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ASSISTED REPRODUCTION TECHNOLOGIES

An introduction to infertility counseling: a guide for mental health and medical professionals

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Abstract The practice of infertility counseling delivered by mental health and medical professionals has become more sophisticated and widespread over the past decade. This paper summarizes information presented at the second campus workshop of the Special Interest Group of Psychology and Counseling of the European Society of Human Reproduction and Embryology (ESHRE). This group is dedicated to improving infertility services by creating meaningful connections between mental health and medical professionals. The paper identifies key issues that infertility counselors must consider in their work with couples experiencing infertility. The use of supportive psychosocial interventions and treatments are highlighted. The paper also details the process for choosing the most appropriate type of infertility counseling, and the use of assessment tools that assist in understanding infertility related symptoms. Infertility counselors should also consider gender differences, the impact of infertility on a couple's sexual relationship, and the unique challenges couples face regarding third-party conception. Finally, the paper addresses specific recommendations for infertility counselors in mental health and medical settings.

Keywords Assessment tools · Gender · Infertility counseling · Sexuality · Third-party reproduction

Capsule This paper highlights issues that infertility counselors must consider in their work with couples experiencing infertility, and outlines psychosocial interventions and treatments to support couples during the infertility experience.

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Introduction

The practice of infertility counseling delivered by mental health and medical professionals has become more sophisticated and widespread over the past decade [1]. This article highlights selected issues in the practice of infertility counseling and addresses key challenges that couples and practitioners may face at different phases of the infertility experience. The guidelines and recommendations in this paper were presented at the second campus workshop of the Special Interest Group (SIG) of Psychology and Counselling of the European Society of Human Reproduction and Embryology (ESHRE) – a group dedicated to improving patient care and the delivery of infertility services by creating meaningful connections between mental health and medical professionals.

The focus of the ESHRE campus workshop was "Raising Competence in Psychosocial Care." Topics were aimed at promoting enhanced collaborations between medical and mental health care providers in the treatment of infertility

patients. The workshop faculty was comprised of an international group of experts in infertility counselling (4 psychologists, 2 social workers, 1 marriage and family therapist, 1 medical doctor). Following the conference, speakers collaborated to disseminate the workshop proceedings to a wider interdisciplinary audience via the present article. The material presented in this paper is based on research and current practice in the specialization of infertility counseling [1].

The topics of this paper are presented in five main sections. First, various assessment and screening tools that can be used by medical and mental health providers are examined. Second, the process for matching infertility counselling to patient need is described. Third, typical gender issues that can be used as a resource in couple counseling are outlined. Fourth, the interaction between infertility and couple's sexual relationship is discussed. Finally, the complexities and unique challenges in counseling couples considering third-party conception are presented.

Assessment and evaluation

Historically, the main role of mental health professionals (MHP) in infertility clinics was to provide support for the crisis of infertility and/or carry out screening before treatment, and these roles continue to be important [1]. More recently, however, MHPs have also been called upon to develop and evaluate interventions tailored to specific challenges, such as coping with the two-week waiting period before the pregnancy test [2], helping men prepare for semen analysis [3], or deciding about fertility preservation [4]. These more recent developments are due to three main factors. First, many people with fertility problems desire psychosocial help, but not necessarily in an individual, couple or group counseling format, thus creating a need for adjunct self-administered interventions. Second, the high success rate of medical treatment and its protracted nature has created a need for treatment specific interventions. Third, growing awareness of high discontinuation rates in fertility treatment has created a need for psychosocial interventions that can be easily implemented by staff during the routine day-to-day delivery of treatment (see [5] for a detailed discussion of this issue and role of the counselor).

