Evolution of psychology and counseling in infertility

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Five key paradigm shifts are described to illustrate the evolution of psychology and counseling in infertility. The first paradigm shift was in the 1930s when psychosomatic concepts were introduced in obstetrics and gynecology as causal factors to explain why some couples could not conceive despite the absence of organic pathology. In the second shift, the nurse advocacy movement of the 1970s stimulated the investigation of the psychosocial consequences of infertility and promoted counseling to help couples grieve childlessness when medical treatments often could not help them conceive. The third shift occurred with the advent of IVF, which created a demand for mental health professionals in fertility clinics. Mental health professionals assessed the ability of couples to withstand the demands of this new high technology treatment as well as their suitability as potential parents. The fourth shift, in the 1990s, saw reproductive medicine embrace the principles of evidence-based medicine, which introduced a much more rigorous approach to medical practice (effectiveness and safety) that extended to psychosocial interventions. The most recent paradigm shift, in the new millennium, occurred with the realization that compliance with protracted fertility treatment depended on the adoption of an integrated approach to fertility care. An integrated approach could reduce treatment burden arising from multiple sources (i.e., patient, clinic, and treatment). This review describes these paradigm shifts and reflects on future clinical and research directions for mental health professionals. (Fertil Steril® 2015;104:251–9. ©2015 by American Society for Reproductive Medicine.)

Key Words: Psychology, counseling, history, assisted reproductive techniques

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The evolution of psychology and counseling in infertility can be traced through five paradigm shifts in reproductive medicine that still impact the work of mental health professionals (MHPs) working at present in fertility clinics. Table 1 presents a timeline for these shifts, which are then individually presented in the next five sections. In each section we present an account of the historic context motivating the shift, a précis of current research and practice influenced by it, and then conclude with future directions for this line of investigation.

PSYCHOSOMATIC CONCEPTS AND PSYCHOGENIC INFERTILITY

The psychology of infertility emerged from what Berg and Wilson (1) later named the psychogenic model of infertility, which proposed psychopathology as an etiologic factor in infertility. The psychogenic model was introduced in the 1930s to account for infertility that had no identifiable biomedical cause. At that time the diagnosis of "unexplained infertility" was given to more than 30% of presenting cases (2). Menninger (3) described unexplained infertility as "a psychic conflict sailing under a gynecologic flag," with numerous forms of psychic conflict proposed (e.g., a conflicted sexual identity [same-sex sexual attraction] or a conflicted relationship between the self and mother [4]). Fischer (5) characterized women with unexplained infertility according to two personality styles perceived to be incompatible with motherhood: weak, emotionally immature, overprotected women or ambitious, masculine, aggressive, and domineering career women. Infertility in men (whether explained or not) was attributed to domineering mothers who expected conformity to rigid moral codes, overcontrolled their sons by threatening withdrawal of love, and created anxiety in their sons by their own sexual inhibitions (6). Such explanations were recycled during the sexual revolution to account for the so-called new impotence where men were thought to be infertile due to performance pressures from sexually liberated women who expected sexual encounters to be mutually rewarding

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TABLE 1

Five key paradigm shifts illustrate the evolution of psychology and counseling in infertility, and the historic context that motivated the shifts.

Section	I. Psychosomatic concepts and psychogenic infertility	II. Nurse advocacy and the psychological sequelae model of infertility	III. IVF and the integration of mental health professionals in fertility clinics	IV. Evidence-based medicine and the quality of psychological support	V. Integrated approach to fertility care
Timeline	1940	1974	1978	1999	2012
Historic context	High rate of unexplained infertility	High failure rate of available treatments	IVF and the era of new reproductive technologies	Evidence-based medicine using the best research evidence as basis of all clinical decision-making	Treatment "dropout" and compliance
Paradigm shift into	Psychological causes of infertility	Psychological consequences of infertility	Pretreatment psychological assessment, welfare of the child, third party reproduction, and monitoring of child outcomes	Development and evaluation of psychological interventions	Focus on burden of treatment and treatment engagement & disengagement

Note: Dates of paradigm shifts are approximate only.

Boivin. Evolution of psychology and counseling. Fertil Steril 2015.

(7). Over time the psychogenic model fell out of favor due to the increased ability of newer diagnostic technologies to account for unexplained infertility (e.g., 78% of patients with unexplained infertility showed pelvic pathology [8]). Psychoanalytic analyses of fertility problems occasionally still surface (e.g., Christie [9]), but it has generally been concluded that long-standing infertility is unlikely to be caused exclusively by psychological problems (10).

The demise of traditional psychosomatic theory has not put an end to research on psychological influences on fertility. As psychosomatic theories segued into multifactorial models of disease etiology (e.g., biopsychosocial model [11, 12]), researchers directed their attention to the vulnerability of all patients to psychological influences. According to these models disease states have diverse determinants and consequences (i.e., biological, environmental, social, psychological), with individuals more or less susceptible to each depending on their own personal history (e.g., genetic background, life events, learning). A main continuing line of research has been the study of stress and fertility. A plethora of studies has been published describing this psychobiological link according to characteristics (e.g., gender, treatment type, stressor), explanatory mechanisms (e.g., hormones, lifestyle, patient compliance, methodological confounders), time course (e.g., over single or multiple treatment cycles), and protective factors and interventions (e.g., education, information provision, counseling). This voluminous research shows that psychological factors are undoubtedly implicated in fertility problems. However, stress effects may not be directed to reproductive physiology or hormones but instead operate through patient behavior, for example, lifestyle habits known to affect fertility (e.g., smoking, alcohol consumption) or suboptimal help seeking behavior (13). The impact of psychological interventions on stress-fertility link is still hotly debated with some investigators proposing an effect and others not (14–16).

The legacy of the psychogenic model has been significant. It made possible entry of psychology into the exclusive obstetrics and gynecology club, which might not have happened if psychologists had only offered methods to make patients feel better. Psychosomatic questions are also the origin of much of the research contributing to our present multifactorial and broad understanding of the factors that influence conception and the capacity to reproduce. However, there are less positive legacies. Early case reports are the source of many persistent myths and unhelpful and ineffective advice given to couples trying to conceive (relax and you'll get pregnant, don't think about it and you'll get pregnant) that sometimes unnecessarily delay treatment (13). The near exclusive focus on women in psychiatric contexts caused disproportionate focus on women as a main cause of couple (unexplained) infertility, which still persists, and undoubtedly contributes to men being excluded from research and neglected during treatment. Finally, the strong emphasis on psychological factors as causes of infertility rather than consequences did not benefit couples struggling with the emotional, relational, social, or physical fallout of this medical condition.