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Attitudes of women with reproductive problems towards pregnancy and childbirth and their life satisfaction[1]

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Abstract: *Introduction:* Infertility is defined as the failure to conceive after 12 months of regular unprotected intercourse (3-4 times per week). *Objective:* The aim of this study was to assess life satisfaction and attitudes toward pregnancy and childbirth among women undergoing infertility treatment. *Materials and methods:* The study involved 103 women treated for infertility. Data were collected using a diagnostic survey, including a self-designed questionnaire and two standardized tools: the Test for Assessing Women's Attitudes Toward Pregnancy and Childbirth, and the Satisfaction With Life Scale (SWLS). *Results:* The average score for attitudes toward pregnancy was M = 23.18 (SD = 3.35), with scores ranging from 15 to 32 points. For attitudes toward childbirth, the mean score was higher at M = 26.11 (SD = 4.36), ranging from 10 to 36 points. The mean SWLS score was M = 22.34 (SD = 6.11), with scores between 10 and 35 points. A significant negative correlation was found between duration of attempts to conceive and life satisfaction (r = -0.250; p = 0.011). A weaker but significant negative correlation was observed for attitude toward pregnancy (r = -0.216; p = 0.029). Significant differences were found in attitudes toward pregnancy across groups (H = 13.95; p = 0.003). Differences in attitudes toward childbirth by age groups showed a statistical trend (H = 7.156; p = 0.067). *Conclusions:* Women undergoing infertility treatment showed varied but generally average life satisfaction levels. Most women had positive attitudes toward pregnancy and childbirth. Prolonged infertility treatment was associated with a decrease in overall life satisfaction among respondents.
Keywords: attitude, childbirth, infertility, life satisfaction, pregnancy

Introduction

Infertility is defined as the inability to conceive after 12 months of having regular intercourse (3-4 times a week) without using any contraception. In women over 35 years of age, infertility is diagnosed after 6 months of having regular intercourse without successful conception (Łukaszuk et al., 2018; Szamatowicz and Szamatowicz, 2020; Practice Committee of the American Society for Reproductive Medicine, 2015).

Infertility can be divided into two basic types: primary and secondary. Primary infertility affects women who, despite engaging in regular unprotected sexual intercourse for at least 12 months, have never

1 Article in Polish language: https://stowarzyszeniefidesetratio.pl/fer/63P_Palu.pdf

gotten pregnant. Secondary infertility, on the other hand, refers to situations in which a woman, despite having been pregnant before, encounters difficulties in conceiving again, in spite of having regular intercourse without contraception for at least one year (Waheed, 2019; Vander, 2018).

Infertility is a significant public health problem that affects both men and women around the world. The global strain of infertility is steadily increasing, as evidenced by a significant rise in both its prevalence and disability-adjusted life years (DALY) between 1990 and 2019. This trend is projected to persist between 2020 and 2029 (Huang et al., 2020). Infertility affects approximately 17.5% of the population, with the problem being more prevalent in high-income regions and countries (Bhattacharjee et al., 2024). In Poland, approximately 15-20% of couples struggle with infertility (Koperwas et al., 2017).

Infertility treatment includes a variety of methods, from pharmacological and surgical interventions to assisted reproductive technology (ART) procedures (Łukaszuk et al., 2018; Liu et al., 2021). Treatment is usually long-term and does not always yield the desired results. Ultimately, assisted reproductive technologies often prove to be the most effective solution to infertility. However, it should be remembered that ART are expensive and require complex procedures such as ovarian stimulation, oocyte retrieval and embryo transfer to the uterus, which further increases the psychological burden on couples affected by infertility. The success rate of in vitro fertilisation (IVF) is approximately 30% per cycle (Toftager et al., 2017), with many couples having to face the possibility of failure. For this reason, some women give up treatment or never initiate it (Crawford et al., 2017).

