Psychological Resilience During Infertility and Fertility Treatment

A Complete Modern and Unani Guide to the Two-Week Wait, Anxiety, Family Pressure, Relationship Intimacy, Sexual Health and Emotional Well-Being

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Introduction

When couples come to me for infertility treatment, they usually expect our conversation to be about ovulation, sperm count, fallopian tubes, hormones, medicines, IUI or IVF. These are important, but over the years I have also seen another part of infertility that is less visible on laboratory reports: **the psychological burden of waiting, uncertainty, repeated disappointment, social pressure and the gradual transformation of an intimate relationship into a fertility project**.

Infertility is therefore not merely a reproductive diagnosis. It can affect emotional health, self-confidence, sexual relationships, marriage, family interactions, work and financial wellbeing. The background material prepared for this article correctly describes the fertility journey as a repeated cycle of hope and grief and identifies three particularly difficult areas: the waiting period after ovulation or embryo transfer, social and family pressure, and the loss of spontaneity or intimacy when intercourse becomes medically scheduled.

The World Health Organization's first global infertility guideline, published in November 2025, explicitly recognizes this psychological dimension. WHO states that infertility can cause significant distress, stigma and financial hardship and may contribute to anxiety, depression and social isolation. Importantly, the guideline calls for **ongoing access to psychosocial support** as part of comprehensive fertility care.

At **Saira Health Care**, I believe this is especially important because my clinical practice is focused on both **sexual disorders and infertility**. Fertility treatment can affect sexual function, while sexual difficulties can themselves interfere with conception. Emotional health, reproductive biology and couple intimacy therefore cannot always be separated.

My Unani training also encourages me to consider the patient as a whole. Classical Unani medicine recognizes the influence of psychological states, sleep, lifestyle and emotional balance through concepts such as **Harakat-o-Sukoon Nafsani**, **Naum-o-Yaqzah**, the **Asbab-e-Sitta Zarooriya**, and **Ilaj Nafsani**. Official CCRUM literature recognizes psychological treatment, attention to sleep and verbal psychotherapy within the broader Unani approach to mind-body health.

The most responsible approach, in my view, is to combine that whole-person philosophy with modern reproductive psychology—without ever telling patients that infertility occurred because they were “too stressed” or that simply becoming positive will make pregnancy happen.

Infertility Is a Medical Condition With Psychological Consequences

WHO defines infertility as failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse** and estimates that approximately **one in six people of reproductive age experience infertility during their lifetime**.

This is important because people experiencing infertility are not simply “impatient couples who need to relax.”

They may be living with PCOS, blocked fallopian tubes, endometriosis, diminished ovarian reserve, azoospermia, severe oligozoospermia, sexual dysfunction, recurrent pregnancy loss or unexplained infertility.

At the same time, infertility affects far more than reproductive organs.

WHO's 2025 work documenting patients' lived experiences describes recurring themes of emotional strain, guilt, stigma, financial difficulties and gaps in access to clear fertility care.

A recent 2025 meta-analysis also found a high psychological burden among women receiving infertility care. Across the included studies, pooled estimates suggested symptoms of anxiety in approximately 41% and depression in approximately 42% of women, although prevalence varied substantially across settings and methods of assessment.

These numbers should not be interpreted to mean that every fertility patient has a psychiatric disorder.

They tell us something different:

fertility clinics must take emotional distress seriously rather than treating it as an irrelevant side effect of infertility.

Psychological Support Is Part of Fertility Medicine

The European Society of Human Reproduction and Embryology has long recommended incorporating psychosocial care into fertility treatment. Its guidance emphasizes that fertility staff should be attentive to patients' emotional, cognitive, social and relational needs, involve both partners where appropriate, and refer patients with clinically significant psychological difficulties for specialized counselling or psychotherapy.

ASRM similarly recognizes fertility counselling as a specialized area that may include supportive counselling, grief work, crisis intervention, education, decision-making counselling and treatment or referral for mental-health disorders.

For me, this means counselling is not what we offer because “the medical treatment did not work.”

It should be available **during the fertility journey itself**.

The Two-Week Wait: Why Waiting Can Feel So Difficult

One of the most emotionally demanding periods in fertility treatment is the interval between ovulation or embryo transfer and the pregnancy test.

