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The IVF Experience as Lived: A Psychosocial Perspective on Emotional Health and Relationship Adjustment in Couples

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Abstract

This study investigated the emotional and relational experiences of Indian women undergoing in vitro fertilization, a process that holds significant social and psychological weight in many Indian communities. To capture both measurable outcomes and personal perspectives, a mixed-methods approach was used. Sixty women participated in the quantitative phase by completing standardized assessments that measured fertility-related quality of life and the quality of their intimate relationships. In the qualitative phase, twenty women took part in detailed interviews that explored their emotional journeys and the interpersonal challenges they faced during treatment.

The quantitative results showed a clear decline in emotional well-being as the number of treatment cycles increased, indicating that repeated procedures intensified psychological stress. Women who reported stronger and more harmonious relationships with their partners also reported higher relational satisfaction, suggesting that supportive couple dynamics play a protective role during treatment. Perceived support from family members was associated with better social quality of life, while financial difficulties were linked with greater dissatisfaction and higher levels of stress related to treatment.

The qualitative analysis revealed six major themes that shaped women's lived experiences: ongoing cycles of hope and disappointment, emotional exhaustion caused by prolonged treatment, changes in self-identity, reduced control over decisions, silence resulting from social stigma, and strain on romantic relationships. These themes highlight the deeply personal and culturally influenced nature of fertility treatment.

Overall, the findings show that in vitro fertilization is not solely a medical procedure but a complex emotional and relational process shaped by cultural expectations and social pressures. The study stresses the importance of holistic and culturally aware support systems that address psychological needs, relationship dynamics, and social factors alongside clinical care. This work adds to the limited research on the psychosocial aspects of infertility in non-Western populations and calls for comprehensive care models for women undergoing fertility treatment.

Keywords: IVF, Infertility, Indian Women, Emotional Distress, Dyadic Adjustment, FertiQoL, RDAS, Cultural Stigma, Fertility Counseling, Mixed-methods research

Introduction

Infertility remains one of the most emotionally distressing and socially sensitive health concerns for women in India. Motherhood is often closely tied to feminine identity, marital stability, and social acceptance, making the inability to conceive a source of intense personal and interpersonal strain. In vitro fertilization has created new pathways to parenthood, yet it introduces its own set of psychological, relational, financial, and cultural challenges. Women undergoing treatment frequently experience fear, fluctuating optimism, physical discomfort, and uncertainty, while also navigating expectations from partners and extended family members. These multidimensional pressures underscore the need to examine infertility not merely as a biomedical issue but as an experience deeply embedded within social norms, gender roles, and relational dynamics.

Earlier research indicates that women undergoing fertility treatment are at heightened risk for emotional distress, including anxiety, depressive symptoms, and diminished quality of life. Much of this distress arises from repeated treatment cycles, long waiting periods, and the unpredictable nature of reproductive procedures. Studies have also shown that relationship

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adjustment plays a crucial role during infertility treatment, as supportive couple communication and shared coping can buffer against stress, whereas conflict, blame, or emotional distance can intensify psychological strain. In the Indian context, where marriage is often embedded within joint family structures, expectations from extended family members and cultural pressure to conceive can further complicate the emotional experience of treatment.

Existing literature highlights important gaps, particularly in non-Western settings where cultural norms strongly influence experiences of infertility. Most psychosocial research on in vitro fertilization has focused on Western populations, leaving limited understanding of how women in India navigate treatment within collectivistic family systems, patriarchal expectations, and stigma associated with infertility. Women may feel compelled to silence their struggles, submit to externally driven decisions, or endure financial burdens, all of which can shape the emotional and relational impact of treatment.

The present study addresses these gaps by examining both psychological well-being and couple adjustment among women undergoing in vitro fertilization. By employing a mixed-methods design, the research integrates standardized assessments with detailed personal narratives to provide a comprehensive understanding of women's experiences. This approach allows for the examination of measurable patterns in emotional health and relationship functioning, while also capturing the nuanced realities of navigating infertility within an Indian sociocultural context.

The study therefore aims to contribute to a more holistic and culturally grounded understanding of in vitro fertilization. Its findings are intended to inform clinicians, mental health professionals, and fertility specialists about the emotional, relational, and social support needs of women in treatment, and to encourage the development of supportive interventions that address each dimension of the infertility experience.