It is worth noting that the mental state of couples affected by infertility can influence the results of treatment. Significant correlations have been demonstrated between levels of depression and anxiety prior to ART treatment and reduced chances of success (Purewal et al., 2017). Attitudes towards assisted reproduction methods also vary greatly. The willingness of couples to attempt in vitro fertilisation and the psychosocial consequences of this choice depend on, for example, the opinions of those around them, general social attitudes, the social support they receive and their religious affiliation (Stankiewicz et al., 2023).

Couples struggling with infertility face many personal problems, the most important of which is the stress associated with unsuccessful attempts to conceive, diagnosis and the long treatment process (Tavousi et al., 2022). Infertility treatment is associated with strong, often negative emotions that can lead to emotional crisis and feelings of unfulfillment. For many couples, having a child is a life goal, and repeated failures lead to frustration and helplessness. The problem of infertility is often associated with reduced self-esteem, guilt, increased stress, depression, and problems in marital and sexual interactions (Alirezaei et al., 2022). Women struggling with infertility are more prone to experience negative emotions than their partners. Comorbidities such as endometriosis or ovarian cancer can be an additional psychological burden, increasing anxiety and reducing quality of life (Gica et al., 2021; Gica et al., 2020). It has been shown that a deterioration in mental health in the form of anxiety and depression can further reduce the chances of conceiving a child (Zhou et al., 2019). These factors significantly affect the overall life satisfaction of women struggling with infertility (Nagórska et al., 2022). Patients may feel either satisfied or dissatisfied with various aspects of their lives, including the quality of medical care. Patient satisfaction is not only an important indicator of the quality of care, but also an integral part of it, as it directly influences compliance with medical recommendations and increases the likelihood of achieving positive treatment outcomes (Galic et al., 2021). Attitudes towards pregnancy are complex and shaped by a variety of cognitive, emotional and socio-cultural factors. In the cognitive sphere, beliefs and knowledge, for example about planning conception or the need to adjust one's lifestyle, are important. The emotional aspect includes feelings such as joy, fears or anxiety related to pregnancy. It is worth noting that many women feel ambivalent in this context, i.e. simultaneous, conflicting emotions towards both the pregnancy itself and its course (Tobey et al., 2020). The attitudes of women who have undergone assisted reproductive treatment towards pregnancy and childbirth vary, as they can be both positive and negative. Some women have a positive attitude towards

pregnancy but a negative attitude towards childbirth, or vice versa. Every pregnancy, even a physiological one, requires a change in lifestyle and, consequently, in attitudes. The attitudes adopted by individual women are influenced by, for example, their age, financial status, the length of infertility treatment, as well as the course of the pregnancy and its outcome. Pregnancies resulting from assisted reproductive technologies are associated with an increased risk of obstetric complications, which necessitates individualised medical care. From a psychological perspective, these procedures can evoke negative emotions that potentially disrupt the natural course of pregnancy (Łepecka-Klusek et al., 2011).

Infertility is not only a medical problem, but also a profound personal and psychosocial experience that requires a holistic, interprofessional approach. A study of attitudes towards pregnancy and childbirth in a group of women with reproductive problems is particularly warranted, as more than a decade has passed since the last Polish study on women's attitudes towards pregnancy and childbirth after assisted reproductive technologies, authored by Łepecka-Klusek et al. (2011). During this time, there have been significant developments in medicine and medical technology, including reproductive medicine, as well as dynamic social changes that may have influenced patients' attitudes. For this reason, it is reasonable to conduct up-to-date research in order to understand the current situation.

Aim of the study

The aim of the study is to assess the level of life satisfaction and attitudes towards pregnancy and childbirth among women undergoing infertility treatment.

1. Research material and tools

The study was conducted using a diagnostic survey method, with a self-designed questionnaire and two standardised tools: a test to examine women's attitudes towards pregnancy and childbirth, and the Satisfaction With Life Scale (SWLS).