Patients commonly call this the **Two-Week Wait**, or TWW, although the exact number of days differs according to the natural cycle or fertility-treatment protocol.

The source material describes this period as one of intense uncertainty because active treatment suddenly gives way to waiting. Instead of injections, scans or procedures, the patient is left with very little to “do,” and attention often turns inward toward every physical sensation.

Research supports the idea that this interval can be highly stressful. In a randomized controlled trial of 231 patients after embryo transfer, anxiety and distress increased during the waiting period. A brief empathic physician phone call significantly reduced the rise in both anxiety and distress compared with usual care.

An earlier prospective study also found that anxiety tended to become particularly prominent during the waiting phase before pregnancy-test results.

This tells us something important:

sometimes support does not require another medicine. It requires good communication and the feeling that the patient has not been abandoned after embryo transfer.

The Body Can Produce Pregnancy-Like Symptoms Without Pregnancy

One of the biggest psychological traps during the waiting period is **symptom interpretation**.

After ovulation, progesterone naturally rises. During fertility treatment, progesterone may also be given as medication.

Progesterone and normal luteal-phase hormonal changes can produce breast tenderness, abdominal bloating, fatigue, mood changes and other symptoms that overlap with what patients associate with early pregnancy. The source material accurately highlights this overlap as an important reason women may become confused or hyper-alert to bodily sensations.

Therefore:

Breast tenderness does not prove implantation.

A lack of breast tenderness does not prove that treatment has failed.

Mild cramping does not confirm pregnancy.

Feeling completely normal does not mean that pregnancy has not occurred.

The scheduled pregnancy test remains much more informative than symptom interpretation.

“Symptom Spotting” and the Anxiety Loop

During the Two-Week Wait, patients may repeatedly check their breasts, abdominal sensations, cervical mucus, spotting, temperature or other bodily signs.

The supplied report describes this process as **hyper-vigilance** or symptom spotting and notes how repeated online searches can amplify uncertainty rather than resolve it.

I see this frequently in clinical conversations.

A woman searches:

“5 days after embryo transfer mild cramps positive pregnancy?”

Then:

“No symptoms 7 days after embryo transfer success?”

Then:

“Breast pain stopped after IVF—is embryo okay?”

Every search produces contradictory stories because individual experiences vary tremendously.

The problem is not that the patient is doing something foolish.

Her mind is attempting to reduce uncertainty.

But fertility anecdotes cannot reliably predict her outcome.

A useful counselling goal is therefore **reducing repeated checking without demanding that she stop thinking about treatment completely**.

A Healthier Approach to the Two-Week Wait

I usually advise patients to treat the waiting period as a time for **ordinary living with sensible medical precautions**, not as fourteen days of constant reproductive surveillance.

The goal is not to achieve perfect calm.

The goal is to create structure while accepting that the final result cannot be controlled through repeated checking.

Patients may decide in advance when the pregnancy test will be performed, limit internet searches, maintain work or hobbies where comfortable, continue normal meals and sleep, and identify one or two trusted people for emotional support.

The source material proposes several similar strategies, including planning the testing approach in advance, engaging in absorbing activities, journaling concerns and reducing triggering social-media exposure.

These techniques should be viewed as **coping tools**, not as methods for increasing implantation.

Do Not Force Yourself to "Stay Positive"

Fertility patients often hear:

"Think positive."
"Don't worry."
"Stress will stop the embryo implanting."

These statements can produce additional guilt.

The background material makes an important observation: emotional neutrality is often more realistic than forced optimism, and negative thoughts should not be interpreted as biologically causing treatment failure.

Current IVF research also provides reassurance. In a randomized trial analysis, women's measured anxiety during IVF was **not associated with whether clinical pregnancy occurred**.

This does not mean mental health is unimportant.

It means:

we support mental health because anxiety and depression deserve treatment and because patients deserve a better quality of life—not because they must become emotionally perfect in order to become pregnant.

Anxiety Is Not Intuition

During infertility, fear can feel predictive.

A patient may say:

“I know this cycle has failed.”

Another may say:

“I feel something different, so I know I am pregnant.”

Neither hope nor fear is a pregnancy test.

One of the most useful psychological ideas in the supplied report is the distinction between emotional experience and biological prediction.

I often explain it simply:

You are allowed to feel anxious without treating anxiety as evidence that something bad will happen.

