



The Relationship between Infertility Stigma, Perceived Infertility Stress, and Fertility-Related Quality of Life in Women: The Mediating Role of Sexual Function

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Abstract

Introduction: Infertility, a prevalent global health concern, imposes significant psychological and social burdens—including stigma and distress—particularly on women, adversely affecting their well-being. This study examines the associations among infertility stigma, perceived infertility stress, and fertility-related quality of life (FertiQoL) in women, emphasizing the mediating role of sexual function.

Methods: A descriptive-correlational design utilizing structural equation modeling (SEM) was employed. The study population comprised married women aged 20–45 years with a confirmed diagnosis of primary infertility in Ahvaz, Iran, in 2024. A convenience sample of 295 women was recruited. Data were collected using validated Persian versions of the Infertility Stigma Scale (ISS), Fertility Problem Inventory (FPI), Female Sexual Function Index (FSFI), and Fertility-Related Quality of Life (FertiQoL) scale (Cronbach's alphas: 0.89–0.93). SEM was conducted using SPSS v.26 and AMOS v.24 to analyze relationships among variables.

Results: The SEM model exhibited a good fit. Perceived infertility stress showed a significant negative direct effect on FertiQoL ($P < 0.01$), whereas the direct effect of infertility stigma on FertiQoL was non-significant. Sexual function significantly mediated the relationships between both infertility stigma and perceived stress ($P < 0.01$) with FertiQoL, indicating an indirect effect.

Conclusions: These findings underscore the importance of addressing psychological stress and sexual dysfunction to enhance FertiQoL in infertile women. While infertility stigma lacks a direct effect, its influence is fully mediated through sexual function. Clinical interventions should prioritize stress reduction and sexual health, which may also positively influence infertility treatment outcomes, to improve well-being.

INTRODUCTION

Infertility, defined as the inability to achieve a clinical pregnancy after one year of regular unprotected intercourse, can be classified as primary (failure to conceive a first child) or secondary (inability to conceive or carry to term following a prior pregnancy). It is a widespread global health concern affecting an estimated 10-15% of couples worldwide [1], with causes encompassing female factors (such as ovulatory disorders and tubal blockages, accounting for approximately 40% of cases), male factors, combined etiologies, or unexplained origins. In Iran, the prevalence of infertility is estimated at 10.5% (ranging from 7.8% to 13.2%), with primary infertility comprising about 10.6% and secondary 2.7% of cases [2]. For many women—who bear a disproportionate share of the diagnostic and emotional load—this diagnosis

transcends a mere medical condition, evolving into a profound life crisis that triggers intertwined psychological distress (e.g., grief, failure, and inadequacy), social isolation, and relational strain [3]. These burdens are often compounded by the physically and emotionally demanding nature of diagnostic procedures and assisted reproductive technology (ART) treatments, which can be prolonged, invasive, and unpredictable [4]. The lived experience of infertile women is thus marked by a complex interplay of personal loss, social exclusion, and relational challenges, underscoring the critical need for a holistic understanding of their well-being that extends beyond clinical reproductive outcomes.

One of the most debilitating psychological aspects of the infertility journey is the social stigma that women often

endure. Infertility stigma refers to the negative societal beliefs, attitudes, and discrimination directed at individuals because of their inability to conceive, frequently leading to profound feelings of shame and social isolation [5]. This stigma can manifest in various forms, from insensitive comments and intrusive questions by family members to a broader cultural perception that infertile women are somehow “flawed” or “incomplete” [6]. Research consistently indicates that higher levels of perceived stigma are associated with a range of negative mental health outcomes, including increased anxiety, depressive symptoms, and lowered self-esteem [7]. The pervasive feeling of being judged and misunderstood can lead women to withdraw from social circles, further exacerbating their emotional distress [8]. Furthermore, infertility stigma correlates with poorer treatment outcomes, such as delayed help-seeking, higher dropout rates from ART cycles, and reduced adherence, as it intensifies psychological distress that undermines engagement with care [9, 10]. While prior research has examined the direct link between infertility stigma and well-being [11], the specific pathways through which this stigma ultimately impacts a woman's fertility-related quality of life (FertiQoL), particularly within the context of her intimate relationships, remain a crucial area for further investigation [12, 13].