The test to examine women's attitudes towards pregnancy and childbirth was developed by Łepecka-Klusek & Jakiel (2011). The test consisted of 16 statements, half of which concerned pregnancy and the other half concerned childbirth. The study used a typical Likert scale with five response options: I completely agree, I agree, I have no opinion, I disagree, I completely disagree. Positive statements (1, 3, 5, 7, 9, 11, 13, 15) were scored as follows: I completely agree – 5 points, I agree – 4 points, I have no opinion – 3 points, I disagree – 2 points, I completely disagree – 1 point. Reverse scoring was used for negative statements. The maximum number of points, both in the section on pregnancy and childbirth, was 40. A score of up to 16 points indicated a negative attitude, and above 16 points a positive attitude. Cronbach's alpha coefficient was 0.76 for pregnancy and 0.82 for childbirth. The average correlation between statements was 0.3 and 0.37, respectively.

The Satisfaction With Life Scale (SWLS) by Diener et al. (1985) from the Department of Psychology at the University of Illinois was based on a questionnaire containing 48 statements concerning various aspects of subjective well-being. Factor analysis revealed three factors, namely: positive affect, negative affect and satisfaction. After eliminating statements related to affect and statements correlating below 0.60 with the satisfaction factor, 10 statements remained. Another 5 statements were eliminated due to their semantic similarity to the remaining ones. The result was a short scale consisting of 5 statements rated on a 7-point scale.

The SWLS scale consists of 5 statements that the respondent rates on a 7-point scale (from 1 – 'strongly disagree' to 7 – 'strongly agree'). The results of each response are added up to obtain an overall score ranging from 5 to 35 points.

The higher the score, the greater the sense of life satisfaction. A sten scale is used to interpret the results:

- 1-4 sten – low life satisfaction
- 5-6 sten – average life satisfaction
- 7-10 sten – high life satisfaction

Comparisons can be made with the results of normative groups (e.g. the general adult population, students, patients). The scale is suitable for assessing quality of life in the general population as well as in clinical populations (Diener et al., 1985).

The study was conducted between January 2025 and April 2025. The data collection process lasted a total of 11 weeks. Purposeful sampling was used. The study included women over the age of 18 who had been diagnosed with primary infertility and had never been pregnant before. Recruitment took place through an advertisement posted on an internet forum. The advertisement included a link to a Google Forms questionnaire and guaranteed anonymity. Candidates were informed about the purpose of the study and the rules of participation. The study was conducted in the form of an online questionnaire, available on the specialist internet forum OvuFriend, dedicated to couples with infertility issues. Participants recruited themselves by clicking on the link to the questionnaire. The respondents gave their informed consent to participate in the study and their GDPR consent by ticking the appropriate box in the questionnaire.

The questionnaire was approved by the Psychological Testing Laboratory in Warsaw due to the use of the SWLS scale. The study was conducted in accordance with the principles of the Helsinki Declaration.

SPSS Statistics V26 and Microsoft Excel were used for the analyses conducted for the study. Excel was used for the initial preparation of the database and its visualisation. Statistical tests and correlation analyses were performed in the SPSS environment.

In order to examine the relationship between quantitative variables, Pearson's correlation coefficient r was used, which allows to determine the strength and direction of the relationship between quantitative variables. On the other hand, the Kruskal–Wallis test H, which is a non-parametric equivalent of the one-way ANOVA, was used to compare multi-category groups in terms of quantitative or ordinal variables.

The analyses adopted the classic level of statistical significance $p < 0.05$ – statistically significant result, $0.05 < p < 0.099$ – treated as a statistical trend, indicating a possible, though uncertain, variation in results. All analyses were two-sided, and the selection of tests was adjusted to the measurement level of the variables and their distribution.

2. Results of the study

2.1. Characteristics of the study group

The study included 103 women undergoing treatment for infertility. The group of women was diverse in terms of age, place of residence, level of education, marital status, nature of work and socio-economic conditions.

