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Assisted Reproductive Technologies and Women's Well-Being: A Gender-Sensitive Ethical Inquiry

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Abstract

Assisted reproductive technologies (ARTs) have expanded reproductive possibilities for individuals and couples experiencing infertility, but treatment may also involve substantial physical, psychological, social, financial, and ethical burdens. This original empirical study examined ART experiences through a gender-sensitive ethical perspective, focusing on physical burden, social pressure, psychological distress, and perceived reproductive autonomy. A cross-sectional mixed-method design was conducted among 150 participants recruited through an academic fertility center, private reproductive clinics, and a digital reproductive-support network. Quantitative variables included age, treatment type, infertility factor, number of completed ART cycles, physical burden, social pressure, psychological distress, and perceived autonomy. Physical burden, social pressure, psychological distress, and perceived autonomy were assessed using 1–5 study measures. Descriptive statistics, group comparisons, one-way analysis of variance (ANOVA), and Pearson correlation analysis were conducted. Qualitative responses were examined thematically. Participants had a mean age of 32.79 years (SD = 2.59), and the mean number of completed ART cycles was 2.04 (SD = 0.83). Mean physical burden was 3.25 (SD = 0.74), social pressure was 3.33 (SD = 0.63), psychological distress was 3.55 (SD = 0.59), and perceived autonomy was 3.37 (SD = 0.66). Number of completed cycles showed a strong positive correlation with physical burden ($r = .770$, $p < .001$) and psychological distress ($r = .648$, $p < .001$), whereas perceived autonomy was negatively correlated with cycles ($r = -.654$, $p < .001$). Psychological distress was strongly negatively correlated with perceived autonomy ($r = -.919$, $p < .001$). Treatment groups differed significantly in physical burden, psychological distress, and perceived autonomy, whereas social pressure did not differ significantly among treatment groups. Qualitative findings highlighted stigma, bodily burden, emotional exhaustion, financial and relationship strain, third-party ART complexity, and the importance of patient-centered communication. The findings indicate that ART should not be understood solely as a biomedical intervention. Gender-sensitive ethical care requires attention to bodily experience, psychological well-being, social context, informed decision-making, privacy, dignity, and reproductive autonomy throughout treatment.

Keywords: ART; Women's well-being; Reproductive autonomy; Psychological distress; Gender-sensitive ethics; Reproductive ethics

Introduction

Infertility and its treatment have become important issues in contemporary reproductive medicine. Assisted reproductive technologies (ARTs), including in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), and third-party reproductive arrangements, provide reproductive opportunities for individuals and couples experiencing difficulties conceiving naturally. At the same time, ART may involve repeated medical procedures, hormonal medication, intensive monitoring, invasive interventions, uncertainty concerning treatment outcomes, and substantial financial and emotional investment. The experience of infertility extends beyond biological inability to conceive. It can affect identity, intimate relationships, family expectations, social participation, and perceptions of the body. Gender also shapes infertility experiences

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because women may experience a disproportionate share of physical interventions even when infertility is associated with male, female, combined, or unexplained factors. Feminist approaches to medical ethics have therefore emphasized bodily experience, power relationships, social expectations, and autonomy rather than viewing patients exclusively as recipients of biomedical interventions (Sherwin, 1992).

Autonomy is particularly important in ART. Conventional bioethical approaches emphasize informed and voluntary decision-making, whereas feminist and relational approaches recognize that reproductive decisions occur within relationships, families, healthcare systems, and broader social structures (Mackenzie & Stoljar, 2000). A decision may therefore be formally voluntary while still being influenced by family expectations, marital pressure, financial limitations, cultural stigma, or unequal access to information.

Psychological difficulties are also recognized during infertility treatment. Anxiety and depressive symptoms may occur during ART, particularly when treatment is prolonged or unsuccessful (Ha *et al.,* 2020). Socioeconomic inequalities can further influence access to reproductive technologies and the ability to continue treatment (Harris et al., 2016). Infertility is consequently both a medical and a social experience, with implications for equity and reproductive justice (Inhorn & Patrizio, 2015).