Complementing the external pressures of stigma are the internal psychological stressors directly related to the infertility diagnosis. Perceived infertility stress encompasses the emotional and psychological distress a person experiences in response to the multifaceted challenges of infertility, including feelings of grief, frustration, anger, and anxiety about an uncertain future [13]. This type of stress is highly complex, stemming from the demanding medical procedures, the significant financial burden of treatment, and the persistent uncertainty of a positive outcome [14]. Studies have consistently demonstrated a strong correlation between elevated perceived infertility stress and a decline in mental health, leading to a higher incidence of clinical depression and anxiety disorders among affected women [15, 16]. The relentless cycle of hope and disappointment inherent in fertility treatments can create a state of chronic stress that not only impacts emotional health but can also strain a couple's ability to cope with other life challenges, making it a pivotal variable in understanding overall well-being [17]. Notably, studies show that managing perceived infertility stress and stigma through psychological interventions—such as cognitive-behavioral therapy or coping skills training—can enhance treatment adherence, reduce dropout rates, and improve reproductive outcomes by alleviating distress and bolstering resilience [15, 18].

Another critical yet often overlooked dimension of the infertility experience is its impact on a woman's sexual

function [19]. For many couples, the journey of infertility can fundamentally alter the nature of sexual intimacy, transforming a spontaneous, pleasurable act into a scheduled, goal-oriented task for procreation [20]. This shift can lead to feelings of pressure, performance anxiety, and a significant loss of libido, which can profoundly impair sexual satisfaction and overall function [21]. Research has linked sexual dysfunction in infertile women to a variety of factors, including treatment-related stress, anxiety, and depression [18]. Importantly, impaired sexual function can create a negative feedback loop, leading to further emotional distress and relationship strain [22]. It is plausible that the adverse effects of infertility stigma and perceived stress on a woman's psychological state and well-being are, at least in part, channeled through their damaging impact on her sexual health.

Despite a growing body of literature on the psychological dimensions of infertility, a significant gap remains in our understanding of the complex interrelationships among these variables. Specifically, while a direct link between infertility-related stress and reduced FertiQoL has been established, the role of sexual function as a potential mediator has not been fully explored. Investigating this specific mediating pathway is crucial because it could offer a more nuanced and clinically actionable understanding of how these psychosocial factors ultimately affect a woman's well-being. By identifying sexual function as a key link in this chain, targeted therapeutic interventions could be developed to address this often-neglected area of life, thereby enhancing overall FertiQoL. Therefore, the present study aims to investigate the relationships among infertility stigma, perceived infertility stress, and FertiQoL in women, with a specific focus on the mediating role of sexual function. The findings of this research will provide valuable insights for healthcare professionals and mental health practitioners in designing more effective and comprehensive support programs for infertile women.

METHODS

This study employed a descriptive-correlational design using a structural equation modeling (SEM) approach to investigate the complex relationships between the study variables. The statistical population consisted of all married women with a confirmed diagnosis of primary infertility who attended infertility treatment centers, including the university-affiliated Jahad Daneshgahi Khuzestan Infertility Center and the hospital-based Imam Khomeini Hospital Infertility Center, in Ahvaz, Iran, in 2024. A convenience sample of 295 women was recruited for the study. This sample size was determined based on SEM guidelines recommending a minimum of 10 cases per estimated parameter to ensure model stability, adequate statistical

power, and reliable parameter estimation (approximately 15 free parameters in the model). Inclusion criteria were as follows: a confirmed medical diagnosis of primary infertility (due to female factors, defined as the inability to conceive after one year of regular unprotected intercourse), age between 20 and 45 years (selected to align with peak reproductive years and typical eligibility criteria for assisted reproductive technologies in Iran, where fertility declines significantly after age 45, despite the broader definitional range up to 50), sufficient literacy to complete the questionnaires, and providing informed consent to participate. Given that perceived stress levels may differ between primary and secondary infertility, with primary cases often involving higher emotional intensity due to the absence of prior parenthood, the study focused exclusively on primary infertility to maintain sample homogeneity and avoid confounding variability. Exclusion criteria included any major psychiatric disorders (assessed via clinical history), such as schizophrenia, bipolar disorder, or severe major depressive disorder; chronic physical illnesses, such as uncontrolled diabetes, cardiovascular disease, or cancer; or concurrent psychological treatment. The study was conducted in full compliance with the ethical guidelines for human research and received approval from the university's Research Ethics Committee (Ethics Code: IR.IAU.AHVAZ.REC.1403.445), ensuring participant confidentiality, voluntary participation, and the right to withdraw at any time.