Scheduled Worry Can Be More Realistic Than “Stop Worrying”

Some patients find it impossible to stop fertility thoughts throughout the day.

Rather than fighting every thought, a cognitive-behavioural approach may involve setting aside a limited period to write down or think through the worries, then returning to ordinary activities.

The background report describes this as a “worry window.”

This is not suitable for everyone, but the principle is useful:

give worry a boundary rather than allowing fertility concerns to occupy every hour of the day.

Recent evidence also supports structured psychological interventions. A 2025 meta-analysis of randomized trials found that cognitive interventions, particularly CBT-based approaches, improved quality of life and reduced anxiety and depressive symptoms among women with infertility, although overall evidence quality was low to moderate and more high-quality trials are needed.

Family Pressure Can Become a Second Infertility Burden

In South Asian societies in particular, couples may face questions almost immediately after marriage:

“When will you give us good news?”

“Why are you waiting?”

“Have you seen a doctor?”

“Whose problem is it?”

“Why don't you just do IVF?”

“Why don't you adopt?”

These questions may be intended as concern, but repeated questioning can be deeply painful.

WHO's research on lived infertility experiences highlights stigma, guilt and social pressure as important parts of the infertility burden.

The patient is therefore dealing with two problems at once:

the reproductive problem itself, and the need to repeatedly explain or defend a private medical situation.

Privacy Is a Medical Right

A couple is not required to tell relatives:

which partner has the fertility factor,

what the semen analysis showed,

whether the woman has PCOS,

how many embryos were created,

whether IVF has begun,

or the date of the pregnancy test.

The amount of information shared is a personal decision.

The source document appropriately emphasizes **selective disclosure and boundary setting** rather than treating family access to fertility information as automatic.

A simple response can be enough:

“We're keeping our family plans private, but we'll share news when we're ready.”

Or:

“We are receiving appropriate medical care. We would prefer not to discuss the details.”

A boundary does not require an argument.

Well-Meaning Advice Can Still Hurt

Patients frequently hear:

“Just relax.”

“Take a holiday.”

“My cousin did IVF once and got twins.”

“Stop thinking about it.”

“You already have one child, be grateful.”

These comments are usually not malicious.

But they can unintentionally minimize a very real medical and emotional experience.

The source report describes several types of such social comments and correctly suggests that patients may choose between redirection, education, direct boundary setting or simply ending the conversation depending on the relationship.

Not every comment deserves a detailed explanation.

Protecting emotional energy is sometimes more useful than educating everyone.

Social Media During Fertility Treatment

Social media can be unusually difficult during infertility.

Pregnancy announcements, gender reveals, baby photos and parenting content may appear repeatedly at precisely the time a patient is waiting for her own result.

Feeling sadness in response to another person's pregnancy does **not** mean the infertile patient wishes them harm.

Two emotions can coexist:

“I am happy for you.”

and

“This reminds me of something painful in my own life.”

The source report discusses muting or reducing exposure to triggering social-media accounts as a legitimate form of emotional self-protection.

I consider this reasonable.

Patients should not feel guilty for temporarily reducing exposure to content that repeatedly intensifies distress.

Holidays, Weddings and Family Functions

Family-centred events can be especially difficult when relatives repeatedly ask about pregnancy.

Couples should decide beforehand how much they want to disclose and how long they want to remain at an event.

It is perfectly acceptable to decline an invitation when the emotional cost is temporarily too high.

It is also helpful for couples to agree on how they will support each other if an uncomfortable conversation begins.

The supplied report proposes having a pre-agreed signal allowing the couple to leave an overwhelming event without debate.

Whether or not a couple uses an actual signal, the underlying principle is sound:

partners should protect each other rather than leaving one person to manage intrusive questions alone.

Infertility Can Change a Sexual Relationship

One of the most important issues in my practice is the effect infertility has on sexuality.

Before trying for pregnancy, intercourse may represent affection, attraction, spontaneity and pleasure.

After months of fertility tracking it may become:

“Today the LH test is positive.”

“The doctor said tonight.”

“We have to do it even though we're exhausted.”

This can fundamentally change the emotional meaning of sex.

The supplied report describes this as the “Project Baby” effect, where intercourse gradually becomes a task rather than a form of connection.