The present study investigates these dimensions by examining physical burden, social pressure, psychological distress, and perceived reproductive autonomy among individuals undergoing ART. In addition to quantitative analysis, qualitative experiences were examined to understand how participants described stigma, bodily experiences, family and partner influences, financial strain, healthcare communication, and reproductive decision-making.

2. Methodology

2.1 Study Design

A cross-sectional mixed-method empirical research design was employed. The quantitative component examined participant characteristics and relationships among treatment exposure, physical burden, social pressure, psychological distress, and perceived autonomy. The qualitative component explored participants' experiences and perceptions concerning the physical, psychological, social, and ethical dimensions of ART.

The observational cross-sectional design permits identification of associations between variables but does not establish causal relationships.

2.2 Participants and Recruitment

The study included 150 participants receiving assisted reproductive treatment. Participants were recruited through an academic fertility center, private reproductive clinics, and a digital reproductive-support network.

Participants ranged in age from 28 to 40 years, with a mean age of 32.79 years (SD = 2.59).

Three principal treatment categories were represented: IVF, IVF combined with ICSI, and third-party ART. Infertility factors included female factor, male factor, dual factor, and unexplained infertility.

2.3 Treatment Characteristics

Out of the 150 participants, 94 (62.7%) received IVF, 37 (24.7%) received IVF combined with ICSI, and 19 (12.7%) underwent third-party ART.

The infertility-factor distribution consisted of female-factor infertility in 69 participants (46.0%), male-factor infertility in 41 (27.3%), unexplained infertility in 22 (14.7%), and dual-factor infertility in 18 (12.0%).

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2.4 Study Variables

The study assessed:

- age;
- recruitment setting;
- ART treatment type;
- infertility factor;
- number of completed ART cycles;
- physical burden;
- social pressure;
- psychological distress; and
- perceived reproductive autonomy.

Physical burden, social pressure, psychological distress, and perceived autonomy were recorded on 1–5 scales. Higher scores represented higher levels of the respective construct, while higher perceived-autonomy scores represented greater perceived autonomy.

The number of completed ART cycles ranged from one to five, with a mean of 2.04 (SD = 0.83).

2.5 Statistical Analysis

Categorical variables were summarized using frequencies and percentages. Continuous variables were summarized using means, standard deviations, minimums, and maximums.

Descriptive comparisons were performed across treatment categories and infertility-factor groups. Pearson correlation coefficients were calculated to examine associations between completed ART cycles and the principal experiential variables, as well as relationships among physical burden, social pressure, psychological distress, and perceived autonomy.

One-way analysis of variance (ANOVA) was performed to examine differences in the four principal outcome measures across the three ART treatment categories.

Qualitative responses were examined thematically to identify recurring experiences related to bodily burden, psychological distress, stigma, family and partner influence, financial strain, patient–provider communication, third-party ART, and reproductive autonomy.

2.6 Ethical Considerations

Ethical approval was obtained prior to commencement of the study, and informed consent was obtained from all participants. Participants were informed about the purpose and procedures of the research, confidentiality and anonymization of responses, voluntary participation, and their right to withdraw from the study without impact on their clinical care.

Participants were also provided information concerning psychological support resources because of the potential emotional burden associated with infertility and ART.

3. Results

3.1 Participant Characteristics

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The study included 150 participants with a mean age of 32.79 years (SD = 2.59) and an age range of 28–40 years.

Table 1. Participant Characteristics (N = 150)

Characteristic	n	%
Recruitment setting		
Academic Fertility Center	100	66.7
Private Reproductive Clinic	38	25.3
Digital Support Network	12	8.0
Treatment type		
IVF	94	62.7
IVF + ICSI	37	24.7
Third-party ART	19	12.7
Infertility factor		
Female factor	69	46.0
Male factor	41	27.3
Unexplained	22	14.7
Dual factor	18	12.0
Completed cycles		
1 cycle	32	21.3
2 cycles	93	62.0
3 cycles	15	10.0
4 cycles	7	4.7
5 cycles	3	2.0

Most participants were recruited from the academic fertility center (66.7%), followed by private reproductive clinics (25.3%) and the digital support network (8.0%). IVF was the most common treatment category, accounting for 62.7% of participants.