Procedure

Following the acquisition of necessary permissions from the Ethics Committee and the collaborating infertility centers in Ahvaz, data collection was initiated. The researcher visited the centers and provided a comprehensive explanation of the study's purpose and procedures to eligible volunteers. After obtaining written informed consent from those who agreed to participate, a set of self-report questionnaires was distributed. The participants completed the questionnaires in a quiet and private setting to ensure the confidentiality of their responses. The researcher was available to clarify any ambiguities or questions that arose during the completion of the forms. To ensure data accuracy despite the substantial number of items across questionnaires (totaling approximately 128 items) and the 60-minute estimated completion time, the researcher provided on-site supervision, monitored for signs of respondent fatigue or confusion, and offered optional short breaks; responses were preliminarily reviewed for completeness immediately after submission, with prompts for missing data where feasible. Data were collected from 308 women; however, after review, 13 cases were excluded due to incomplete questionnaires, yielding a final analytic sample of 295. The approximate time required to

complete the entire set of questionnaires was around 60 minutes per participant.

Measures

Demographic questionnaire

A researcher-developed, structured demographic questionnaire was administered to capture key participant characteristics. It included items on age (continuous), educational attainment (categorical: high school or lower; university degree), employment status (binary: homemaker; employed), duration of marriage (continuous, in years), and duration of infertility (continuous, in months). These variables were selected as potential confounders and were descriptively summarized in the results.

Fertility-Related Quality of Life (FertiQoL) Scale

The FertiQoL scale, developed by Boivin et al. [23], is a 36-item questionnaire designed to assess quality of life in individuals with infertility. It comprises four subscales: Emotional, Social, Relational, and a Structural section. Responses are scored on a 5-point Likert scale ranging from "never" (0) to "very much" (4), with total scores ranging from 0 to 144. Higher scores on this scale indicate a better quality of life. The reliability of the Persian version of this scale was previously confirmed by Hekmatzadeh et al. [24], who reported a Cronbach's alpha coefficient of 0.82. In the current study, the total scale's reliability was confirmed with a Cronbach's alpha of 0.93.

Fertility Problem Inventory (FPI)

The FPI, developed by Newton et al. [25], is a 46-item scale used to measure perceived infertility stress. It includes six subscales: Social, Sexual, Relational, Need for Control, and a Personal section. Participants respond on a 6-point Likert scale from "strongly disagree" (1) to "strongly agree" (6). Higher scores on this scale indicate greater perceived stress. The reliability of this scale was previously reported by Samani et al. [26], who found a Cronbach's alpha of 0.70. In the present research, the Cronbach's alpha coefficient for this scale was 0.91.

Female Sexual Function Index (FSFI)

The FSFI, created by Rosen et al. [27], is a 19-item questionnaire that evaluates various aspects of female sexual function. It measures six domains: desire, arousal, lubrication, orgasm, satisfaction, and pain. Each item is scored on a 5- or 6-point scale, with a total score ranging from 2 to 36. A total score below 26.5 is considered indicative of sexual dysfunction. The Persian version has demonstrated good reliability, with a reported Cronbach's alpha of 0.91 in a previous Iranian study [28]. In the current study, the reliability of this tool was confirmed with a Cronbach's alpha of 0.92.

Infertility Stigma Scale (ISS)

Developed by Fu et al. [9], the ISS is a 27-item tool designed to assess perceived infertility stigma. Items are rated on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree." Higher scores on this scale indicate higher levels of perceived stigma. The reliability of this scale was confirmed by Rajabi et al. [29], who reported a Cronbach's alpha of 0.95. In the present study, the reliability of this scale was found to be 0.89 using Cronbach's alpha.