Research supports this concern. A major systematic review found increased risk of sexual difficulties among couples experiencing infertility, with reduced desire and erectile problems among the commonly reported concerns.

More recent research in couples with unexplained infertility found that sexual-function problems were already present in a meaningful proportion of patients even relatively early in the fertility journey.

Timed Intercourse Can Create Performance Anxiety in Men

A man may have no erectile problem during spontaneous sexual activity but experience difficulty when told:

“Tonight is the fertile day.”

The erection is then no longer only part of intimacy.

It becomes a reproductive performance test.

If erection fails once, he may anticipate the same problem the following fertile cycle.

This can create a cycle:

pressure → anxiety → erection difficulty → disappointment → greater pressure next month.

At Saira Health Care, I consider this a legitimate sexual-health issue.

It should not be dismissed as weakness or lack of masculinity.

In some couples, treating performance anxiety or another sexual disorder may be as important as prescribing a fertility medicine.

Women Can Also Develop Fertility-Related Sexual Difficulties

Women undergoing fertility treatment may experience reduced desire, vaginal dryness, pain during intercourse, resentment toward scheduled sex or the feeling that their body exists only for reproduction.

Hormonal treatment, pelvic pain, endometriosis, repeated examinations or previous pregnancy loss may further influence sexual comfort.

Therefore, sexual counselling should not focus solely on male performance.

Fertility treatment should preserve **consent, comfort and emotional safety for both partners**.

Reclaiming Intimacy Outside the Fertile Window

One useful strategy is to consciously preserve forms of intimacy that have nothing to do with pregnancy.

That may involve affection, conversation, shared time, touch, dates or sexual intimacy without fertility scheduling.

The aim is not to prescribe a rigid relationship exercise.

The aim is to remind the couple:

You were partners before you became fertility patients.

The source report recommends separating “fertility business” from the rest of the relationship and intentionally protecting non-reproductive connection.

A 2025 systematic review of 14 counselling studies involving 550 participants found that several forms of psychological and couple counselling appeared to improve marital intimacy among people experiencing infertility, although the evidence base remains heterogeneous and stronger clinical trials are still needed.

Do Not Assume Your Partner Copes the Same Way You Do

One partner may want to discuss every scan, laboratory value and fear.

The other may cope by researching treatment, managing finances, staying busy or temporarily avoiding fertility conversation.

Neither automatically means that one cares more.

Research suggests that women and men may show different average patterns of anxiety, depression and coping during infertility, although individual variation is substantial.

Therefore, I advise couples not to interpret different coping styles too quickly.

A partner who does not cry may still be grieving.

A partner who talks constantly about infertility may not be “dwelling unnecessarily.”

Different styles can coexist.

The practical question is whether the partners can communicate without dismissing each other's experience.

Sometimes Listening Is More Helpful Than Solving

Many conflicts occur because one partner expresses sadness and the other immediately offers solutions.

“Let's change doctors.”

“We can try IVF.”

“Don't think negatively.”

“Everything will be fine.”

Sometimes the person speaking does not need a solution.

They need acknowledgement.

A response such as:

“I know this is really difficult. I'm here with you.”

can be more helpful than another treatment idea.

The source material highlights this difference between emotional and problem-solving coping and emphasizes validation as an important bridge between partners.

Limit How Much of the Day Belongs to Infertility

For some couples, fertility gradually becomes the only subject they discuss.

Appointments.

Medicines.

Ovulation.

Embryos.

Money.

Symptoms.

Other people's pregnancies.

One practical strategy described in the supplied material is to designate a limited period for fertility logistics and then intentionally return to normal couple life.

It does not have to be exactly twenty minutes.

The useful principle is:

infertility deserves attention, but it should not be allowed to become the couple's entire identity.

Secondary Infertility Has Its Own Psychological Burden

Secondary infertility refers to difficulty achieving another pregnancy after a previous pregnancy.

These patients may hear:

“At least you already have one child.”

This can produce guilt.

The woman may wonder whether wanting another child means she is ungrateful.

The source report accurately describes this as a “gratitude trap”: gratitude for an existing child and grief about difficulty expanding the family can exist at the same time.

I consider this an important counselling point.

A previous child does not eliminate the emotional reality of secondary infertility.

Nor does previous fertility guarantee that current reproductive health is unchanged.