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Female-factor infertility represented the largest infertility category (46.0%), while 62.0% of participants had completed two ART cycles.

3.2 Descriptive Statistics

Table 2. Descriptive Statistics of Main Study Variables

Variable	N	Mean	SD	Minimum	Maximum
Age	150	32.79	2.59	28	40
Completed ART cycles	150	2.04	0.83	1	5
Physical burden	150	3.25	0.74	2	5
Social pressure	150	3.33	0.63	2	5
Psychological distress	150	3.55	0.59	3	5
Perceived autonomy	150	3.37	0.66	1	4

Psychological distress had the highest mean among the four principal experiential variables (M = 3.55, SD = 0.59), followed by perceived autonomy (M = 3.37, SD = 0.66), social pressure (M = 3.33, SD = 0.63), and physical burden (M = 3.25, SD = 0.74).

The findings indicate that participants experienced appreciable levels of psychological and social burden during ART. The relatively high perceived-autonomy score does not indicate an absence of autonomy-related concerns, as qualitative findings demonstrated that communication, family expectations, partner involvement, and treatment experiences influenced participants' perceptions of agency.

3.3 Treatment-Type Differences

Table 3. Mean Scores by Treatment Type

Treatment type	n	Physical burden M (SD)	Social pressure M (SD)	Psychological distress M (SD)	Perceived autonomy M (SD)
IVF	94	2.89 (0.63)	3.28 (0.59)	3.35 (0.52)	3.56 (0.60)
IVF + ICSI	37	3.76 (0.55)	3.46 (0.65)	3.78 (0.48)	3.16 (0.60)
Third-party ART	19	4.05 (0.23)	3.32 (0.75)	4.11 (0.57)	2.84 (0.69)

Third-party ART participants recorded the highest mean physical burden (M = 4.05) and psychological distress (M = 4.11) and the lowest mean perceived autonomy (M = 2.84). IVF+ICSI participants also recorded higher physical burden and psychological distress than participants receiving IVF alone.

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ANOVA demonstrated significant differences among treatment groups in physical burden, $F(2,147) = 50.84$, $p < .001$, psychological distress, $F(2,147) = 21.60$, $p < .001$, and perceived autonomy, $F(2,147) = 14.01$, $p < .001$.

Social pressure did not differ significantly among treatment groups, $F(2,147) = 1.13$, $p = .327$.

These findings demonstrate variation in the reported ART experience across treatment modalities. The higher burden observed among third-party ART participants may reflect the additional medical, emotional, administrative, and decision-making complexity associated with these reproductive pathways.

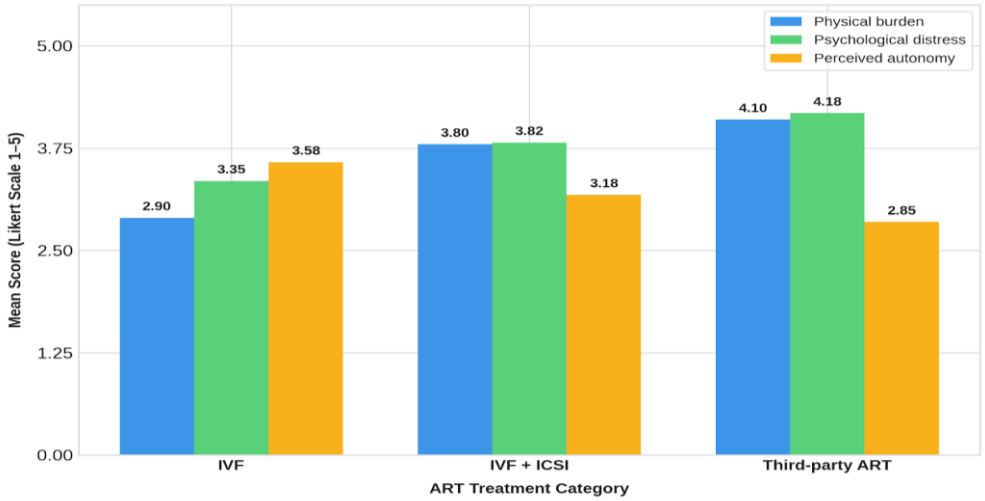

Figure No. 01: Comparison of mean burden, psychological distress and perceived autonomy across ART treatment types