MHP's are best placed to assist in the development and evaluation of self-administered and tailored interventions. Several measures have already been developed including SCREENIVF, FertiQoL and FertiSTAT. SCREENIVF was developed to assist medical staff in identifying patients that should be referred for psychological support [6]. Research shows that a positive pre-treatment SCREENIVF is highly predictive of high treatment distress [6]. The Fertility Quality of Life Tool (FertiQoL) is a reliable and valid international tool available in 23 languages (see www.fertiqol.org) developed to assess the impact of fertility problems and treatment on personal, social and relational life domains [7]. The Positive Reappraisal Coping Intervention (PRCI) was designed to help couples cope with the two-week waiting period before treatment by facilitating the use of coping strategies known to be effective in uncontrollable and unpredictable situations [2]. FertiSTAT (Fertility Status Awareness Tool) was developed to help women and their partners learn about their fertility status and in doing so engage in behavior change that could optimise their fertility (e.g., reduce negative life style habits, seek more timely medical advice) [8]. Several online tools (e.g., AmnioDex, [9]; Infertility Source, [10]), support groups (e.g. [11]) and moderated forums (e.g. [12]) show promise due to high feasibility and acceptability as well as effectiveness for some patients. These advances demonstrate growing opportunities for MHP's to broaden the ways in which they can assist patients (and staff) with challenges provoked by fertility problems.

Choosing a form of counseling

When a couple is in need of infertility counseling services, medical staff and couples are left to determine the timing and type of counseling most appropriate for their situation. Typically, providing psychosocial care and psychological help for infertile couples or individuals is seen as a stepwise process (see Fig. 1). Patient-centered care can be conceptualized in two parts – first, information gathering and analysis as well as implications and decision-making counseling. Infertility counseling can cover three areas including implications and decision-making counseling, as well as support counseling and short-term crisis counseling. Psychotherapy primarily includes therapeutic counseling, but can also include crisis counseling that is long-term in nature [13].

Medical and mental health professionals can deliver infertility counseling services according to their expertise. Medical doctors and the staff of the fertility center should deliver patient-centered care. They should offer sufficient information about the pros and cons of medical treatments so that the patient knows enough about treatment implications to make informed decisions. MHPs and other qualified infertility counselors should provide support counseling (e. g. grief work after a miscarriage) and short-term crisis counseling to

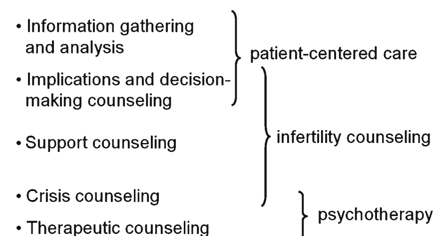

Fig. 1 Types of counseling

patients after a failed IVF or ICSI trial. MHPs (e.g., family therapists, psychologists) should address severe psychological problems (e.g., anxiety, depression, marital/sexual problems).

Infertility counseling and psychotherapy should be offered by independent providers rather than by the medical team so that issues about ART success rates [14], ART with third-party reproduction [15], and issues related to stopping treatment [16] can be sufficiently addressed. Furthermore, medical and mental health professionals must be aware of the risk factors for high distress (e. g. suffering from childlessness and depression for women and relative dissatisfaction with partnership and sexuality for men) that may necessitate counseling [17]. These include *personal factors* (e. g. pre-existing psychopathology, primary infertility, being a woman, viewing parenting as a central adult life goal, general use of avoidance coping strategies); *situational or social factors* (e.g., poor marital relationship, impoverished social network, frequent reminders of infertility); and *treatment-linked factors* (e.g., side-effects of medication, miscarriage, prior treatment failure) [18]. Referrals to a psychotherapist can be made if patients experience major depressive symptoms, severe marital or sexual problems, and/or psychological distress that may directly impact infertility [19, 20].

Gender differences and infertility counseling

It is essential that infertility counselors be aware of how men and women experience infertility differently. Nearly all studies confirm that women experience greater amounts of infertility-related stress [21]. Women are also more likely than men to report depression and anxiety symptoms, take a more active role in medical treatment, and respond more poorly following treatment failure [22–24]. Men experience infertility stress, but appear less emotionally affected and are more willing to consider treatment termination [23, 24]. With regard to counseling services, women have more positive attitudes towards seeking psychological help than men [25], and they are more likely to seek couple counseling for general distress [26].