The most numerous age group were respondents between 26-30 years of age, who represented 38.8% of the sample (N = 40). Women aged 31-40 were slightly less numerous (35.9%, N = 37). The youngest participants in the study, aged up to 25, accounted for 16.5% (N = 17), while the smallest group were women over 40 (8.7%, N = 9).

The majority of respondents lived in cities (65.0%, N = 67), while 35.0% (N = 36) were rural residents. The vast majority of respondents had higher education (85.4%, N = 88), while the remaining 14.6% (N = 15) had secondary education. Married women dominated among the respondents, accounting for 77.7% (N = 80). Single women accounted for 17.5% (N = 18), and widows or divorcees for 4.8% (N = 5). The largest group consisted of white-collar workers (77.7%, N = 80). Manual labour was performed by 18.4% (N = 19) of respondents, while the remaining 3.9% (N = 4) were unemployed, on leave, on sick leave or studying. Most respondents rated their socio-economic situation as good (49.6%, N = 51). Another 41.7% (N = 43) rated their conditions as very good, while 8.7% (N = 9) rated them as average.

The respondents were most often people who had been trying to conceive for 1 to 2 years (39.8%, N = 41). 16.5% (N = 17) of the respondents had been trying to conceive for less than 1 year. 16.5% (N = 17) of respondents had been trying to conceive for more than 2 to 3 years. Meanwhile, 27.2% (N = 28) of respondents had been trying to conceive for more than 3 years.

Most respondents declared that there were no cases of infertility in their family (57.3%, N = 59), while 18.4% (N = 19) confirmed that this problem had occurred in their family. The remaining 24.3% (N = 25) had no knowledge in this regard. Most of the study participants had already undergone infertility treatment (66.0% (N = 68). Surgical interventions related to infertility treatment were performed in 49.5% (N = 51) of respondents. When it came to psychological support in the context of infertility, the vast majority of respondents (80.6%, N = 83) did not use this form of help. Respondents who used psychological help chose individual consultations (9.7%, N = 10) and meetings with a psychologist together with their partner (9.7%, N = 10). The vast majority of participants (90.3%, N = 93) monitored their menstrual cycle. The most commonly used method of cycle monitoring was hormonal monitoring (60.2%, N = 62). The Billings method (54.4%, N = 56) and the Ogino-Knaus method (44.7%, N = 46) were also frequently used. The thermal method based on body temperature measurement was used slightly less frequently (38.8%, N = 40). Other methods of observation were indicated by 4.8% (N = 5) of respondents.

2.2. Attitudes towards pregnancy and childbirth and life satisfaction

The study assessed attitudes towards pregnancy and childbirth using a test based on 16 statements rated on a five-point Likert scale. The section on attitudes towards pregnancy (8 items) and the section on attitudes towards childbirth (another 8 items) were analysed separately. In each section, the maximum score was 40 points, with a score above 16 points being considered a positive attitude and a score of 16 or below being considered a negative attitude.

The average score for attitudes towards pregnancy was M = 23.18 (SD = 3.35), with values in this group ranging from 15 to 32 points. Considering that the threshold separating a negative and positive attitude was set at 16 points, the average obtained indicates that positive attitudes prevailed among the respondents. At the same time, it should be noted that the lower score range also included borderline values, suggesting that some respondents may have had difficulties in adapting to pregnancy.

With regard to attitudes towards childbirth, the average was even higher, at M = 26.11 (SD = 4.36), with scores ranging from 10 to 36 points. In this case, positive attitudes also prevailed, although the minimum value indicates that some women may have had strongly negative beliefs and emotions related to childbirth. The results are shown in Table 1.

The level of life satisfaction was assessed using the Polish adaptation of the Satisfaction with Life Scale (SWLS). This tool consists of 5 statements rated on a 7-point Likert scale, where 1 indicates complete disapproval and 7 indicates complete approval of a given statement. The final score ranges from 5 to 35 points – the higher the score, the greater the sense of satisfaction with one's life.