Materials and Methods

Research Design

The study employed a convergent parallel mixed-methods design, which allowed quantitative and qualitative data to be collected simultaneously and analyzed independently before being integrated during interpretation. This approach aligns with Creswell and Plano Clark's framework for mixed-methods research and was specifically suited to capturing both the measurable psychological outcomes of fertility treatment and the subjective relational experiences of participants. This methodological structure supported a comprehensive examination of emotional well-being and dyadic adjustment among women undergoing in vitro fertilization.

Study Area

Participants were recruited from fertility clinics located in Delhi and Rohtak, two metropolitan and semi-urban regions in North India with well-established assisted reproductive technology (ART) services. These clinics serve a socio-demographically diverse population, providing an appropriate setting for studying experiences influenced by cultural, familial, and economic factors.

Sample and Sampling Strategy: A total of 60 women undergoing IVF treatment participated in the quantitative

component. Purposive sampling was used to ensure representation across age groups, treatment durations, and socio-demographic backgrounds, thereby enhancing diversity and relevance of the findings.

Inclusion Criteria

Participants were eligible if they:

- Identified as female and fell between 22–45 years of age.
- Were undergoing or had completed at least one IVF cycle.
- Were in a committed marital/heterosexual partnership.
- Could understand the consent form and psychometric tools in English.

Exclusion Criteria

Participants were excluded if they:

- Had clinically diagnosed psychiatric conditions (e.g., depression, anxiety, bipolar disorder).
- Were using psychotropic medication.
- Could not provide informed consent.
- Were involved in donor-based or surrogate reproductive arrangements.

Ethical Considerations

The study followed institutional ethical guidelines. Participants received detailed information about objectives, procedures, and potential risks, and written informed consent was obtained prior to data collection. Confidentiality was rigorously maintained through anonymized coding of questionnaires and interview transcripts. Data were stored securely on encrypted, password-protected devices accessible only to the researcher.

Given the sensitive nature of infertility, care was taken to minimize psychological distress. Participants could skip questions or withdraw at any time, and emotional support or referrals to psychological counseling were offered when needed.

Data Collection Procedures

Data collection occurred over a three-month period. After securing ethical approval, participants were recruited through collaborating clinics using flyers and clinician referrals.

Quantitative Data

Participants completed two standardized self-report scales:

1. Fertility Quality of Life Scale (FertiQoL)
2. Revised Dyadic Adjustment Scale (RDAS)

Qualitative Data

A subset of 20 women was purposively selected for semi-structured interviews to capture diversity in IVF history and relational contexts. Interviews were conducted in Hindi or English based on participant preference and designed to be culturally sensitive.

Tools and Instruments

1. Fertility Quality of Life (FertiQoL) Scale

Developed by Boivin, Takefman, and Braverman (2011), FertiQoL is the first internationally validated measure assessing the quality of life specific to fertility challenges. It contains **36 items**, comprising:

- **Core FertiQoL (24 items):** Emotional, Mind-Body, Relational, and Social domains
- **Treatment FertiQoL (10 items):** Treatment Environment, Treatment Tolerability

Scoring uses a 5-point Likert scale, with final scores converted to a 0–100 scale, where higher scores indicate better quality of life. The tool has demonstrated strong internal consistency (Cronbach's $\alpha > 0.80$) and good construct validity.

2. Revised Dyadic Adjustment Scale (RDAS)

The RDAS is a 14-item self-report measure designed to assess marital/relationship adjustment. Developed by Busby *et al.* (1995), it evaluates relationship quality through three subscales: consensus, satisfaction, and cohesion. It is widely used in psychological and clinical settings to measure relational functioning.

Software and Data Analysis

Although the dissertation text does not explicitly list software tools, standard practice for mixed-methods research typically involves:

- **Statistical analysis software** (e.g., SPSS, R or equivalent) to compute correlations, descriptive statistics, and reliability indices.
- **Qualitative analysis software** (e.g., NVivo, ATLAS.ti or manual thematic coding) to identify patterns and themes in interview transcripts.

Results

Quantitative Findings

The quantitative phase included sixty women undergoing in vitro fertilization. Descriptive statistics showed that participants were between 23 and 44 years of age, had been married for an average of seven years, and had undergone between one and five treatment cycles. Most women lived in urban settings and were part of joint families, and just over half reported high or moderate family support.

Scores on the Fertility Quality of Life scale indicated moderate levels of emotional, physical, relational, and social functioning. Emotional quality of life remained the lowest, reflecting substantial strain associated with treatment. Social functioning also showed considerable difficulty, suggesting significant impact from societal expectations and family pressures.

