Addressing the needs of fertility treatment patients and their partners: are they informed of and do they receive mental health services?

Lauri A. Pasch, Ph.D.,[a] Sarah R. Holley, Ph.D.,[b] Maria E. Bleil, Ph.D.,[c] Dena Shehab, Ph.D.,[d] Patricia P. Katz, Ph.D.,[e] and Nancy E. Adler, Ph.D.[a]

[a] Department of Psychiatry, University of California, San Francisco, California; [b] Department of Psychology, San Francisco State University, San Francisco, California; [c] Department of Family and Child Nursing, University of Washington, Seattle, Washington; [d] Private Practice, Portland, Oregon; and [e] Department of Medicine, University of California, San Francisco, California

Objective: To determine the extent to which fertility patients and partners received mental health services (MHS) and were provided with information about MHS by their fertility clinics, and whether the use of MHS, or the provision of information about MHS by fertility clinics, was targeted to the most distressed individuals.
Design: Prospective longitudinal cohort study.
Setting: Five fertility practices.
Patient(s): A total of 352 women and 274 men seeking treatment for infertility.
Intervention(s): No interventions administered.
Main Outcome Measure(s): Depression, anxiety, and MHS information provision and use.
Result(s): We found that 56.5% of women and 32.1% of men scored in the clinical range for depressive symptomatology at one or more assessments and that 75.9% of women and 60.6% of men scored in the clinical range for anxiety symptomatology at one or more assessments. Depression and anxiety were higher for women and men who remained infertile compared with those who were successful. Overall, 21% of women and 11.3% of men reported that they had received MHS, and 26.7% of women and 24.1% of men reported that a fertility clinic made information available to them about MHS. Women and men who reported significant depressive or anxiety symptoms, even those with prolonged symptoms, were no more likely than other patients to have received information about MHS.
Conclusion(s): Psychological distress is common during fertility treatment, but most patients and partners do not receive and are not referred for MHS. Furthermore, MHS use and referral is not targeted to those at high risk for serious psychological distress. More attention needs to be given to the mental health needs of our patients and their partners. (Fertil Steril® 2016;106:209–15. ©2016 by American Society for Reproductive Medicine.)

Key Words: Fertility treatment, depression, anxiety, mental health

Discuss: You can discuss this article with its authors and with other ASRM members at http://fertstertforum.com/paschl-fertility-patients-mental-health/

The idea that mental health services (MHS) are an important component of quality care for fertility treatment patients is not new. In 1980, Menning advocated for MHS to help infertile couples manage emotional distress (1). In 1992, Domar et al. showed that infertile women seeking fertility treatment had twice the prevalence of depressive symptoms as control subjects and concluded that MHS should be implemented as a routine component of care (2). Since then, many additional studies have revealed high rates of psychological distress in fertility treatment patients (3–6). The need for help with the emotional aspects of infertility has been endorsed by professional groups, government authorities, and patients themselves (7–10). Benefits of MHS for fertility treatment patients have been demonstrated. There is good evidence that MHS can reduce psychological distress and could even

Received November 19, 2015; revised February 24, 2016; accepted March 3, 2016; published online March 24, 2016.
L.A.P. has nothing to disclose. S.R.H. has nothing to disclose. M.E.B. has nothing to disclose. D.S. has nothing to disclose. P.P.K. has nothing to disclose. N.E.A. has nothing to disclose.
Supported by the National Institute of Child Health and Human Development, grant no. PO1 HD37074.

Reprint requests: Lauri A. Pasch, Ph.D., 2356 Sutter St., 7th Floor, San Francisco, CA 94115 (E-mail: lauri.pasch@ucsfmedicalcenter.org).

Fertility and Sterility® Vol. 106, No. 1, July 2016 0015-0282/$36.00

http://dx.doi.org/10.1016/j.fertnstert.2016.03.006

be associated with improvement in specific treatment outcomes (11–15). For example, studies have shown that the emotional toll of fertility treatment is one of the primary reasons that patients discontinue treatment prematurely when their chances of pregnancy are still good (14, 16). MHS could decrease premature treatment discontinuation, thereby increasing the chance that patients remain in treatment long enough to reach their goal of pregnancy.