In the group of women undergoing infertility treatment, the average SWLS score was M = 22.34 (SD = 6.11), with values ranging from 10 to 35 points. This means that the results of the respondents were within the average range (6), although the spread of results suggests a diversity of individual assessments – from very low to very high. The results are presented in Table 2.

No statistically significant correlations were found in the analysis of the relationship between overall life satisfaction and attitudes towards pregnancy and childbirth (Table 3). The correlation coefficient between life satisfaction and attitudes towards pregnancy was r = 0.087 (p = 0.382), indicating a very weak, insignificant positive relationship. This means that the level of life satisfaction was not related to the perception of pregnancy by the women surveyed. In the case of attitudes towards childbirth, the correlation was almost nonexistent (r = -0.011; p = 0.916), which means that there was no relationship between these variables.

In the analysis of the relationship between the duration of trying to conceive and life satisfaction and attitudes towards pregnancy and childbirth, statistically significant relationships were found in two cases (Table 4). A negative, significant correlation was found between the length of time spent trying to conceive and the level of life satisfaction (r = -0.250;

Table 1. Attitudes towards pregnancy and childbirth in a group of women treated for infertility

Variable	M	SD	Min	Max
Attitude towards pregnancy	23.18	3.35	15	32
Attitude towards childbirth	26.11	4.36	10	36

M – mean, SD – standard deviation, Min – minimum value, Max – maximum value

Table 2. Life satisfaction in a group of women treated for infertility

Variable	M	SD	Min	Max
Life satisfaction	22.34	6.11	10	35

M – mean, SD – standard deviation, Min – minimum value, Max – maximum value

Table 3. The relationship between women's life satisfaction and their attitudes towards pregnancy and childbirth

Variable		Attitude towards pregnancy	Attitude towards childbirth
Life satisfaction	r	0.087	-0.011
	p	0.382	0.916

Table 4. Relationship between the length of time spent trying to conceive and women's life satisfaction and attitudes towards motherhood

Variable	Correlation coefficient r	Significance of correlation p
Life satisfaction	-0.250	0.011
Attitude towards pregnancy	-0.216	0.029
Attitude towards childbirth	-0.086	0.389

p = 0.011). This means that the longer the attempts to conceive lasted, the lower the overall level of life satisfaction reported by the respondents. A similar, albeit slightly weaker, relationship was found in relation to attitudes towards pregnancy – here a significant negative correlation was observed (r = -0.216; p = 0.029), indicating that longer infertility treatment was associated with a more ambivalent or less positive attitude towards pregnancy itself. In the case of attitudes towards childbirth, the correlation with the duration of treatment was minimal and did not reach statistical significance (r = -0.086; p = 0.389), suggesting no clear relationship between these variables.

The level of life satisfaction was analysed according to the age of the respondents (Table 5). The Kruskal-Wallis H test was used for multi-group comparisons, which did not show any statistically significant differences between the analysed age groups (H = 5.049; p = 0.168). The highest average level of satisfaction was recorded in the group of women under 25 years of age (M = 24.29), while the lowest was among participants aged 41 years or older (M = 20.11). Women aged 26-30 (M = 22.23) and 31-40 (M = 22.11) achieved average results that were similar to each other. Although differences in mean values were visible, they did not reach statistical significance, which means that age did not significantly differentiate the level of life satisfaction in the study group.

Significant differences were noted in attitudes towards pregnancy (H = 13.95; p = 0.003). The lowest reported positive attitude was among women aged 31-40 (M = 21.68), while the highest was among respondents aged 41 or older (M = 24.78). High scores were also achieved by respondents up to 25 years of age (M = 23.59) and those aged 26-30 (M = 24.05). This means that middle-aged women showed a relatively less positive attitude towards pregnancy than younger and older respondents.

