fertility care and adapted to each patient's needs, preferences and stage of treatment.

What it means in practice → Psycho-emotional care is not a luxury or an optional extra; it is a recognised component of patient-centred fertility care.

Limitations → A 2015 guideline and therefore best read alongside more recent studies and meta-analyses. It does not evaluate Holistic Fertility® or any single complementary technique.

8. Systematic review & meta-analysis (2025)

The efficacy of psychological interventions for infertile women

Original source

What it studied → A systematic review and meta-analysis evaluating psychological interventions for infertility-related distress and well-being in infertile women.

What it found → Psychological interventions overall were effective in reducing infertility-related distress and improving aspects of psychological well-being, with variation according to intervention type and methodological quality.

What it means in practice → The fact that distress is real does not mean it is inevitable or something women must simply endure. Interventions can help reduce and manage it.

Limitations → Interventions, duration and outcome measures were heterogeneous. Improvement in psychological well-being should not automatically be translated into improved reproductive outcomes.

Library conclusion

The psychological burden of infertility and IVF is well documented and multidimensional. It should not be reduced to a generic reference to 'stress'. It includes anxiety, depressive symptoms, stigma, loss of control, relationship pressure, sexual burden, financial and practical strain and, in some cases, treatment discontinuation. The website should present psychosocial support as part of comprehensive fertility care without implying that a woman's emotional state is responsible for treatment outcome.

Template for future maintenance

For future updates, keep evidence in distinct categories: prevalence, quality of life, stigma/social burden, couple/sexual impact, treatment discontinuation and effectiveness of psychosocial interventions. New research should be classified into the appropriate category rather than accumulated in one generic 'mental health' list. For each new source: Full citation + link → What it studied → What it found → What it means in practice → Limitations → Date last reviewed.