In terms of coping behaviors, women seek more social support through medical professionals and those also going through infertility stress [27]. However, they also use more avoidance strategies compared to men such as avoiding women with young children and other reminders of infertility [27]. While women use avoidance strategies to reduce their psychological distress, research has consistently found that the use of avoidance coping strategies actually increases psychological distress [27–29]. Thus, there is a paradoxical relationship to avoidance coping strategies – namely, the more one avoids reminders of the infertility to protect one from psychological distress, the more distress is likely to be reported [29]. Men, on the other hand, are more likely to distance themselves from the pain of infertility and use more problem-solving strategies [27, 28]. It is important to note that individual coping strategies can also impact one's partner. For example, the way a partner copes with infertility impacts the partner's depression and marital distress with avoidance coping being linked to increased psychological distress and meaning-based coping being linked to decreased marital distress [28, 29].

Counselors must understand the larger cultural socialization patterns that define and shape gender in the couples they work with (i.e., traditional masculinity emphasizing emotional stoicism and interpersonal distance, traditional femininity emphasizing connection through the sharing of emotional experience with others). These macro socialization patterns can be found in the micro gender-based interactions in their relationship [30].

For the couple counselor, a common dynamic occurs when couples become stuck in an "emotional trap." For example, when a woman experiences chronic infertility-related emotional pain and her partner uses instrumental coping strategies (e.g., problem solving) to attempt to protect her from the pain. However, because men cannot ultimately fix their partner's emotional response, they leave these interactions feeling helpless and frustrated while women feel emotionally invalidated. This dynamic results in a circular pattern of polarization and interpersonal distance when both partners actually seek emotional connection and support [16].

When confronted with this dynamic, the infertility counselor can assist couples by engaging in the emotional paradox. In this emotional paradox, a man can let go of the need to solve problems of his partner by validating her emotions and letting her feel the depth of the infertility-related pain. By simply allowing her to experience her emotions, she feels validated, understood, and supported. Rather than engage in a traditional-based gender interaction in which needs are not met and emotional distance created, the use of paradox allows the partners to create meaningful connections.

Sexual dysfunction and infertility counseling

The diagnosis of infertility can have a powerful impact on a couple's sexual relationship. Once a couple fails to achieve pregnancy, the meaning of the sexual relationship and prior sexual behaviors begin to change. Women can report a decrease in sexual desire, lower levels of sexual satisfaction, and severe marital strain [20, 31]. Men, on the other hand, can report a decreased ability to control ejaculation, lower levels of sexual satisfaction, lower self-esteem and increased feelings of anxiety [20, 31]. Men and women also experience a loss of control and confidence in their own body as well as a sense of failure in themselves [32]. This can negatively influence self-esteem and self-confidence.

The specific elements of the couple's sexual relationship should be carefully examined during a fertility clinic's intake procedure. Certain sexual dysfunctions, including erectile and ejaculatory dysfunctions for men and vaginismus for women, can play a decisive role in infertility [33]. Sexually transmitted diseases and a reduced desire or libido loss may also result in infertility for men and women. It is important that medical professionals ask friendly, yet direct questions to obtain an accurate picture of their sexual relationship. As there is general discomfort when talking about sexual behavior, many couples provide socially desirable answers. However, hidden sexual problems may play a partial role in some patients – particularly those with unexplained infertility [20].

Infertility counselors can play a key role in addressing sexual difficulties in a couple's relationship. During the early phase of counseling, the counselor should empathically ask permission to address the couple's sexual life while providing the couple with educational information, addressing sexual myths, and providing specific suggestions in response to a couple's questions. When the sexual issues confronting the couple are far more complex, the counselor may refer the couple to a therapist specializing in couple or sex therapy.

Fertility counselors must be alert to the unique challenges in the couple's sexual relationship that are related to infertility. It is clear that sexual dysfunctions are far more the consequence than the cause of an infertility diagnosis. While sexual problems can present challenges to many couples, studies have shown that couples who have a positive reinterpretation of their fertility problems and also have an active coping style can exert a positive influence in the quality of their lives [28].