Data Analysis

The collected data were analyzed using SPSS v.26 and AMOS v.24 statistical software. First, descriptive statistics (e.g., mean, standard deviation, and frequency) were used to summarize the demographic characteristics and study variables. Potential confounding factors, including age, educational level, employment status, and marriage duration, were examined via preliminary correlation analyses and controlled for in the SEM by including significant covariates as exogenous predictors to isolate the effects of the primary variables. Subsequently, to test the direct relationships and examine the mediating role of sexual function within the proposed model, SEM was employed. This analytical approach allows for the simultaneous examination of complex relationships between latent and observed variables.

RESULTS

The study included 295 married women with a confirmed infertility diagnosis, recruited from infertility treatment centers in Ahvaz, Iran, in 2024. The mean age of participants was 34.46 years ($SD = 6.41$). Regarding educational attainment, 75 participants (25.4%) held a high school diploma or lower, while 220 (74.6%) had a university degree. In terms of employment status, 198 women (67.1%) were homemakers, and 97 (32.9%) were employed. The mean duration of marriage was 8.45 years ($SD = 3.67$). The mean duration of infertility was 4.2 years ($SD = 2.1$), reflecting a typical timeframe for women seeking specialized treatment. These demographic characteristics provide a comprehensive profile of the sample, reflecting a diverse group of infertile women in terms of education and employment, with a relatively stable marital duration, which may influence the psychological and social dimensions of infertility-related experiences. As potential confounders, these variables—particularly education, employment status, marriage duration, and infertility duration—were evaluated for their associations with the primary study variables. Bivariate analyses revealed that higher educational attainment was linked to lower perceived infertility stress ($r = -0.18$, $P < 0.01$) and higher FertiQoL ($r = 0.14$, $P < 0.05$), employment was positively associated with sexual function ($r = 0.16$, $P < 0.01$), and both longer marriage duration ($r = 0.12$, $P < 0.05$) and infertility duration ($r = 0.20$, $P < 0.01$)

correlated with elevated infertility stigma. Consequently, these significant confounders were incorporated as covariates in the SEM to adjust for their effects and enhance the robustness of the estimated relationships.

Table 1 presents the means, standard deviations, skewness, kurtosis, and Pearson correlations for infertility stigma, perceived infertility stress, sexual function, and FertiQoL. The mean score for infertility stigma was 76.07 ($SD = 24.93$), indicating moderate to high stigma levels, with acceptable skewness (-0.73) and kurtosis (0.01). Perceived infertility stress had a mean of 144.08 ($SD = 46.02$), suggesting significant stress, with minimal skewness (-0.13) and kurtosis (0.13). Sexual function, with a mean of 18.81 ($SD = 7.69$), indicated prevalent dysfunction (scores < 26.5), with skewness (-1.14) and kurtosis (0.56). FertiQoL had a mean of 39.63 ($SD = 19.92$), reflecting impaired quality of life. Significant correlations were observed: infertility stigma and perceived stress negatively correlated with FertiQoL ($r = -0.27$, $r = -0.35$, $P < 0.01$), while sexual function positively correlated with FertiQoL ($r = 0.39$, $P < 0.01$), supporting the hypothesized relationships.

Table 2 summarizes the goodness-of-fit indices for the proposed and final SEM. The proposed model demonstrated acceptable fit: $\chi^2/df = 1.66$, CFI = 0.93, TLI = 0.92, IFI = 0.93, GFI = 0.88, and RMSEA = 0.04, indicating alignment with observed data. The final model, refined by removing the non-significant path from infertility stigma to FertiQoL, showed improved fit: $\chi^2/df = 1.60$, CFI = 0.94, TLI = 0.93, IFI = 0.94, GFI = 0.90, and RMSEA = 0.04. These indices suggest that the final model better represents the data, with all values meeting or exceeding thresholds for good fit (e.g., RMSEA < 0.08 , CFI > 0.90). The improved fit in the final model supports the validity of the mediated pathways, particularly the role of sexual function in linking infertility-related stressors to FertiQoL. Figure 1 illustrates the proposed SEM, depicting direct and indirect paths among infertility stigma, perceived infertility stress, sexual function, and FertiQoL.

