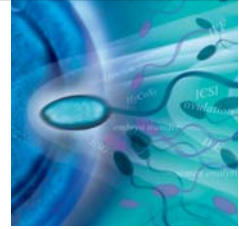




Infertility and its treatment

An emotional roller coaster



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BACKGROUND Receiving a diagnosis of infertility is a significant life crisis, and subsequent in vitro fertilisation (IVF) treatment presents a physical and psychological challenge for many patients.

OBJECTIVE This article aims to provide the health professional with an insight into the psychological stressors associated with the experience of infertility, and provide strategies for providing support during this difficult journey.

DISCUSSION Feelings of grief and loss are very common as couples come to terms with the fact that they are not able to conceive naturally. Different emotional coping styles between men and women may add to what is an already stressful time. The grieving process in IVF is often stagnated and chronic, and acceptance and resolution is not psychologically possible until closure is achieved, either by becoming pregnant and giving birth, or ending infertility treatment and ceasing trying to conceive.

The experience of infertility has long been recognised and documented in the research literature as a significant life crisis.¹⁻⁴ The majority of patients who present to an in vitro fertilisation (IVF) clinic for fertility treatment usually have travelled an arduous and emotionally painful journey before making the decision to undergo treatment. For many, it is the only option left in order to fulfill the desire to have a child.

The level of publicity and media attention given to advancing technologies in IVF also plays a large part in elevating the expectations of people entering IVF programs, which in turn heightens the disappointment when treatment fails. The aim of this article is to track the journey of an infertile couple in order to give the health practitioner insight into the psychological trauma experienced, and also to highlight the stages where people are at their most vulnerable so that effective supportive interventions can be offered.

The infertility journey

The diagnosis

Unless there is a pre-existing condition where someone is aware they have a medical problem that will impact on their fertility, most people embark on the journey of planning a family with the expectation that once they commence trying to conceive they will be successful. So typically it is not until after several months – if not years – of trying to conceive that a couple will first attend their general practitioner. By this time, the couple have already undergone months of disappointment, anguish and feelings of anxiety about what could be wrong. Often after preliminary investigations a couple will then be referred to an infertility specialist for further investigations and decision making about a course of action. For many it will be IVF.

Feelings of grief and loss are very common as people come to terms with the fact they are not able to conceive naturally. Symptoms of anxiety and depression have been reported to be significant in couples who must undergo infertility treatment.⁵ Newton et al⁶ indicated that the desire for parenthood may be the underlying cause of stress among women experiencing infertility, whereas depression may be due more to their perceptions about themselves following treatment failure, ie. loss of role as mother, failure to fulfill role of motherhood, and social comparison with other women who do have children. Other studies have shown that people develop coping styles where feelings of inadequacy are internalised and repressed and result in couples becoming avoidant of other people and situations that trigger feelings of distress.^{7,8} This in turn highlights the important issue of support networks for couples undergoing infertility treatment.

Some people are fortunate to have excellent family and friendship support networks to assist them in coping with this difficult period of their lives. Others are less fortunate or make the conscious choice not to tell anyone about something they consider to be very personal and private. Reasons for this include feeling a sense of shame about their infertility, and not wanting people to add to their stress by constantly asking questions (albeit well intended) about their progress. Initially the rationales behind these decisions may be based on self protection, but they can lead to feelings of isolation and perceived abandonment by those they value as close.

Parents and families of people with infertility often report feelings of helplessness and grief in relation to the distress their loved ones are experiencing; this group is also vulnerable and may require counselling support. Their feelings of distress may be related to not knowing how to support their loved one through their infertility journey, while others also experience feelings of loss due to the possibility of never becoming grandparents. Cultural and religious beliefs can also play a role in the emotional conflicts people experience with infertility, especially if they come from a background that is not supportive of IVF technology, which further exacerbates the couple's perception of shame and isolation.

In some cases where the infertility diagnosis is due to male factors, the fertile female partner may experience feelings of resentment toward her partner for having to undergo intrusive medical procedures. This can lead to difficulties in their relationship and the level of support a couple can provide to each other when undergoing IVF. Men are typically less likely to seek out

counselling support to deal with their infertility and are a particularly vulnerable group when it comes to dealing with treatment outcome.

