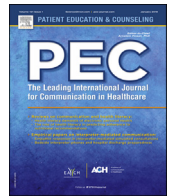




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Fertility patients demonstrate an unmet need for the provision of psychological information: A cross sectional study

Shrinkhala Dawadi^a, Janet Takefman^b, Phyllis Zelkowitz^{a,*}

^a Department of Psychiatry, McGill University, Montreal, Canada

^b Department of Obstetrics and Gynecology, McGill, Montreal, Canada

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ABSTRACT

Objectives: To examine the provision of information by health care providers (HCPs) to fertility patients about accessing psychological resources.

Methods: This study utilized data from a cross-sectional survey of 659 male and female patients seeking fertility treatment at clinics in Toronto and Montreal. Regression analyses were used to assess if sociodemographic and treatment variables were associated with the receipt of information, the desire for information, the helpfulness of the information, and the likelihood that participants had sought counselling.

Results: The majority of respondents (79.8%) said that their HCP had not given them information about accessing psychological resources. Of the patients who did not receive this information, most (60%) said that they wanted it. Regression analysis revealed that immigrants, women, and patients with higher perceived stress scores were significantly more likely to desire this information. Furthermore, having received this information was associated with increased odds of counselling seeking (odds ratio = 3.31, $p = 0.013$).

Conclusion: Fertility patients demonstrated an unmet need for information about accessing psychological resources, and HCPs may play an integral role in bridging this information gap.

Practice Implications: To improve the patient-centeredness of fertility care, HCPs should be proactive in informing all patients about how to access psychological resources.

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1. Introduction

Infertility, defined as the inability to conceive after 12 months of unprotected sexual intercourse, affects approximately 11–16 % of Canadian couples [1]. The psychological consequences of infertility, such as increased stress, anxiety, depressive symptomatology, and stigma have been well documented [2–4]. In addition to being distressed because of involuntary childlessness, a fertility patient may also experience stress because of the physically arduous and time-consuming nature of their treatment [5,6].

There is an emerging trend that advocates for more patient-centeredness within fertility care. Patient-centered care (PCC) is a practice that accounts for patient's needs, preferences, and values during the treatment process [7]. Increased patient-centeredness of fertility treatment is associated with higher quality of life, and

decreased anxious and depressive symptomatology, although the direction of this association warrants further investigation [8]. To our knowledge, few studies examine if PCC affects fertility outcomes.

One tenet of PCC is that health care providers (HCPs) should address patient's emotional and psychological needs and preferences, in addition to their physical ones [2,9,10]. However, patient-centered fertility care does not necessarily entail the incorporation of formalized psychological services, such as counselling, into fertility treatment. Rather, it encompasses a range of services and practices, from the HCP taking the time to provide emotional support to a patient after a distressing event (such as a negative pregnancy test), to the provision of information about services that patients could benefit from, but are not offered by the fertility clinic [11].

Sociodemographic factors (such as gender, and cultural background) and treatment factors (such as duration of treatment) may also be associated with greater levels of distress in some fertility patients. The psychological consequences of infertility are documented in both women and men. Infertile women report increased levels of anxiety, depression, and lowered self-esteem, compared to fertile women [2,12,3]. There are fewer studies of the psychological impacts of male infertility, but extant research

* Corresponding author: The Institute of Community and Family Psychiatry, Jewish General Hospital, McGill University, 4333 Côte-Sainte-Catherine Road, Montreal, QC, H3T 1E4, Canada.

E-mail address: phyllis.zelkowitz@mcgill.ca (P. Zelkowitz).

suggests that infertile men present with greater distress, stigma, and lower self-esteem and quality of life compared to fertile men [13–15]. Although there are well-documented gender differences in how patients cope with infertility, differences regarding the desire for psychological support services may not be as pronounced as previously thought [16]. Masculine norms of stoicism and a fear of stigma may dissuade men from seeking such services [17,18], however, studies assessing patient satisfaction with fertility care indicate that both men and women want more information about the emotional and psychological aspects of fertility treatment [9,19].

Research comparing infertility-related distress in immigrants and non-immigrants has yielded mixed results [20–22,32]. Immigrants are more likely than non-immigrants to encounter barriers to accessing healthcare, such as a lack of familiarity with the host country's health system, language barriers, the cost of psychological services and the long waiting times to access them [23–25]. Some factors are also intersectional in nature: Immigrants are more likely to be unemployed or have lower incomes than non-immigrants [26,27], and the cost of fertility treatments may be a stressor that immigrant patients are particularly vulnerable to [28,29]. Accordingly, these factors may be fundamental in shaping immigrants' experience of infertility and its treatment.