Table 3 details the direct and mediating relationships in the proposed and final SEM models. In the proposed model, perceived infertility stress had a significant negative direct effect on FertiQoL ($\beta = -0.20$, $P < 0.001$), while the direct path from infertility stigma to FertiQoL was non-significant ($\beta = 0.04$, $P = 0.611$). Both infertility stigma ($\beta = -0.21$, $P < 0.001$) and perceived stress ($\beta = -0.27$, $P < 0.001$) negatively predicted sexual function, which positively predicted FertiQoL ($\beta = 0.32$, $P < 0.001$). In the final model, the non-significant stigma-to-FertiQoL path was removed, maintaining significant paths: perceived stress to FertiQoL ($\beta = -0.20$, $P < 0.001$), stigma to sexual function ($\beta = -0.21$, $P < 0.001$), perceived stress to sexual function ($\beta = -0.26$, $P < 0.001$), and sexual function to FertiQoL ($\beta = 0.28$, $P < 0.001$).

These results highlight sexual function's mediating role and were consistent after covariate adjustment.

Table 1. Descriptive statistics and correlations among study variables

Variables	Mean $\pm$ SD	Skewness	Kurtosis	1	2	3	4
1- Infertility stigma	76.07 $\pm$ 24.93	-0.73	0.01	1			
2- Perceived infertility stress	144.08 $\pm$ 46.02	-0.13	0.13	0.43**	1		
3- Sexual function	18.81 $\pm$ 7.69	-1.14	0.56	-0.41**	-0.38**	1	
4- FertiQoL	39.63 $\pm$ 19.92	-0.47	0.25	-0.27**	-0.35**	0.39**	1

** $: P < 0.01$

Table 2. Fit Indices for the proposed and final structural equation model

Fit indicators	(χ^2/df)	CFI	TFI	IFI	GFI	RMSEA
Proposed model	1.66	0.93	0.92	0.93	0.88	0.04
Final model	1.60	0.94	0.93	0.94	0.90	0.04

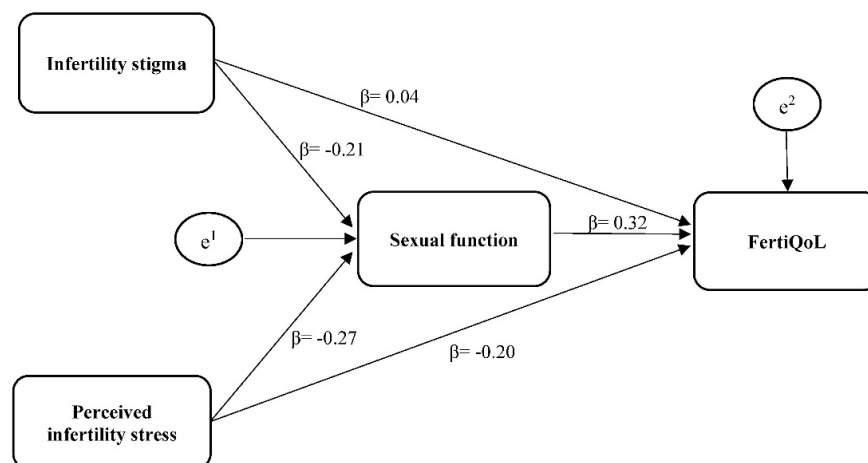


Figure 1. Proposed structural equation model of study variables

Table 3. Direct relationships in the proposed and final models

Path	Proposed model		Final model	
	β	P	β	P
Infertility stigma to FertiQoL	0.04	0.611	-	-
Infertility stigma to Sexual function	-0.21	0.001	-0.21	0.001
Perceived infertility stress to Sexual function	-0.27	0.001	-0.26	0.001
Sexual function to FertiQoL	0.32	0.001	0.28	0.001
Perceived infertility stress to FertiQoL	-0.20	0.001	-0.20	0.001

Table 4. Indirect effects of study variables on FertiQoL in the final model

Path	β	P
Infertility stigma to FertiQoL through Sexual function	-0.06	0.001
Perceived infertility stress to FertiQoL through Sexual function	-0.04	0.001