IVF

One of the common frustrations many IVF couples comment about is the long period of waiting before being able to commence IVF treatment. The waiting is often inevitable as specialists are busy, and vital investigations, appointments and subsequent tests results take time to process. It might be several weeks – if not months before IVF can commence.

Once the treatment process begins, the roller coaster of emotions also begins. From the outset there is a mixture of excitement and anticipatory anxiety about the whole medical process; excitement about the hope the treatment presents and anxiety about the potential for failure. For many, the anxiety is also about the discomfort and possible side effects of medical interventions ranging from hormone injections to laparoscopy. This anxiety heightens around the time of egg retrieval. Up until this point, there is some perception of being in control and having active participation in the treatment process, however this changes once the eggs and sperm are retrieved and remain in the laboratory while the couple returns home. Again the sense of waiting is exacerbated by the fact that from this point onward 'success' is contingent upon technology and a lot of good luck.

Questions that often plague IVF couples are: 'Will the eggs fertilise?', 'Will there be any viable embryos for transfer?', 'What if it doesn't work?' For couples whose eggs fertilise, the anxiety subsides 48–72 hours later when they return to the hospital for an embryo transfer and is replaced once again by relief and hope. This is usually temporary, and anxiety levels begin to elevate again once the time for their pregnancy test approaches. Anxiety reaches high levels on the day of the pregnancy test while they wait for the outcome of the blood test.

The IVF outcome

Failure

If the treatment is unsuccessful, it is normal for couples to experience feelings of grief, loss, disappointment and anger. Some target and externalise their emotions toward the clinic, doctors, scientists and nurses, while others internalise and self blame. Others experience the loss and disappointment earlier on with treatment cycles being cancelled due to poor response to hormone treatment, or they may reach the egg retrieval stage but have no viable embryos for transfer. This is particularly difficult for

patients, who often report feeling cheated and fatalistic about their chances of ever conceiving.⁹

The grieving process in IVF is often stagnated and chronic. Couples report the acute symptoms of grief such as feelings of sadness, loss, anger, depression and denial, but are not able to move through to the final stages of acceptance and resolution. This is not psychologically possible until they can achieve closure by either becoming pregnant and giving birth, or ending infertility treatment and ceasing trying to conceive. What is more commonly observed in clinical practice is a pattern of acute grief symptoms that develop into depressive symptoms as the infertility becomes chronic.³ Once another IVF treatment cycle has been booked in, the emotional roller coaster starts all over again. Treatment represents hope, but it also represents the potential for continued failure. This becomes increasingly difficult to cope with as time passes, especially without any positive outcome.

After months of repeated failures, patients may present to health professionals exhibiting symptoms of depression. Although the technical aspects of treatment become more familiar and – in theory – should become easier to manage, patients often report that it becomes harder emotionally.

An additional complicating factor is the self perception patients hold that they are 'well' people undergoing a medical procedure, so therefore they should be able to continue functioning as they did pre-IVF treatment. What isn't taken into consideration is the impact of chronic stress and grief on a person's psychological functioning.⁷ When patients present for counselling, it is important to not only deal with their grief and loss over failed treatment, but also their perceptions of failure and self loathing over their reduced capacity to function in their employment and normal everyday activities.

Positive pregnancy result

For those who do achieve a positive pregnancy result, the emotional journey is just beginning. This first trimester is a highly anxious one for patients who are all too aware of the risks of miscarriage. The anxiety is particularly heightened when there is a prior history of miscarriage.⁹⁻¹¹ Many couples delay informing family or friends about their pregnancy until they have reached the end of the first trimester; some may delay it even longer when they have had a previous loss after 12 weeks. Some women have reported that they were unable to relax throughout their pregnancy, and as a consequence felt cheated and resentful that they could not enjoy a process that most women take for granted. In addition, this group can experience

significant emotional isolation; they report that they can't complain about morning sickness or feelings of anxiety because the perception from family and friends is that they 'should be happy now that they are pregnant'. The literature also indicates that these groups of women are at higher risk of postnatal depression.^{12,13}

