Creating a collaborative model of mental health counseling for the future

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Infertility patients report high levels of anxiety and depressive symptoms, leading to a variety of challenges for the health care team. These include the impact of patient distress on nurses and physicians, patient treatment termination, and potentially lower pregnancy rates. Integrating a mental health professional into the infertility treatment team has the potential to lower distress for patients, support staff, and clinicians, leading to increased patient retention and an easier working environment. (Fertil Steril® 2015;104:277–80. ©2015 by American Society for Reproductive Medicine.)

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The psychological aspect of infertility treatment has been mainly addressed by the mental health and nursing communities, both in terms of clinical approaches to treating distress and research on interventions which could have the greatest potential to offer the most relief to patients. However, physicians and other members of the medical team might well benefit from including more of a mental health focus in their patient care model.

Patient distress can have an adverse effect on the patient, their treatment, and their health care providers through a variety of ways, including the following:

1. Experiencing symptoms of anxiety, depression, or both are unpleasant for the patient.
2. Working with anxious and/or depressed patients poses more challenges to their caregivers.
3. Distressed patients are more likely to terminate treatment.
4. Psychological distress may be correlated with lower pregnancy rates.

It is proposed that a collaborative model of mental health counseling can address each of these issues, thus potentially leading to less stress among the patients and then the caregivers, with patients remaining in treatment longer and achieving higher pregnancy rates. The results of a recent meta-analysis support the hypothesis that relieving distress through psychological interventions is associated with significantly higher pregnancy rates (1).

IMPACT OF WORKING WITH DISTRESSED PATIENTS

Infertility patients report high levels of distress, including symptoms of depression, anxiety, anger/irritability, and social isolation (2). In one study of women who underwent a structured psychiatric interview before their first infertility clinic visit, 40.2% met the criteria for a psychiatric disorder (3). The most common diagnosis was generalized anxiety disorder (23.2%), followed by major depressive disorder (17.0%) and dysthymic disorder (9.8%).

It is likely that the majority of patients being cared for in an infertility center are experiencing symptoms of anxiety and/or depression. Although most patients report that they can cope with the stress of treatment and do not participate in psychological counseling (4), it is unknown how many of these patients are in fact coping well and how many eventually drop out of treatment. The challenges of how to incorporate counseling into the patient care model will be addressed later in this review.

Caring for highly distressed patients can be difficult. Caregivers may empathize with the suffering their patients are experiencing and feel helpless to comfort them when treatment fails (5). In addition, stressed patients may complain more, call more often, and

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be dissatisfied with their care, leading to caregiver burnout and job dissatisfaction (6).

Another rarely mentioned issue that faces most infertility treatment caregivers is the fact that our successes disappear. In fact, once patients have a normal prenatal ultrasound scan, they are discharged from the infertility practice and sent back to their obstetrician. The patients who are seen over time are the ones who experience treatment failure. Oncologists, who treat a patient population with levels of anxiety and depression equivalent to those of infertility patients (7), continue to see their "cures" in addition to their patients who have failed initial rounds of treatment. Cancer patients who have no active disease continue to see their oncologist for years, whereas the reproductive endocrinologist rarely sees a pregnant patient through the first trimester. Thus, the oncologic community sees a balance of treatment success and failure, whereas the infertility community treats only patients who have yet to see success in their current attempt to conceive a healthy baby.

RELATIONSHIP BETWEEN DISTRESS AND TREATMENT TERMINATION

There have been a large number of studies indicating a significant relationship between patient distress and treatment termination, even in insured patients. In the first cohort of studies, published in 2004, patient distress was the most commonly cited reason for treatment termination (8). In a subsequent prospective study of 132 insured patients who were $\leq$39 years old, who were insured for up to six IVF cycles, and who did not initiate a third cycle, the most common reason given for dropping out of treatment was stress (39%) (9). The top contributors to distress were the toll that infertility took on the couple's relationship and being too anxious or depressed to continue with treatment.

More recently, research has indicated that less perceived social support was a major contributing factor (10), and in one study psychological burden had the highest impact on the decision to stop treatment (11). In a recent systematic review of 22 studies on the topic (12), the top-cited reasons were postponement of treatment (39%), relational and personal reasons (17%), and psychological burden (14%). Thus, it is clear that psychological issues are a major cause, if not the greatest contributor, to treatment termination in insured patients.

In the most recent study, and perhaps the first randomized controlled trial to investigate the impact of a psychological intervention on treatment termination rates in insured IVF patients (13), those who were randomized to receive a stress management packet subsequently had a 5% termination rate, compared with a 15% rate in the control group. This suggests that decreasing distress does in fact have a positive impact on termination.

IMPACT OF PSYCHOLOGICAL INTERVENTIONS ON TREATMENT OUTCOME

There have been three meta-analyses to date on the impact of various psychological interventions on pregnancy rates and psychological distress. In the first meta-analysis, published in 2003 (14), no relationship to pregnancy rates was established, and it was determined that the most effective interventions for the treatment of psychological distress were group interventions that emphasized acquisition of skills, such as relaxation training and education, rather than support interventions. The second meta-analysis, published in 2009 (15), found the opposite: There was no significant impact of psychological interventions on psychological distress, but there was evidence for these interventions to have a positive effect on pregnancy rates for couples not undergoing IVF. However, in the most recently published meta-analysis (2015) of 39 eligible studies (1), the authors concluded that psychological interventions, particularly those that included cognitive-behavior therapy, are effective in both increasing pregnancy rates and decreasing psychological distress. They determined that the pregnancy rate of women who participated in some sort of intervention was twice that of the control women. They also observed that larger reductions in anxiety were associated with higher pregnancy rates.

Thus, based on the research summarized above, it is clear that the psychological aspect of infertility plays an important role in the care of the patient. It does not take a large leap of faith to come to the logical conclusion that mental health counseling should be an integral part of every patient's treatment plan.

ROLE OF THE MENTAL HEALTH COUNSELOR IN THE INFERTILITY TREATMENT TEAM

Two recent publications thoroughly describe the benefits and characteristics of a team approach in infertility counseling. The first one (16) summarizes information from the Special Interest Group of Psychology and Counseling of the European Society of Human Reproduction and Embryology (ESHRE). Mental health professionals have provided numerous roles over the years, including supporting patients in crisis, couples counseling, stress reduction, and comforting patients for whom treatment failed. Because third-party reproduction has become so widespread, many mental health professionals (MHPs) have begun to spend all or the majority of their time on third-party evaluations. According to the ESHRE group, three recent developments are changing the role of MHPs, who need to expand their activities beyond third-party responsibilities. They include the need for self-administered interventions instead of group or individual counseling, the need for treatment-specific interventions, and finally the need for easily disseminated interventions in an attempt to decrease treatment discontinuation. They specify that counseling should be offered by MHPs, rather than the medical team, for a variety of reasons, including concerns about stopping treatment, adequately screening for high levels of distress, private discussions on sexuality and sexual dysfunction, and recognizing social factors such as marital issues.

The second publication focuses on optimal patient care, with a focus on reducing treatment burden for the patient (5). In that review, the two main areas were the psychological vulnerability of the infertility patient, including negative experiences with caregivers, as well as how to optimize pregnancy rates by focusing on psychological factors. The authors