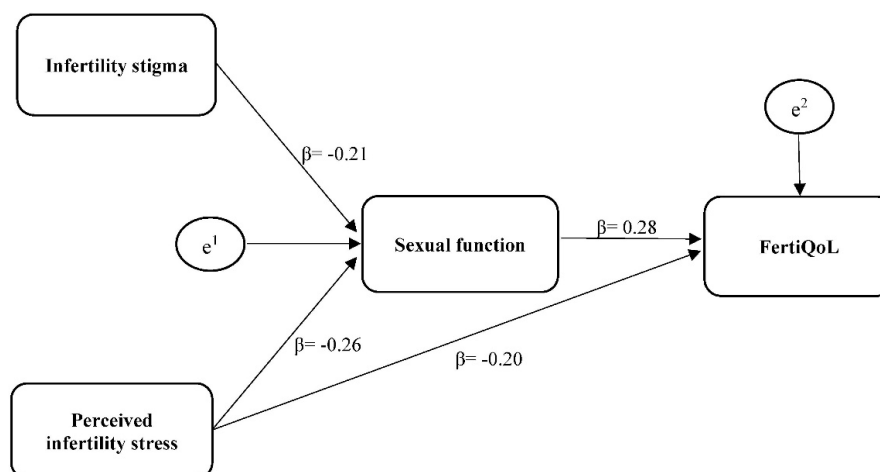


Figure 2. Final structural equation model of study variables

Table 4 reports the indirect effects in the final SEM model. Sexual function significantly mediated the relationship between infertility stigma and FertiQoL ($\beta = -0.06$, $P < 0.001$), indicating that stigma's impact on quality of life operates fully through sexual function. Similarly, sexual function mediated the relationship between perceived infertility stress and FertiQoL ($\beta = -0.04$, $P < 0.001$), suggesting that stress influences FertiQoL indirectly via impaired sexual function. Figure 2 presents the final SEM, refined by removing the non-significant direct path from infertility stigma to FertiQoL. The model explained 28% of the variance in FertiQoL, with mediation effects holding after controlling for confounders.

DISCUSSION

This study was conducted to investigate the intricate relationships among infertility stigma, perceived infertility stress, and FertiQoL in infertile women, with a specific focus on the mediating role of sexual function. The findings from the SEM analysis provide important insights into the psychosocial mechanisms that influence the mental well-being of infertile women. Overall, the results demonstrated that perceived infertility stress has a direct, negative relationship with FertiQoL. In contrast, infertility stigma lacks this direct effect, and its influence is fully mediated through sexual function. A novel aspect of these findings is the demonstration of full mediation for infertility stigma via sexual function, suggesting that stigma's impact on quality of life is entirely indirect and channeled through intimate relational disruptions—a pathway underexplored in prior literature, which predominantly emphasized direct psychosocial links. These findings shed light on new pathways for developing more effective and targeted therapeutic interventions.

One of the key findings of this study is the confirmation of a significant direct and negative relationship between perceived infertility stress and FertiQoL. This result aligns with a substantial body of existing research that shows psychological distress arising from infertility has a detrimental impact on women's overall health and well-being [13, 16]. The chronic stress associated with infertility can lead to elevated levels of anxiety, depression, and feelings of hopelessness, which in turn, diminish an individual's capacity to experience daily life in a satisfying way [15]. Prior studies, such as the one by Bahadur et al. [10], similarly reported a strong correlation between psychological distress and reduced quality of life in women undergoing infertility treatment. Furthermore, research by Jaber et al. [30] also showed that the greater the perceived stress among infertile women, the significantly worse their mental health outcomes. This finding underscores the critical importance of addressing stress management as a central objective in the clinical care of infertile women.

Another important finding that highlights the mediating role of sexual function is that it significantly mediated the effects of both infertility stigma and perceived infertility stress on FertiQoL. This result suggests that the impact of stigma and stress on a woman's overall well-being does not occur directly, but rather is channeled through their damaging effect on sexual intimacy and function. This finding is consistent with previous research that has identified sexual problems as a common consequence of infertility [19, 22]. For instance, a study by Ashraf et al. [31] noted that infertility can transform a sexual relationship from a pleasurable experience into a mechanical, procreation-focused task, which in turn leads to a reduction in desire and satisfaction. This mediating pathway deepens our understanding of how psychological factors influence the mental health of infertile women and identifies a key therapeutic target for interventions. Factors that may mitigate stigma and stress, thereby potentially preserving sexual function and enhancing FertiQoL, include robust social support networks, culturally sensitive psychoeducation, and resilience-building interventions, which have been shown to buffer these effects in similar populations [8, 17].