Coping styles

The response to stress and coping with emotional trauma differs according to personality and also to gender. Couples undergoing IVF treatment often become challenged emotionally and experience stress on their relationship due to their differing coping styles.^{2,8} In very general terms, men are usually practical and respond to problems in a solution focussed manner. Women, on the other hand (although they may reach the same outcome eventually), tend to be more overt in the expression of their emotions and prefer a process of dialogue, reviewing their issues of concern and verbally expressing their emotional frustrations. In other areas of their lives, these differing approaches can work quite well for a couple. When faced with the challenge of IVF, however, these coping styles may clash and cause conflict within the relationship. This is due to the anxiety associated with the length of time on treatment and the uncertainty of treatment outcome.⁵

The problem solvers (men) often find it increasingly frustrating when the same themes and issues keep surfacing and their problem solving strategies are not working. Women often complain that they are not being 'heard' or understood by their partners. The other issue is that men and women will deal with their emotions differently, with men more likely to internalise and repress, and the women being overt and expressive.⁵ This can trigger conflict where the woman may want to talk and vent her emotions while the man becomes avoidant because the very process of talking triggers painful emotions that he may wish to avoid or deny. Misunderstandings can occur and behaviour misinterpreted, eg. the man may be perceived as uncaring and unsupportive and the woman as neurotic. Counselling can be useful to educate couples about the impact of grief and loss, stress, and different coping styles. The couple need to recognise their differences but also identify and articulate exactly what they need from one another in the context of 'being supportive' and set in place a stress management plan.⁷

The role of the GP

General practitioners can play an integral role in the care of their patients undergoing IVF treatment from both a medical and psychological perspective. For reasons already

discussed, the IVF journey is a physically and emotionally demanding one. Symptoms of anxiety and depression can be prevalent in those who do not cope very well. Due to the isolating nature of IVF treatment, some patients may be more inclined to visit their GP to discuss concerns about side effects of their treatment or feelings of anxiety rather than share them with family or friends or burden their IVF specialist. Some people may benefit from practical assistance in pain or symptom relief, whereas others may seek emotional and psychological support. It can be helpful to acknowledge the type of emotional stressors associated with IVF and the impact on a patient's capacity to function.

The research literature recommends approach oriented processes such as problem focussed coping, positive reinterpretation of negative events, referral to external support services, and patient focussed groups to assist in developing emotional coping styles and to minimise avoidant behaviours.⁷ If referral to a psychologist is required, referral to a specialist in cognitive behavioural therapy is suggested as it is reported to be the more effective form of psychotherapeutic intervention. It is also important to normalise feelings of grief and loss and provide empathy as this helps to validate the couple's experiences, which in turn helps them to work through their grief and heal emotionally.

Infertility treatment and medical discussions are often focussed on the woman as she is the one undergoing the majority of medical procedures. Although infertility may be diagnosed in one member of the couple, it is something that affects both parties, albeit in different ways. A number of male patients have reported that they feel excluded from the process. Acknowledging the man's perspective and monitoring his progress through the IVF process is equally as important as that of the woman's (see the article *The IVF experience* by David Rawlings page 173 this issue). It would also be helpful to reinforce the importance of the couple working together as a team, and to nurture constructive coping mechanisms.

Conclusion

As health professionals, the greatest gift we can give our patients who are in a state of emotional crisis is empathy and listening, and creating a respectful, supportive environment in which they can develop the skills and strength to face their life challenges with integrity and self confidence.

Resources

ACCESS – Australia's National Infertility Network
Box 959, Paramatta NSW 2124
Phone 02 9670 2380

Email info@access.org.au
Website www.access.org.au

IVF Friends

GPO Box 482G, Melbourne VIC 3001
Email ivf_friends@hotmail.com
Membership enquiries 03 9509 3597

Donor Conception Support Group

Website www.members.optushome.com.au/dcsg/

Endometriosis Association of Victoria (Australia)

Website www.endometriosis.org.au

Information on polycystic ovaries and access to support groups

Website www.pcosupport.org/

Miscarriage support and information

Website www.sands.org.au/

Website www.incid.org/links.html#Miscarriage

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