A longer duration of treatment may lead to greater levels of distress, stemming from failed cycles of treatment and the ongoing physical discomfort associated with tests and procedures [30,31]. Other studies have found that depressive and anxious symptomatology decreases as duration of treatment increases, as patients adjust to infertility-related stressors [32]. The informational needs of patients undergoing treatment for a variety of diseases have also been documented to change over time [18,33]. However, few studies have examined this question among fertility patients. A better understanding of this issue is needed to ensure timely delivery of information about psychological support services, potentially improving the patient-centeredness of fertility care.

There are several reasons why healthcare providers (HCPs) might not discuss psychological services with their patients. HCPs may expect that patients will ask about psychological services if they feel they need it [34,35], they may feel that it is beyond the purview of their role to provide emotional support to patients, or may not have time to address mental health during their appointments [34,35]. Patients may be dissuaded from asking about psychological support because of the stigma associated with it, or may not believe that such services are necessary for their current difficulties [35].

The structure of the healthcare system can also create barriers. In the western world, the United Kingdom is the only country that legally mandates that counselling be offered to patients (although its uptake is voluntary). There is currently no federal mandate in Canada or the United States that requires that psychological services are offered to infertility patients [10,36], although regulations vary by province/state and type of treatment pursued. There is, however, very little Canadian data that assesses the extent to which psychological services are actually integrated into fertility treatment, and patients' need and/or desire for this integration.

The latter question has been studied in European fertility clinics, revealing that patients want to receive more emotional/psychological support [9,37,38]. Nevertheless, Canadian data are needed on the issue, as the European studies generally gathered data from small, racially homogenous samples.

1.1. Objectives

To contribute to literature and practice regarding patient-centered fertility care, the current study examines the following questions:

- 1 Did fertility patients report receiving psychological information from their HCP?
 - a If so, was gender, income, immigration status, parity, duration of treatment, stress, and depressive symptomatology associated with finding this information useful?
 - b If not, which of the above characteristics were associated with desiring this information?
- 2 Was the receipt of this information associated with having sought counselling services?

2. Materials and methods

2.1. Participants

Eligible participants were recruited from four fertility clinics in Montreal and Toronto, and met the following inclusion criteria: (1) they were seeking fertility treatment, (2) were at least 18 years of age, (3) able to answer questions in either English or French, and (4) able to navigate an online survey. Across all four clinics, 795 (98.4%) of the 808 patients approached met inclusion criteria. From this eligible pool, 746 (93.8%) accepted and 49 (6.2%) refused. Reasons for refusal included: lack of interest, time constraints, personal stress levels, unprepared to discuss infertility experiences. Recruitment took place between July 2015 and December 2016.

A total of 659 participants (82% of those approached) submitted responses to the survey. Participants were aged 22–62 years (mean = 36 years, SD = 5.48). Women comprised 56% of the sample (n = 370), with a mean age of 35 (SD = 4.46). Men comprised 44% of the sample (n = 289), with a mean age of 38 years (SD = 6.36). 543 participants identified as heterosexual (82.5%). The median income bracket of the sample was \$80,000 per year to \$99,000 per year, and the majority of participants had completed a university degree (65.9%). 345 respondents were native born (52.4%), compared to immigrants (47.6%). Table 1 presents descriptive statistics of the participants.

2.2. Procedure

Patients were approached by research assistants at fertility clinics, and those interested in participating were provided with a bilingual letter of presentation and an explanation of the study.

Table 1
Descriptive statistics of patient sample by independent variable.

Independent Variable	N	Percent ^a
Gender		
Male	289	43.9%
Female	370	56.1%
Duration of treatment		
0–6 months	254	38.5%
6 months – 5 years or more	391	59.3%
Immigration Status		
Immigrant	274	41.6%
Non-immigrant	302	45.8%
Income		
Under \$80,000/year	272	41.3%
Over \$80,000/year	294	44.6%
Parity		
Primary infertility	472	71.6%
Secondary infertility	186	28.2%
	Mean (SD)	Range
PSS-4 score ^b	5.81 (2.87)	0–15
PHQ-2 score ^c	1.27 (1.40)	0–6

^a The amount of missing data was small, with values ranging from 2.1% to 14.1%.

^b PSS-4 refers to the four-item Perceived Stress Scale.

^c PHQ-2 refers to the two-item Patient Health Questionnaire.

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