Third party conception and infertility counseling

Third party conception includes donor insemination, egg donation (also referred to as oocyte donation), embryo donation, and surrogacy. For most couples, third party conception becomes an option once treatment with their own gametes has failed, pregnancy is impossible due to infertility, or the couple possesses a genetic disorder they do not wish to pass on to their children. When discussing third party conception, counselors should also explore alternative perspectives such as adoption, foster-care, or living a life without children in order to provide couples with all of their possible family building options.

It is not uncommon for couples to voice concerns or have significant reservations when first learning about third-party conception. These reservations are related to the unusual family composition, the mixture of social and biological parenthood, the fear that bonding between the child and the social parent will be less secure, and the stigma associated with gamete donation in many countries around the world. Because of this, psychosocial professionals have spoken out for pre-treatment counseling intended to educate parents about third-party conception, to explore couple concerns, and to support the management of this family composition [15, British Infertility Counselling Association, Australian and New Zealand Infertility Counsellors Association].

Counselors can also play an important role in providing basic information to patients regarding the medical and legal aspects of the intended treatment. Couples need to be aware of issues such as legal parenthood, the need to adopt a child after surrogacy, and the right of offspring to access information of the gamete donor and/or surrogate. As infertility counselors are not in a position to provide detailed or binding information on these issues, couples should be encouraged to seek comprehensive information and professional legal advice prior to embarking on third party conception.

Finally, counselors can assist couples in understanding the importance of disclosing the nature of the conception to the child. Psychosocial professionals recommend early disclosure (between the age of 3 and 6 years) in order to prevent a family secret [34, 35]. Counselors can assist couples with disclosure issues by providing educational literature or helping with the development of a script they can use for talking to young children. Counselors should also address any fears associated with disclosure (i.e., worries about the couple's bond with the child; concerns that the child will experience confusion regarding their identity), and inform the couple that research and clinical experience suggests that bonding in families resulting from third party conception does not deviate from the norm [36]. Furthermore, counselors can help couples understand that while children are likely to express interest in their genitor, such interest is normal, and does not correlate to strained or devalued parent-child relationships [37, 38]. Finally, counselors can help couples learn to respond to their children's needs regarding disclosure in an age-appropriate manner, while also realizing that disclosure is not a single event but an ongoing developmental process that will take place over the course of the child's life.

Conclusion

The importance of effective management of psychosocial issues in reproductive care is now firmly recognized (5). Accordingly, most clinics endeavour to create a culture of patient-centred care to achieve optimal treatment success and this goal is often achieved [39]. The psychosocial needs of patients can often be met by actions taken by clinic staff. However, psychosocial needs will at times require more in-depth psychosocial intervention that is best delivered by mental health professionals and infertility counselors. These counseling services should be available during all stages of the infertility experience and include proper assessments,

discussion of gender differences, and joint-decision making related to treatment and third-party reproduction.

Before establishing infertility counseling in a clinic, it is important to consider the pros and cons of different settings (counseling within the team or external counseling). Furthermore, the division of labor between medical and mental health professionals concerning different stages of the counseling process should be clarified in advance [40]. Fertility clinic staff can provide adequate services to manage patient needs by assessing the goodness of fit between such needs and the availability of psychosocial resources. The development of patient administered screening tools are available to help the medical team in this process. Medical professionals and staff should develop an understanding of when and how to refer individuals and couples to an infertility counselor, and infertility counselors must be prepared and trained to treat couples emotional distress arising from gender differences, difficulties in the marital or sexual relationship, and decisions regarding third-party reproduction.

In summary, medical and mental health professionals can provide appropriate interventions to alleviate stress and improve patient care through the use of newly developed self-administered screening instruments that can provide meaningful interpretations for patient care [6, 7]. Furthermore, understanding which form of counseling is most appropriate for individuals/couples and for their situation is vital to help them obtain the best form of infertility counseling possible [1, 16]. Understanding and embracing gender differences, rather than avoiding them, as well as being knowledgeable about the impact of infertility on the sexual relationship, are essential in order to improve quality of life within the couple relationships during the process of infertility treatment [28, 29, 31]. Finally, infertility counselors must learn the best ways to educate couples regarding the medical, legal, and psychological issues surrounding third-party conception so that they feel confident if choosing this family building alternative.

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