On the scale of attitudes towards childbirth, the differences between age groups reached statistical significance (H = 7.156; p = 0.067). The highest average score was observed among women aged 26-30 (M = 27.4), while the lowest was in the group of respondents aged 41 or older (M = 23.67). Detailed analyses are presented in Table 6.

3. Discussion

Infertility is not only a medical problem, but also a psychological and social one, as it affects the lives of affected women and their partners. The study confirmed that the longer the time spent trying to

Table. 5. Life satisfaction depending on the age of women

	Age								H	p
	up to 25 years (N = 17)		26-30 years (N = 40)		31-40 years (N = 37)		41 or older (N = 9)			
	M	SD	M	SD	M	SD	M	SD		
Life satisfaction	24.29	6.15	22.23	6.06	22.11	6.46	20.11	4.43	5.049	0.168

Table 6. Attitudes towards pregnancy and childbirth depending on the age of women

Variable	Age								H	p
	up to 25 years (N = 17)		26-30 years (N = 40)		31-40 years (N = 37)		41 or older (N = 9)			
	M	SD	M	SD	M	SD	M	SD		
Attitude towards pregnancy	23.59	3.45	24.05	2.86	21.68	3.59	24.78	1.92	13.950	0.003
Attitude towards childbirth	26.35	5.16	27.40	4.28	25.19	3.91	23.67	3.50	7.156	0.067

N – number of observations, M – mean, SD – standard deviation, H – Kruskal-Wallis test result, p – statistical significance

conceive, the lower the level of life satisfaction reported by women undergoing infertility treatment. A similar relationship was observed in the case of attitudes towards pregnancy: the longer the treatment lasted, the more negative the attitudes declared. However, no relationship was found between the length of treatment and attitudes towards childbirth itself, which means that the duration of treatment did not significantly affect attitudes towards childbirth.

The results indicate that the respondents generally had a positive attitude towards pregnancy and childbirth, which partly coincides with the results of a study by C. Łepecka-Klusek et al. (2011). In the cited study, most women had positive attitudes towards pregnancy, while attitudes towards childbirth were more often negative. The cited study also showed a significant relationship between age and attitudes towards pregnancy and childbirth ($p < 0.01$). A similar correlation was found in this study between the age of the respondents and their attitudes towards pregnancy ($p = 0.003$) and childbirth ($p = 0.067$). The analysis showed that the highest rate of positive attitudes towards pregnancy and childbirth was found among women aged 41 and over. However, these results differ from the data of Łepecka-Klusek et al. (2011), where women over 35 years of age were more likely to have negative attitudes towards pregnancy, affecting almost one in three respondents. This difference may be due to the fact that 15 years have passed since the study by Łepecka-Klusek et al. During this time, there has been intensive development of assisted reproductive technologies, their availability has improved, and the perception of people with reproductive problems in society has changed.

It is worth noting that women's attitudes towards pregnancy and childbirth are complex and depend on many factors, including health, social support, but also previous childbirth experiences and cultural conditions. For example, research conducted by O'Connell et al. (2021) showed that women who feel greater emotional support from their partner and family report a more positive attitude towards childbirth, which translates into lower levels of anxiety during pregnancy. In turn, the European Perinatal Health Report (Euro-Peristat, 2022) points out that fears and negative attitudes towards childbirth are more common in countries with lower levels of access to prenatal education and psychological support. However, these data refer to all women, without taking into account the problem of infertility.

A 2024 qualitative study analysing the experiences of women who became pregnant after long-term infertility treatment identified four main emotional dimensions: enormous emotional burden, overprotectiveness, overthinking and changes in social

relationships. Although the joy of pregnancy was real, it was accompanied by intense anxiety about the course of the pregnancy and delivery, and a need for intensive support from partners, family and medical staff (Hadavibavili et al., 2024).