Recurrent Pregnancy Loss Is Psychologically Different From Difficulty Conceiving

For a woman who has experienced repeated pregnancy loss, the positive pregnancy test itself may no longer feel reassuring.

Instead it can trigger fear:

“Will this happen again?”

Every ultrasound may become an emotionally charged event.

The supplied report notes that repeated loss may produce trauma-like symptoms such as hypervigilance, avoidance and intense anxiety around clinics or scans.

ESHRE's updated recurrent-pregnancy-loss guideline recognizes the importance of organized supportive care alongside appropriate medical investigation and management.

Such patients may benefit from a clinician or therapist familiar with **pregnancy loss and reproductive trauma**, particularly when anxiety, flashbacks or avoidance are interfering with everyday life.

The Non-Pregnant Partner Also Needs Support

In many fertility journeys, the woman undergoes most of the physical procedures.

This can cause people to forget that the male or non-carrying partner may also experience grief, helplessness and anxiety.

Sometimes that partner suppresses distress because they believe their only role is to "stay strong."

The source report appropriately highlights this hidden burden and recommends giving the partner meaningful involvement rather than treating them as a spectator.

At Saira Health Care, I prefer couple-based counselling where appropriate.

Both partners should understand the diagnosis.

Both should have an opportunity to ask questions.

And both should be allowed to say that infertility is difficult.

Stress Does Not Mean Infertility Is "Psychological"

This deserves a separate section because the misunderstanding is so common.

Infertility can produce stress.

Stress may influence sleep, appetite, sexual desire and quality of life.

Certain extreme physiological stress states can affect reproductive hormone signalling.

But infertility should **not** automatically be labelled psychosomatic.

A blocked fallopian tube does not appear because a woman worried too much.

A Y-chromosome abnormality is not caused by anxiety.

A severe sperm-production disorder is not cured by positive thinking.

Therefore psychological treatment should **support medical treatment**, not replace it.

This is one of the most important distinctions in responsible integrative fertility care.

The Unani Concept of Emotional Balance

Unani medicine has historically recognized that emotional states influence physical wellbeing.

Among the Six Essential Factors of health are psychological movement and repose, commonly discussed as **Harakat-o-Sukoon Nafsani**.

Classical Unani physicians described emotions such as prolonged grief, anger, fear and excessive worry as capable of disturbing overall health and *Mizaj*.

Modern medicine uses different terminology—stress physiology, autonomic regulation, sleep, anxiety, depression and behaviour—but the broad idea that mental and physical health interact remains valuable.

The important scientific boundary is this:

Unani emotional concepts should not be translated into claims that a particular emotion directly blocks implantation or causes infertility.

Ilaj Nafsani: Psychological Care in Unani Medicine

Official CCRUM material recognizes **Ilaj Nafsani**, or psychological treatment, within Unani medicine and describes the use of verbal psychological methods together with attention to mind-related processes such as sleep and the Six Essential Factors.

This provides a meaningful traditional basis for integrating counselling into reproductive care.

For infertility patients, an Unani-informed psychosocial approach may therefore include supportive conversation, reassurance based on accurate medical information, sleep regulation, appropriate daily routine, emotional moderation, family-boundary counselling and attention to the patient's overall *Mizaj*.

Where a patient has a diagnosable anxiety disorder, major depression, trauma symptoms or another psychiatric condition, specialist mental-health treatment should be added rather than relying solely on traditional reassurance.

Naum-o-Yaqzah: Sleep and Emotional Regulation

Unani medicine considers **sleep and wakefulness** a fundamental determinant of health.

This remains very relevant during fertility treatment.

A patient who spends the Two-Week Wait searching symptoms until 2 a.m., repeatedly testing and waking early to check her body may gradually worsen her anxiety simply through sleep deprivation.

Good sleep does not guarantee implantation.

But preserving a regular sleep schedule can support emotional regulation, concentration and general health.

This is an example of Unani preventive philosophy being useful without making an exaggerated fertility claim.

Ilaj-bil-Ghiza and Emotional Health

Diet should not be turned into another fertility test.

During emotionally stressful treatment, some patients eat very little because of anxiety, while others use food as a coping mechanism.

The Unani principle of **Ilaj-bil-Ghiza**, or dietotherapy, encourages appropriate nourishment according to the patient's constitution and condition.