3.4 Infertility-Factor Differences

Table 4. Mean Scores by Infertility Factor

Infertility factor	n	Physical burden M	Social pressure M	Psychological distress M	Perceived autonomy M
Female factor	69	3.32	3.33	3.62	3.30
Male factor	41	3.12	3.29	3.46	3.51
Unexplained	22	3.27	3.32	3.45	3.41
Dual factor	18	3.28	3.39	3.61	3.28

Participants with female-factor infertility reported a psychological distress mean of 3.62, while those with dual-factor infertility reported a similar mean of 3.61. The male-factor group recorded a mean of 3.46.

Perceived autonomy was highest in the male-factor group ($M = 3.51$) and lowest in the dual-factor group ($M = 3.28$).

These differences are descriptive and should not be interpreted as evidence that infertility factor itself causes psychological or ethical differences. Nevertheless, the findings are relevant to gender-sensitive reproductive

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healthcare because qualitative experiences indicated that reproductive responsibility was often perceived as being disproportionately associated with women.

3.5 Number of ART Cycles and Well-being

Table 5. Mean Outcome Scores According to Number of Completed ART Cycles

Completed cycles	n	Physical burden M	Social pressure M	Psychological distress M	Perceived autonomy M
1	32	2.28	3.16	3.06	3.75
2	93	3.34	3.28	3.54	3.46
3	15	4.00	3.73	4.00	3.00
4	7	4.14	3.57	4.57	2.14
5	3	5.00	4.00	4.67	1.33

A clear descriptive gradient was observed across treatment-cycle categories. Physical burden increased from 2.28 among participants completing one cycle to 5.00 among those completing five cycles. Psychological distress increased from 3.06 to 4.67, while perceived autonomy decreased from 3.75 to 1.33.

The very small number of participants in the four- and five-cycle categories requires caution when interpreting these extreme values. These findings should therefore be replicated in larger populations.