Prolonged attempts to conceive and long-term infertility treatment can have a negative impact on women's mental health, which is often associated with a deterioration in attitudes towards pregnancy and a decline in overall life satisfaction. The study showed that the relationship between treatment duration and attitudes towards pregnancy and childbirth was statistically significant ($p = 0.029$). This means that the longer the treatment, the more ambivalent or less positive the women's attitudes towards pregnancy were. This result differs from the observations of C. Łepecka-Klusek and G. Jakiel (2007), who found no significant relationship between the length of treatment and adaptation to pregnancy ($p = 0.15$).

The average level of life satisfaction in the study group ranged from low to high, with results indicating a prevalent level of average satisfaction. Similar results were also reported by other authors presenting countries from different cultural circles (Nagórska et al., 2022; Sameer et al., 2023; Adachi et al., 2020). Statistical analysis did not reveal any significant correlations between life satisfaction and attitudes towards pregnancy and childbirth. For attitudes towards childbirth, the correlation was insignificant ($r = -0.011$; $p = 0.916$). Similar results were reported by Polish researchers: Gebuza et al. (2014) found that the level of life satisfaction among women in the perinatal period depended mainly on social support and not directly on perceptions of pregnancy and childbirth. In turn, Skurzak et al. (2019) indicated that the life satisfaction of pregnant women was more related to socio-demographic factors, such as relationship status or education.

In summary, the findings indicate that longer infertility treatment may reduce women's overall life satisfaction, but no significant association was found between life satisfaction and their attitudes towards pregnancy and childbirth. These results highlight the multidimensional nature of the infertility experience and point to the need for further research that takes into account a broader psychological and social context.

4. Limitations of the study

The study was a one-off study conducted online using the author's questionnaire and standardised tools. The use of standardised methods increases the accuracy of the measurement, but the selection of the sample through internet forums may limit the results' representativeness. The participants may have constituted a specific group, more active, seeking support and ready to share their experiences. In addition, the online format made it impossible to control how the questionnaire was completed, which creates a risk of misinterpretation and the influence of the need for social approval. It is also worth noting that participation in the study was based solely on the women's declarations. The lack of formal medical verification means that women have not been clinically confirmed as belonging to the group of women treated for infertility. Therefore, the results should be treated as an approximation of reality and a starting point for more in-depth research involving a more diverse sample and using additional research methods.

5. Conclusions

1. Women treated for infertility are characterised by varying levels of life satisfaction, with a significant decline in overall satisfaction observed as the time spent trying to conceive a child increases. This indicates the need to include regular assessment of patients' mental state in standard medical procedures. The practical implication is to create a psychological screening protocol at various stages of treatment, especially after each unsuccessful treatment attempt. Monitoring mental health after each of these stages will allow for early identification of patients in need of support, which may prevent discouragement and resignation from further efforts.
2. Despite reproductive difficulties, most of the women studied had positive attitudes towards pregnancy and childbirth, indicating an optimistic attitude towards motherhood. At the same time, it was observed that the length of infertil-

ity treatment is associated with an increasingly more ambivalent attitude towards pregnancy, but does not have a significant impact on attitudes towards childbirth itself. This suggests the need for specialist psychological support. This should focus on managing the emotions associated with waiting to conceive a child. It would be good practice to organise workshops and individual therapy sessions to help women cope with negative thoughts and uncertainty. These activities should be available not only to women but also to couples from the moment of diagnosis and should be continued throughout the treatment to facilitate the patients' psychological adaptation.

3. The results obtained indicate the need to integrate psychological care as part of infertility treatment. It is recommended that infertility treatment centres offer: early diagnosis of psychological problems, systematic monitoring of life satisfaction, support programmes tailored to the duration of treatment, with particular emphasis on patients struggling with infertility for a longer period of time. The introduction of these measures may contribute to improving the overall quality of life of patients, increasing their psychological resilience and potentially improving the effectiveness of infertility treatment.

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