In psychological fertility care, this means maintaining regular, nutritious meals rather than pursuing harsh fasting, cleansing or restrictive diets during an already demanding period.

No specific “mood fertility food” can prevent an unsuccessful cycle.

But stable nutrition forms part of overall health.

Does Unani Medicine Treat Anxiety During Infertility?

Unani medicine may contribute through its whole-person approach, sleep regulation, lifestyle counselling, traditional psychological care and, in selected circumstances, physician-supervised pharmacotherapy.

However, I would not claim that an herbal medicine can remove the psychological effects of infertility for every patient.

Moderate or severe anxiety and depression may require structured psychotherapy, psychiatric evaluation or medication when clinically appropriate.

Modern psychological treatments and Unani supportive care should not be viewed as competitors.

The correct approach depends on the severity of the patient's symptoms.

Counselling Can Improve Quality of Life Even If It Does Not Change Fertility Biology

This distinction is very important.

Psychological treatment does not need to increase pregnancy rates in order to be worthwhile.

A 2025 meta-analysis found that cognitive interventions improved quality of life and reduced symptoms of anxiety and depression among women with infertility.

A separate 2025 systematic review found encouraging effects of counselling on marital intimacy.

These outcomes matter.

A fertility treatment can last months or years.

Improving how a patient lives through that time is a legitimate medical goal.

When Should a Patient Seek Professional Mental-Health Support?

Temporary sadness, worry or irritability during fertility treatment is common.

Professional mental-health support becomes particularly important when symptoms begin interfering with normal functioning.

I become more concerned when a patient can no longer work or complete normal daily activities because of anxiety; cannot sleep for a prolonged period; feels persistently hopeless or detached; experiences recurrent panic; cannot stop compulsive checking despite significant distress; has escalating relationship conflict; or has trauma symptoms after pregnancy loss.

The source report identifies similar warning signs and recommends specialist reproductive psychological care when symptoms become persistent or disruptive.

Any thoughts of self-harm, suicide or harming another person require **urgent professional assessment**. Depression and anxiety disorders are treatable conditions, and significant symptoms should never be dismissed as merely part of fertility treatment.

Fertility Counselling Should Be Individualized

Not every patient needs formal psychotherapy.

Some benefit greatly from clear medical information and empathetic communication.

Others need several sessions of fertility counselling.

Some require couple therapy.

Some require treatment for an existing anxiety or depressive disorder.

Some need trauma-focused care after pregnancy loss.

Some simply need their doctor to explain:

“What you are feeling during this wait is understandable.”

ESHRE guidance emphasizes exactly this kind of individualized psychosocial care across different stages of fertility treatment.

A Practical Two-Week-Wait Plan

Rather than prescribing a rigid fourteen-day survival programme, I recommend a flexible plan centred on five principles:

Area	Practical approach
Testing	Decide with the fertility team when pregnancy testing is appropriate and avoid repeated premature tests unless medically advised.
Symptoms	Remember that progesterone, treatment medicines and normal luteal physiology can mimic pregnancy symptoms.
Information	Limit repetitive internet searches and use reliable medical sources.
Daily life	Continue ordinary routines, sleep, gentle activity and enjoyable non-fertility activities unless the fertility team has given restrictions.
Support	Identify the partner, friend, counsellor or clinician you will contact when anxiety becomes difficult.

The objective is not perfect calm.

It is to reduce the amount of unnecessary suffering created by uncertainty.

My Approach as Dr. Nizamuddin Qasmi

When a couple consults me for sexual disorders or infertility, I do not consider the psychological dimension an optional subject.

I want to understand:

How long they have been trying.

What treatment they have already undergone.

How the repeated cycles are affecting them emotionally.

Whether intercourse has become stressful or mechanical.

Whether either partner is experiencing erectile dysfunction, premature ejaculation, vaginal pain, vaginismus or reduced desire.

Whether family pressure is causing conflict.

Whether the woman has experienced pregnancy loss.

Whether the couple understands the medical diagnosis.

And whether either partner is showing signs that require professional mental-health support.

My background in Unani medicine also encourages me to assess broader factors including **Mizaj, sleep, food habits, physical activity, digestive health and emotional balance**.

But psychological care never replaces the reproductive diagnosis.