A clear pattern emerged across variables: emotional well-being declined as the number of treatment cycles increased. Women who had undergone more cycles reported higher emotional fatigue, sadness, and difficulty coping. Relationship adjustment showed a strong positive association with relational quality of life, indicating that women who experienced greater harmony with their partners reported better relational well-being. Higher perceived family support was linked with better overall fertility-related quality of life, while financial strain corresponded with lower treatment satisfaction.

Qualitative Findings

Semi-structured interviews with twenty participants expanded upon the quantitative results. Thematic analysis revealed six central themes describing women's lived experiences during treatment: fluctuating hope, emotional exhaustion, disruption of identity, reduced autonomy in

decision-making, silence shaped by stigma, and strain on romantic partnerships.

Participants frequently discussed emotional numbing, burnout, and pressure to remain outwardly composed despite internal distress. Many women described feeling disconnected from their sense of self and femininity. Others reported feeling obliged to comply with family-driven or partner-driven decisions, contributing to feelings of powerlessness. Several women also described relational distance and lack of emotional reciprocity within their marriages.

Integration of Findings

When quantitative and qualitative findings were considered together, strong convergence emerged. Participants who reported lower emotional and relational well-being on standardized scales also described emotional exhaustion, strained relationships, and feelings of inadequacy in their narratives. In some cases, interview accounts revealed distress that was not clearly reflected in numerical scores, demonstrating that standardized measures alone did not fully capture the depth of participants' emotional experiences.

Overall, the results showed that in vitro fertilization had significant emotional and relational consequences for participants. Declines in emotional well-being, variations in relationship adjustment, and the influence of family dynamics and cultural expectations collectively shaped women's treatment experiences.

Table 1: Demographic Characteristics of the Sample

Demographic Variable	Details
Age (years)	Range: 23–44 Mean: 33.4 ± 4.8
Marital Duration (years)	Range: 2–16 Mean: 7.1 ± 3.5
Number of IVF Cycles	Range: 1–5 Mean: 2.1 ± 1.3
Employment Status	35% Employed; 65% Homemakers
Education Level	58% Graduates; 14% Postgraduates; 28% Secondary or Below
Family Structure	58% Joint Family; 42% Nuclear Family
Language Preference (Interview)	70% Hindi; 30% English
Residential Setting	83% Urban; 17% Semi-urban
Current IVF Cycle Stage	20% Stimulation Phase; 40% Embryo Transfer; 40% Two-week Wait

Perceived Family Support 42% High; 33% Moderate; 25% Low

Table 2: Descriptive Statistics for FertiQoL Domains

FertiQoL Domain	Mean Score (M)	Standard Deviation (SD)
Emotional	55.4	14.2
Mind-Body	58.7	15.1
Relational	63.1	13.8
Social	49.6	12.9

Total Core FertiQoL 61.3 13.5

Note. Higher scores indicate greater fertility-related quality of life.

Table 3: Descriptive Statistics for RDAS Domains

RDAS Domain	Mean Score (M)	Standard Deviation (SD)
Consensus	14.2	3.1
Satisfaction	13.7	2.9
Cohesion	14.8	3.5

Total RDAS Score 42.7 7.9

Note. Higher scores indicate greater couple adjustment as measured by the Revised Dyadic Adjustment Scale (RDAS).

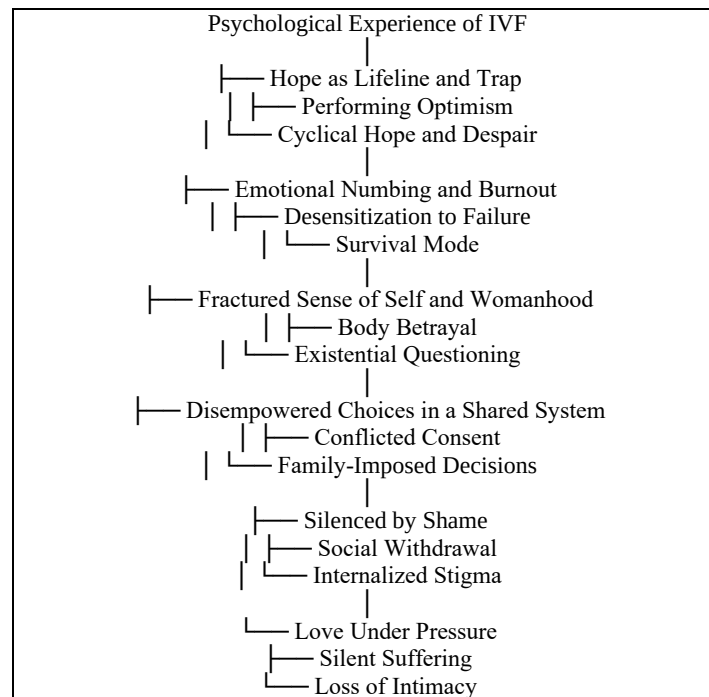
Table 4: One-Way ANOVA and Post-Hoc Comparisons of RDAS Scores by IVF Cycle Group