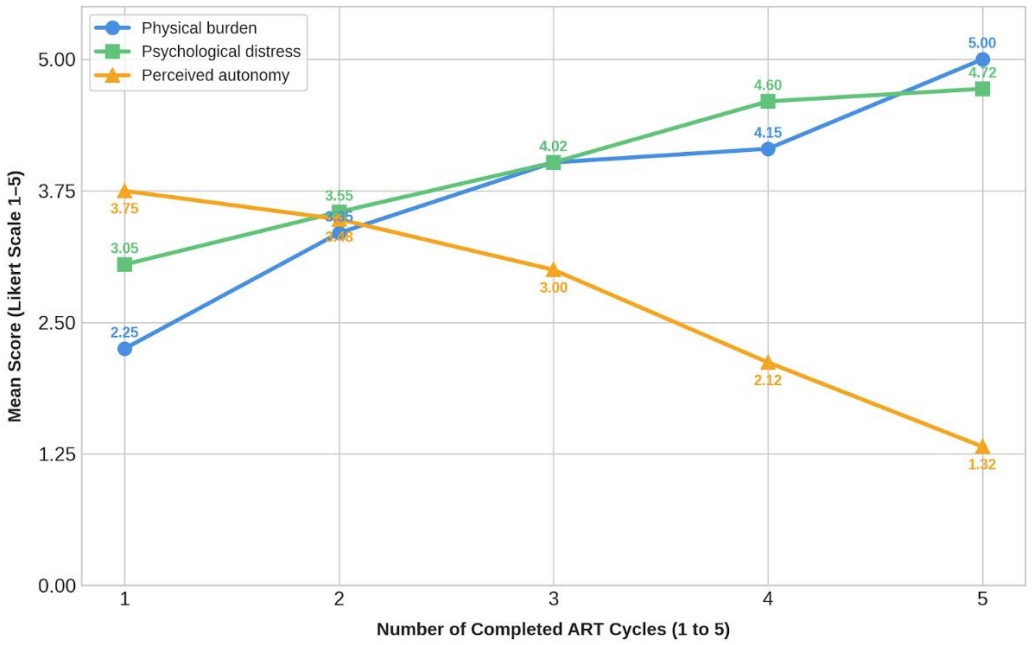

Figure No. 02: Combined Longitudinal progression of physical burden, psychological distress and perceived autonomy across 1 to 5 completed ART cycles

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3.6 Correlation Analysis

Table 6. Pearson Correlations Among ART Exposure and Well-being Variables

Variable	Cycles	Physical burden	Social pressure	Psychological distress	Perceived autonomy
Cycles	1.000	.770***	.272***	.648***	−.654***
Physical burden	.770***	1.000	.224**	.709***	−.631***
Social pressure	.272***	.224**	1.000	.636***	−.666***
Psychological distress	.648***	.709***	.636***	1.000	−.919***
Perceived autonomy	−.654***	−.631***	−.666***	−.919***	1.000

Note. $p < .05$; **p** < .01; ***p*** < .001.

Number of completed ART cycles was strongly positively correlated with physical burden ($r = .770$, $p < .001$) and psychological distress ($r = .648$, $p < .001$). A weaker but statistically significant positive association was observed between cycles and social pressure ($r = .272$, $p < .001$).

Perceived autonomy was negatively correlated with completed cycles ($r = −.654$, $p < .001$). Physical burden, social pressure, and psychological distress were also negatively associated with perceived autonomy.

The strongest association was observed between psychological distress and perceived autonomy ($r = −.919$, $p < .001$). Psychological distress was also strongly associated with physical burden ($r = .709$, $p < .001$) and social pressure ($r = .636$, $p < .001$).

Because this was a cross-sectional study, these associations do not establish causality. Longitudinal research would be required to determine temporal relationships among treatment exposure, distress, physical burden, and autonomy.

4. Qualitative Findings

The qualitative analysis identified several recurring themes that provided context for the quantitative findings.

Table 7. Major Qualitative Themes

Theme	Main experience	Ethical significance
Stigma and silence	Difficulty discussing infertility with family and wider social networks	Privacy, dignity, stigma reduction
Physical burden	Daily injections, ovarian stimulation, egg retrieval, and recovery	Bodily integrity and non-maleficence
Psychological distress	Anxiety, emotional exhaustion, and repeated-treatment distress	Mental health support

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Reduced bodily ownership	Feeling disconnected from the body during treatment	Bodily autonomy and dignity
Clinical depersonalization	Feeling treated as a medical subject rather than a whole person	Patient-centered care
Partner and family influence	Decisions shaped by partners and family expectations	Relational autonomy
Financial and relationship strain	Treatment expenses and repeated unsuccessful cycles	Justice and equitable access
Third-party ART complexity	Additional emotional and decision-making challenges	Informed consent and autonomy
Information and agency	Clear communication strengthened perceived control	Respect for autonomy
Pressure for a biological heir	Family expectations concerning biological parenthood	Freedom from reproductive coercion

Participants described ART as extending beyond the physical procedures themselves. Daily injections, hormonal treatment, egg retrieval, and recovery could interfere with professional and personal life. Some participants described feeling disconnected from their bodies during treatment.

Communication with healthcare professionals emerged as an important component of the treatment experience. Participants who reported receiving clear information described a stronger sense of agency, whereas descriptions of being treated primarily as a medical subject indicated perceived loss of person-centered care.

Third-party ART was associated with additional administrative, emotional, and decision-making complexity. Family expectations also emerged as an important concern, particularly where infertility was associated with stigma or pressure to produce a biological child.