Despite these strong arguments in favor of MHS during fertility treatment, it is not clear that all patients need them. It has been argued that encouraging all patients to use MHS is misguided because many patients can cope with stress of infertility without professional help (17). Researchers have called for fertility treatment programs to screen and target high-risk patients (e.g., patients who exhibit clinically significant psychological distress) for MHS referral, but there are no data regarding whether clinics actually do this (18–20).

Current data on MHS service use and referral for fertility patients are extremely limited. The few studies that do exist were conducted in the United Kingdom and suggest that few patients receive referrals or use MHS. Specifically, in a multicenter study of fertility patients in Scotland, Souter et al. reported that only 14% of patients said they had been offered MHS, though 57% thought they would use MHS if offered to them (21). Regarding actual MHS use, Hernon et al. surveyed fertility clinics in the U.K. and reported that fewer than 25% of patients used MHS (7). In a study focusing on one U.K. fertility clinic, Boivin et al. showed that only 8.5% of women and 6.1% of men currently in treatment reported having used MHS (17).

The purpose of the present study was to determine the extent to which female fertility treatment patients and their male partners experienced clinical levels of distress (depression or anxiety), how many received MHS, and how many were provided with information about MHS by their fertility clinics in the United States. We were particularly interested in whether the use of MHS, or the provision of information about MHS by fertility clinics, was targeted to the most high-risk individuals, that is, those patients who reported clinically significant levels of distress. Additionally, we examined whether the answers to these questions differed based on having had a successful child-related outcome versus failure (i.e., those who remained childless at the end of the study). We reasoned that those who were not successful might experience higher rates of distress as time passed and thus might be more likely to seek MHS; furthermore, owing to their ongoing childlessness, they may have had more contact over time with fertility clinics, which may in turn have afforded the clinics more opportunity to provide these patients with information about MHS. Conversely, those patients who had a successful child-related outcome might report lower rates of depression and anxiety as time passed; furthermore, they would have transferred their care to their obstetrician and therefore perhaps their fertility clinics would have had fewer opportunities to provide those patients with information about MHS.

MATERIALS AND METHODS

Study Population and Protocol

Men and women were participants in the Fertility Experiences Project, an investigation of the experiences of heterosexual couples seeking treatment for infertility. Information regarding the cohort has been published previously (22–25). Couples were recruited from five reproductive endocrinology practices over eight locations in the San Francisco Bay area in 2000–2004. Eligibility criteria included: 1) first visit to the fertility clinic; 2) no previous cycles of in vitro fertilization (IVF); 3) no hysterectomy or sterilization; 4) no recurrent miscarriage; 5) currently trying to get pregnant with a male partner; and 6) English speaking. Potential participants received initial information about the research at the clinic or via mail and were telephoned by research staff to receive additional information, assess eligibility, and schedule the baseline interview. Participants were told that the purpose of the research was to learn more about patients' experiences and decisions surrounding infertility, their perspectives regarding possible fertility treatments, and the impact of infertility on their lives. Both partners were encouraged to participate, but women were allowed to participate alone. Baseline in-person interviews were scheduled within 3 months of the first clinic visit and before the start of fertility treatment. Participants were sent a questionnaire packet in the mail which they completed independently at home; the questionnaire was collected at the baseline interview. From a total of 1,040 eligible women, 416 (41.2%) women completed the baseline interview, 372 (35.1%) refused, 194 (18.3%) were unable to be contacted, and 58 (5.5%) undertook a fertility treatment procedure before the interview could be conducted. In addition, 378 of their male partners also completed the baseline interview. Demographic data recorded at the baseline assessment included age, ethnicity, income, educational level, and the number of months the couple had been attempting conception. Source of the fertility problem was obtained through complete medical record abstraction and was categorized into female only, male only, mixed factors, and no known factors.

Follow-up assessments were conducted 4, 10, and 18 months after the baseline interview and involved the completion of questionnaires and telephone interviews. At each follow-up interview, participants were asked to report on fertility treatments and outcomes since the last interview. Participants remained in the study regardless of their treatment use and outcomes or where they received their fertility care. Retention rates were high, with 96% of the original sample completing the 4-month follow-up, 93% completing the 10-month follow-up, and 89% completing the 18-month follow-up. Of the original sample at baseline, 352 women and 274 men had complete data and were included in the present study.

The study protocol was approved by our Institutional Review Board, and informed written consent was obtained from