Group Comparison	Mean RDAS	SD	Post-hoc Difference	p-value
1 Cycle (n = 20)	46.3	6.5	—	—
2 Cycles (n = 20)	42.8	7.2	1 vs. 2 = 3.5	.216
3+ Cycles (n = 20)	39.2	8.1	1 vs. 3+ = 6.2*	.012

Note. ANOVA Summary: $F(2, 57) = 4.33, p < .05$. * $p < .05$ for post-hoc comparison using Tukey's HSD.

Table 5: Interconnectedness of Repeated Treatment, Partner Dynamics and Social Support

Variable Pair	Test	Significance	Direction
IVF cycles × Emotional QoL	Pearson's r	$p < .01$	Negative correlation
RDAS × Relational FertiQoL	Pearson's r	$p < .001$	Positive correlation
Family Support (High vs. Low) × Social FertiQoL	t-test	$p < .01$	Higher support → higher scores
IVF cycle groups × RDAS	ANOVA + Tukey	$p = .012$	More cycles → lower dyadic adjustment

Table 6: Thematic Map**Table 7:** Refined Themes from Thematic Analysis of IVF Narratives

Initial Code	Supporting Extract (Condensed)	Interpretive Note	Refined Theme and Definition
Cyclical Hope	"This time will be different."	Hope as emotional renewal.	Hope as a Lifeline and a Trap: Hope sustains participants but heightens vulnerability when expectations are unmet.
Hope as Double-Edged Sword	"Hope made it harder."	Emotional investment deepens grief.	Hope as a Lifeline and a Trap
Performing Hope	"I say 'maybe next time' even if I don't believe it."	Social expectation drives emotional masking.	Hope as a Lifeline and a Trap
Emotional Shutdown	"Tired of crying, on autopilot."	Emotional withdrawal	Emotional Numbing and
		Becomes self-protection.	Burnout: Emotional fatigue leads to psychological disconnection as a coping response.
Internalized Blame	"I failed at being a woman."	Self-worth collapses into reproductive failure.	Fractured Sense of Self and Womanhood: Identity is entangled with reproductive ability, leading to shame and loss.
Body Distrust	"I don't trust my body anymore."	Bodily alienation.	Fractured Sense of Self and Womanhood
Existential Questioning	"If I can't become a mother, who am I?"	Crisis in identity.	Fractured Sense of Self and Womanhood
Loss of Autonomy	"My in-laws arranged the consultation."	Reproductive choices influenced by others.	Disempowered Choices in a Shared System: Decisionmaking constrained by family dynamics and cultural expectations.
Conflicted Consent	"It never felt like a real choice."	Consent under pressure.	Disempowered Choices in a Shared System
Social Pressure	"Just someone who hasn't delivered."	Motherhood equated with worth.	Disempowered Choices in a Shared System

Stigma and Exclusion	“Don’t touch the baby—you’ll bring bad luck.”	Infertility seen as contaminating.	Silenced by Shame: Stigma surrounding infertility fosters secrecy, isolation, and emotional suppression.
Social Withdrawal	“I avoid gatherings with babies.”	Avoidance to protect emotional vulnerability.	Silenced by Shame
Waiting Distress	“I couldn’t think of anything else during the two-week wait.”	Anxiety and obsessive focus during treatment delays.	Time Held Hostage by Uncertainty: Waiting becomes emotionally charged and disrupts the flow of life.
Medical Dehumanization	“I felt like a science project.”	Objectification through clinical processes.	The Body as a Medical Object: Invasive procedures diminish embodied identity and increase alienation.
Sexual Disconnect	“We became robotic.”	Loss of intimacy in relationship.	Love Under Pressure: IVF introduces strain, emotional gaps, and communication breakdown in relationships.
Emotional Labor Divide	“He doesn’t talk. I feel alone.”	Unequal emotional burden.	Love Under Pressure
Peer Support	“Online forums helped me feel seen.”	External communities offer validation.	Building Resilience in Silence: Participants create self-affirming emotional practices to endure silently.
Journaling	“I write what I can’t say aloud.”	Expressive writing as private coping.	Building Resilience in Silence
IVF as Gamble	“It’s for the rich, but we go through it.”	Hope pursued despite economic hardship.	The Emotional Price of Persistence