If tubes are blocked, they require appropriate fertility management.

If sperm are severely abnormal, the male partner requires evaluation.

If the woman is not ovulating, the cause must be addressed.

If IVF is indicated, counselling should help the couple cope with IVF—not persuade them that sufficient emotional balance will remove the need for it.

What "Special Treatment" Means at Saira Health Care

When I describe individualized or specialized care at **Saira Health Care**, I do not mean that every fertility patient receives a psychological medicine or a secret infertility formulation.

Specialized care means understanding the interaction among:

the reproductive diagnosis, the sexual relationship, emotional wellbeing and the couple's social environment.

A couple whose main problem is anovulatory PCOS needs appropriate reproductive treatment.

A couple whose major barrier is erectile dysfunction may require sexual-health treatment.

A patient whose IVF cycle is producing severe anxiety may benefit from structured psychosocial support.

A woman after recurrent pregnancy loss may require both medical investigation and trauma-sensitive counselling.

A couple whose relationship is deteriorating under timed intercourse may need help restoring communication and intimacy.

And in each case, Unani lifestyle principles and appropriate supportive care may be incorporated responsibly where they genuinely benefit the patient.

Contribution of Saira Health Care in Sexual Disorders, Infertility and Fertility Counselling

At **Saira Health Care**, sexual disorders and infertility are closely connected areas of practice.

Fertility patients often arrive with more than one concern.

A man may have an abnormal semen report and performance anxiety.

A woman may have PCOS and a fear of intimacy after repeated painful procedures.

A couple may have normal medical findings but severe stress surrounding fertile-window intercourse.

Another couple may be medically ready for IVF but emotionally unprepared for treatment decisions.

Our contribution should therefore not be measured simply by how many medicines are prescribed.

I believe good fertility care should help patients:

understand the diagnosis,

understand what treatment can realistically achieve,

preserve dignity and confidentiality,

protect the sexual relationship,

manage social pressure,

receive psychological support when necessary,

and make informed reproductive decisions without false promises.

This approach is consistent with WHO's current call for **people-centred, evidence-based and psychosocially supportive infertility care**.

Important Scientific Corrections to Common Psychological Fertility Claims

Some common beliefs require careful correction.

“Stress causes infertility.”
Infertility is usually biological or multifactorial. Psychological stress can affect wellbeing and sexual behaviour, but should not automatically be blamed for infertility.

“Thinking negatively will cause IVF failure.”
There is no reliable evidence that ordinary anxiety or negative thoughts determine whether implantation occurs. IVF research has found that measured anxiety does not necessarily predict clinical pregnancy.

“You must stay positive during the Two-Week Wait.”
No. Patients are allowed to feel fear, sadness and uncertainty.

“Every symptom during the TWW indicates implantation.”
No. Progesterone and normal luteal physiology can produce symptoms that overlap with early pregnancy.

“Sexual problems during infertility mean the relationship is failing.”
No. Fertility pressure itself can contribute to loss of desire, erectile difficulties and reduced sexual satisfaction.

“The stronger partner should never show emotion.”
No. Both partners may experience infertility-related distress and deserve support.

“If you already have one child, secondary infertility should not upset you.”
No. Gratitude for an existing child and grief about difficulty conceiving again can coexist.

Frequently Asked Questions

What is the Two-Week Wait?

It is the period between ovulation or embryo transfer and the pregnancy test. The exact duration can vary, but the term “Two-Week Wait” is commonly used by fertility patients.

Why does the Two-Week Wait cause so much anxiety?

The patient has usually completed active treatment and can do little except wait for a biological outcome. Studies have shown increased anxiety during this interval, and even a brief empathic clinical contact can reduce distress.

Does having no pregnancy symptoms mean treatment has failed?

No. Early pregnancy symptoms vary considerably, and many symptoms attributed to pregnancy can also result from progesterone or normal premenstrual hormonal changes.

Does anxiety stop an embryo from implanting?

Ordinary anxiety should not be treated as a cause of implantation failure. In IVF research, patient anxiety has not consistently predicted pregnancy outcome.

Should I test early during the Two-Week Wait?

Follow the pregnancy-testing schedule given by your fertility team. Testing too early can produce confusing results and may increase anxiety.

Why do I keep checking every symptom?