The present study also confirmed a significant negative relationship between perceived infertility stress and sexual function. This finding is plausible, as chronic stress can have a profound impact on the body's physiological functions, including sexual response. Elevated cortisol levels and other stress hormones can decrease libido and disrupt arousal mechanisms [32]. Furthermore, the constant worry, anxiety, and frustration related to infertility treatments can lead to sexual performance anxiety, creating a vicious cycle of stress and sexual dysfunction [20]. This result is consistent with studies that have examined the link between anxiety, depression, and reduced sexual function in various populations [18]. For example, research conducted by Park et al. [18] similarly reported an inverse relationship between psychological distress and sexual function in patients undergoing infertility treatment.

Additionally, this research revealed a significant relationship between infertility stigma and sexual function. This result suggests that the feeling of shame and social judgment, particularly regarding the inability to procreate, permeates the private sphere of a woman's marital life. The stigma can cause women to feel sexually inadequate or incomplete, which leads to reduced sexual desire and avoidance of intimacy [7]. The findings in this section are in line with studies that have explored the impact of socio-cultural factors on sexual health [33]. For instance, research by Luo et al. [33] demonstrated that social stigma was significantly associated with sexual dysfunction in Chinese infertile women. This finding indicates that to improve the

sexual function of infertile women, it is not enough to focus solely on physiological issues; the social and psychological dimensions of stigma must also be addressed.

A particularly noteworthy finding of this study was the absence of a significant direct relationship between infertility stigma and FertiQoL. While this result may initially seem unexpected, it is fully explained by the mediating role of sexual function in the final model. In other words, the impact of stigma on an infertile woman's quality of life is not direct, but rather is fully channeled through the disruption of her sexual function. This finding highlights that social stigma can weaken sexual intimacy by creating stress and a diminished sense of self-worth, and it is this impairment in sexual function that ultimately leads to a reduction in FertiQoL. The result underscores the importance of focusing on underlying mechanisms and suggests that interventions should target the psychological and sexual consequences of stigma rather than addressing the stigma in isolation.

Despite its valuable findings, this study has several limitations, including the correlational nature of the research design, which restricts causal inferences, and the use of a convenience sample, which limits the generalizability of the findings to other populations. Additionally, while key demographic confounders (e.g., education, employment, and marriage duration) were controlled in the SEM, numerous other factors influencing sexual dysfunction—such as hormonal imbalances, medication side effects, or partner-related dynamics—were not fully examined or adjusted for, potentially introducing residual confounding; future studies should incorporate comprehensive assessments of these multifaceted determinants to strengthen causal attributions.

CONCLUSION

This study provides valuable insights into the complex relationships between psychosocial factors and FertiQoL in infertile women. Our findings clearly demonstrate that perceived infertility stress directly contributes to a decline in quality of life. However, the most critical finding is the pivotal mediating role of sexual function, which indirectly transmits the negative effects of both stigma and stress on FertiQoL. This outcome suggests that to enhance the overall health and well-being of infertile women, therapeutic interventions must not be limited to stress management alone, but should comprehensively address sexual health as well. Practically, these results advocate for the routine integration of sexual function screening and couple-based therapy into fertility clinic protocols, alongside stigma-reduction workshops, to optimize FertiQoL and potentially improve treatment engagement and success rates. In summary, this research underscores the

necessity of understanding the underlying mechanisms through which stigma and stress impact daily life, thereby illuminating new pathways for designing more targeted support programs in fertility clinics.

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ETHICAL CONSIDERATIONS

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AUTHORS' CONTRIBUTIONS

ABM: Study concept and design, acquisition of data, analysis and interpretation of data, and statistical analysis. RH and FH: Administrative, technical, and material support, study supervision. MTS: Critical revision of the manuscript for important intellectual content.

CONFLICT OF INTEREST

No conflict of interest to declare.

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