Discussion

The findings of this study showed that in vitro fertilization had a substantial impact on the emotional and relational well-being of women, illustrating that infertility treatment extends far beyond its clinical procedures. Emotional quality of life consistently declined with an increasing number of treatment cycles, indicating that prolonged engagement with assisted reproduction intensified psychological fatigue. This pattern aligned with earlier research suggesting that repeated treatment attempts heighten distress due to ongoing uncertainty, physical discomfort, and emotional investment without assured success.

Relationship adjustment emerged as an important protective factor. Women who reported stronger dyadic adjustment also experienced better relational quality of life, highlighting the role of mutual understanding, emotional reciprocity, and supportive communication within partnerships. Although many participants described receiving logistical or financial help from their partners, qualitative accounts revealed that emotional support was frequently limited. This distinction emphasized that positive relational outcomes depend not only on cooperation but also on shared emotional engagement.

Perceived social support further shaped women’s experiences. Higher levels of familial support corresponded with better emotional and social functioning. However, the interviews revealed a more complex picture: while some family members provided genuine empathy, others exerted pressure or influenced treatment decisions, reducing women’s autonomy. This dual role of family involvement reflects the cultural context of infertility in India, where collectivistic norms can contribute both comfort and control. The qualitative themes deepened the understanding of these results. Women described fluctuating hope, emotional exhaustion, identity disruption, stigma-induced silence, and strain on romantic relationships. These narratives demonstrated the cumulative emotional burden of infertility and the cultural expectations surrounding womanhood and motherhood. Importantly, the qualitative findings explained areas where psychometric tools did not fully capture distress, showing that emotional suppression or cultural norms may limit self-disclosure in standardized assessments.

Overall, the study highlighted that infertility treatment is experienced as a holistic psychosocial journey influenced by

emotional vulnerability, marital dynamics, family pressures, and cultural beliefs. The convergence of quantitative and qualitative findings reinforces the need for fertility care models that incorporate psychological support, culturally sensitive counseling, and interventions aimed at strengthening couple communication. These insights underscore the importance of addressing the emotional and relational dimensions of treatment alongside its medical components.

Conclusion

The present study offered a comprehensive understanding of the emotional and relational experiences of women undergoing in vitro fertilization within the Indian sociocultural context. The findings demonstrated that infertility treatment is not limited to medical procedures but encompasses a wide range of psychological, relational, and cultural challenges. Quantitative results showed that emotional well-being steadily declined with an increasing number of treatment cycles, revealing the cumulative strain that repeated procedures impose. Relationship adjustment emerged as a strong predictor of relational quality of life, suggesting that supportive, communicative partnerships act as key buffers against treatment-related distress.

Social support also played a meaningful role. Women who perceived strong family support reported better emotional and social functioning, while those facing financial strain or family pressure experienced greater dissatisfaction and stress. Qualitative results deepened this understanding by highlighting the nuanced ways in which cultural expectations shaped women’s experiences. Participants described fluctuating hope, emotional fatigue, disrupted identity, silencing due to stigma, and strain on intimate relationships. These themes illustrated how the weight of societal expectations surrounding motherhood, coupled with limited autonomy in decision-making, intensified their emotional burden.

The convergence of quantitative and qualitative findings reinforced that standard psychometric tools alone may not fully capture women’s internal experiences. Interviews revealed hidden distress, emotional suppression, and fear of judgment that were not always reflected in numerical scores. This indicates the importance of integrating narrative approaches with standardized measures to gain a complete picture of women’s lived realities.

Overall, the study concludes that infertility treatment in India is deeply intertwined with cultural values, family structures, and gendered expectations. Emotional health and couple adjustment are central—not peripheral—to the fertility journey. The results highlight the need for holistic fertility care models that incorporate psychological screening, culturally sensitive counseling, and interventions that strengthen partner communication and shared coping. Such integrated approaches can contribute to more compassionate, equitable, and responsive reproductive healthcare for women undergoing in vitro fertilization.

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