Uncertainty commonly leads to hypervigilance. Repeated symptom checking may briefly provide reassurance but can then strengthen the cycle of anxiety.

Is it normal to feel jealous or sad when someone announces a pregnancy?

Yes. Difficult emotions about your own infertility can coexist with genuine happiness for someone else.

Do I have to tell my family about IVF?

No. Fertility information is private medical information. You and your partner can decide what to share and with whom.

Can infertility damage a marriage?

Infertility can create significant relational and sexual strain, but outcomes vary greatly among couples. Counselling interventions may improve marital intimacy and communication.

Can timed intercourse cause erectile dysfunction?

It can contribute to performance anxiety in some men, particularly when sexual activity feels compulsory rather than spontaneous.

Should couples stop having sex except during ovulation?

No. Preserving intimacy outside fertility-focused intercourse may actually help protect the couple's sexual relationship.

Is psychological counselling useful if infertility is a physical disease?

Yes. Counselling does not replace reproductive treatment; it helps patients cope with the emotional, relational and decision-making burden of treatment. WHO and ESHRE both support psychosocial care as part of fertility services.

Can Unani medicine help with fertility-related stress?

Unani medicine can contribute through attention to psychological balance, sleep, daily routine, nutrition and traditional **Ilaj Nafsani** concepts. When symptoms are moderate or

severe, specialist psychological or psychiatric treatment should also be used where appropriate.

Is stress management a fertility treatment?

It is better described as **supportive fertility care**. It may improve quality of life and coping, but should not replace diagnosis or evidence-based reproductive treatment.

When should I see a reproductive psychologist or counsellor?

Seek additional help when anxiety, depression, panic, trauma symptoms, relationship conflict or obsessive fertility thoughts are interfering significantly with daily life, sleep, work or normal functioning.

My Final Message to Couples Going Through Infertility

When I speak with couples who have been trying for pregnancy for a long time, I want them to understand something that fertility medicine sometimes forgets:

You are not only reproductive organs. You are two people trying to build a family while living through uncertainty.

You are allowed to become tired.

You are allowed to be frightened before a pregnancy test.

You are allowed to protect your privacy.

You are allowed to temporarily mute pregnancy announcements.

You are allowed to tell family members that you do not want to discuss your treatment.

You are allowed to love your partner and still become frustrated with each other.

You are allowed to have sexual difficulties during fertility treatment.

And you are allowed to seek psychological help without anyone implying that infertility is “all in your mind.”

My Unani training teaches me the importance of **Harakat-o-Sukoon Nafsani, Naum-o-Yaqzah, Mizaj, Ilaj Nafsani and the broader balance of daily life**.

Modern reproductive psychology teaches us to recognize anxiety, depression, grief, trauma, relationship strain and treatment-related sexual dysfunction more precisely.

I believe both perspectives can contribute.

But we must maintain one very important boundary:

psychological care supports infertility treatment—it does not replace the investigation or treatment of the biological cause.

At **Saira Health Care**, my aim is therefore to treat fertility as a couple's reproductive and human experience.

We investigate the cause.

We address sexual disorders when they interfere with conception or intimacy.

We explain treatment realistically.

We protect confidentiality.

We support emotional wellbeing.

And where a patient needs specialist psychological or psychiatric help, appropriate referral is part of responsible treatment.

The supplied background concludes that resilience during infertility does not mean forced positivity; it means acknowledging the reality of the experience while protecting the individual and the relationship from being completely consumed by fertility treatment.

I consider that an important message.

The goal is not only to achieve pregnancy. The goal is also to help the couple reach that destination without losing their emotional health, dignity, intimacy and partnership along the way.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** focuses on sexual disorders and infertility, including male and female reproductive problems, sexual-function concerns, fertility counselling and individualized integration of Unani supportive care with appropriate modern fertility assessment.

Medical Disclaimer

This article is intended for **general education and public awareness** and does not constitute an individualized fertility or mental-health diagnosis.

Infertility-related anxiety, sadness and relationship stress are common, but persistent or severe symptoms deserve professional assessment. Psychological counselling should complement—not replace—appropriate investigation and treatment of the underlying reproductive condition.

Patients experiencing severe depression, persistent hopelessness, panic, inability to function normally, or thoughts of self-harm or suicide should seek urgent professional mental-health care.