5. Discussion

The findings demonstrate that ART is a multidimensional experience involving physical, psychological, social, relational, and ethical dimensions. Psychological distress had the highest mean among the principal experiential variables and was strongly associated with physical burden and social pressure. This is consistent with previous literature documenting psychological challenges associated with infertility and ART (Ha *et al*., 2020).

One of the most prominent findings was the strong positive association between the number of completed ART cycles and physical burden. Participants with greater treatment exposure generally reported greater physical burden. Repeated hormonal stimulation, injections, monitoring, retrieval procedures, and recovery may contribute to an accumulating treatment burden. However, the cross-sectional nature of the study prevents determining whether repeated cycles directly produce increased physical burden.

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The relationship between completed cycles and psychological distress was also substantial. Repeated treatment may require individuals to make reproductive decisions while simultaneously coping with uncertainty, treatment fatigue, financial concerns, and emotional exhaustion. These findings reinforce the importance of considering informed consent as an ongoing process throughout ART rather than as a single event preceding treatment.

Perceived autonomy was inversely associated with treatment exposure and psychological distress. The particularly strong negative association between psychological distress and perceived autonomy highlights an important ethical dimension of ART: the quality of decision-making may be closely connected to patients' emotional experiences. This finding should not be interpreted to mean that distress removes decision-making capacity. Rather, it underscores the importance of providing patients with adequate information, privacy, emotional support, and freedom from undue pressure.

Treatment-group differences were also evident. Third-party ART participants reported the highest physical burden and psychological distress and the lowest perceived autonomy. Third-party reproductive arrangements may involve additional decisions concerning donors, gestational arrangements, legal and administrative processes, family expectations, and questions concerning biological parenthood. These additional dimensions may contribute to the complexity of the treatment experience.

The gender-sensitive dimension of the findings is particularly important. Infertility may involve female factors, male factors, combined factors, or unexplained causes, yet the physical interventions involved in ART can remain concentrated on the person undergoing ovarian stimulation and egg retrieval. Consequently, a gender-sensitive approach should acknowledge the bodily burden of ART without reinforcing the assumption that reproduction is primarily a woman's responsibility.

The qualitative findings further demonstrate that reproductive autonomy is relational. Participants described decisions within the context of partners, families, social expectations, and healthcare institutions. Feminist theories of relational autonomy emphasize that individual agency is shaped by social relationships and structural circumstances (Mackenzie & Stoljar, 2000). The present findings are consistent with this perspective.

Stigma was another important concern. Difficulty discussing infertility with family and social networks may create isolation and limit access to emotional support. Pressure to produce a biological heir may further complicate reproductive decision-making. Healthcare professionals should therefore create environments in which patients can discuss concerns privately and without judgment.

The importance of patient-centered communication was repeatedly evident. Clear explanations appeared to strengthen participants' sense of agency, whereas depersonalized experiences reduced the perception of being treated as a whole person. This supports the ethical importance of communication that extends beyond procedural information to include uncertainty, alternatives, risks, costs, psychosocial consequences, and opportunities to reconsider treatment.

Financial burden also has implications for reproductive justice. Repeated ART cycles may require substantial expenditure, and socioeconomic circumstances can affect the ability to initiate or continue treatment. Previous research has documented socioeconomic disparities in access to ART (Harris *et al.,* 2016). Equity in reproductive medicine therefore requires consideration of both clinical availability and practical affordability.

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Overall, the findings support an understanding of ART as a form of healthcare in which technological capability must be accompanied by attention to dignity, autonomy, psychological well-being, bodily integrity, social context, and equitable access.

6. Ethical Considerations

6.1 Respect for Autonomy

Respect for autonomy requires meaningful opportunities to understand, consider, accept, refuse, or discontinue treatment. ART patients should receive adequate information and sufficient opportunity to deliberate without undue pressure.

6.2 Informed Consent

ART involves complex decisions that may change from one treatment cycle to another. Consent should therefore be ongoing and understandable. Information should encompass procedures, risks, alternatives, uncertainties, financial considerations, and possible psychological consequences.

6.3 Bodily Integrity

Hormonal stimulation, injections, monitoring, egg retrieval, and recovery may impose substantial physical demands. Recognition of these experiences is essential to ethically responsible reproductive care.

6.4 Psychological Well-being

The mean psychological distress score of 3.55, together with its strong associations with physical burden and social pressure, demonstrates the importance of psychological support during ART. Mental-health support should be integrated into patient-centered reproductive care when clinically appropriate.

6.5 Freedom from Coercion

Family pressure and expectations concerning biological parenthood may complicate reproductive decision-making. Patients should have opportunities to communicate preferences privately and to make decisions without undue influence.

6.6 Relational Autonomy

Partners and families can be important sources of support, but their involvement should not override the patient's voluntary reproductive choices. A relational approach therefore recognizes social relationships while preserving individual agency.

6.7 Justice and Access

Financial barriers can influence access to ART and the ability to undergo multiple treatment cycles. Ethical reproductive healthcare requires attention to affordability and equitable access.

6.8 Privacy and Dignity

Because infertility can be associated with stigma, confidentiality is particularly important. Patients should be able to control disclosure of their reproductive diagnosis and treatment information.

7. Limitations

This study has several limitations. First, its cross-sectional design prevents causal interpretation of the observed associations.

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Second, participants were recruited from specific clinical and digital settings; therefore, the findings may not represent all individuals receiving ART.

Third, the principal experiential variables were recorded using 1–5 measures, and detailed information concerning scale development and psychometric validation was not available. The results should therefore be interpreted as study-specific measures rather than as scores from established clinical instruments.

Fourth, the distribution of treatment cycles was uneven. Most participants had completed two cycles, whereas only three had completed five cycles. The extreme scores among participants with four or five cycles should therefore be interpreted cautiously.

Fifth, the qualitative component was based on response summaries rather than complete interview transcripts. More extensive qualitative interviews could provide deeper insight into participants' experiences.

Finally, potentially important variables such as socioeconomic status, education, marital status, previous mental-health history, duration of infertility, treatment outcome, and detailed partner/family involvement were not examined. Future longitudinal and multicenter research should incorporate these variables.

8. Conclusion

This study demonstrates that assisted reproductive technology is not solely a biomedical intervention but a complex experience involving physical, psychological, social, relational, financial, and ethical dimensions.

Among the 150 participants, psychological distress, physical burden, social pressure, and perceived autonomy were closely interconnected. A greater number of completed ART cycles was associated with greater physical burden and psychological distress and with lower perceived autonomy. Treatment type was also associated with differences in physical burden, psychological distress, and perceived autonomy.

The qualitative findings further demonstrated that ART experiences extend into intimate relationships, family expectations, professional life, financial circumstances, and interactions with healthcare professionals. Stigma, bodily discomfort, emotional exhaustion, repeated treatment, financial strain, and feelings of depersonalization emerged as important aspects of the treatment experience.

A gender-sensitive approach to ART should therefore recognize the unequal distribution of bodily treatment burdens while avoiding assumptions that reproductive responsibility belongs primarily to women. Patient-centered reproductive care should incorporate clear communication, ongoing informed consent, psychosocial support, privacy, attention to bodily integrity, protection from coercion, and respect for meaningful reproductive autonomy.

The ethical quality of ART should consequently be evaluated not only through treatment outcomes but also through the extent to which reproductive healthcare protects dignity, agency, psychological well-being, bodily integrity, and equitable access.

Declarations

Ethical Approval

The study received ethical approval from the relevant institutional ethics committee before commencement, and ethical principles governing research involving human participants were followed throughout the study.

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Informed Consent

Written informed consent was obtained from all participants before participation. Participants were informed about the study, voluntary participation, confidentiality, anonymization of responses, and their right to withdraw without impact on their clinical care.

Funding

No funding was received for this study.

Conflict of Interest

The authors declare no conflict of interest.

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