Dignity and Mental Health in Fertility Clinics

Josyan Madi-Skaff, M.D.
Head of Psychiatry Dept - The Lebanese Hospital - Geitawi
3 Questions

- What is the Psychological and Psychiatric impact of Infertility and of its Treatments on infertile individuals and couples?
- What happens to the Dignity of infertile individuals and couples when they come to Fertility Clinics?
- What should be done in Fertility Clinics to improve individuals and couples’ well-being?
Infertility

1 year of unprotected coitus without pregnancy

In 10 - 15% on average
30 - 40% in sub-Saharan Africa

1/3 due to female factor; 1/3 to male factor; 1/3 to combination of both or not identifiable
⇒ Infertility: a problem affecting the couple

More common because of start of a family at a later age:
- Availability of contraception,
- Age of newly weds ➪
- Number of working women ➪

Demands for Fertility Tts have ➪: have become more successful:
70% cumulative pregnancy rate
(Pinborg – Hum. Reprod, - 2009)
Infertility: Financial burden

- Ambiguous status: medical problem?

- In many European countries & Australia: infertility treatments covered by governments and health insurances

  In USA: no subsidies for infertility pbs in most states & cost is exorbitant

  In low income countries: fertility treatments available in private sector & only accessible to the wealthy elite

- In Lebanon: Government funding is denied for fertility treatments
  Law on Medical Ethics (1993) only addresses sperm donation and abortion issues
Motivation for Parenthood

- In high income countries: wish for personal fulfilment
  - Recognized as an adult
  - Being needed by another human being
  - Providing a bridge to the future
  - Diminishing the fear of one’s death

- In resource-poor settings: response to social pressure
  - Continuation of the family line
  - Compliance with religious & societal rules
  - Assurance of security in old age
  (Okonofua FE- Health Transition in Review – 1997)
Infertility – Emotional Impact

In high income countries:
- Anxiety and Depression symptoms,
- Low self-esteem, reduced life satisfaction, social isolation
- Relationship difficulties, diminished sexual satisfaction & “sex on demand
(Boivin J. et al. – BMJ - 2011)

In low income countries:
- Marital instability, Social Stigmatization, Abuse (Africa)
- Impaired psychological wellbeing & deteriorating MH (China)
- Feeling incomplete, impaired social status, neglect by family & local community, domestic violence, polygamy (Middle East)
(Obeisat et al – Fertil. Steril. – 2012)
Infertility: Psychological Impact in Women

- **Women** tend to be more distressed than Men:
  - Sense of loss of identity, feelings of defectiveness and incompetence, increased self-blame, greater psychological distress, feeling of shame,

- Women must carry the burden of infertility diagnosis: invasive treatments, frequent monitoring, scheduling disruption: they become the “identified patient”

- Women have to grieve multiple losses:
  - Pregnancy, childbirth, breastfeeding, parenthood
  - Genetic continuity
  - Key element of adult & gender identity

→ For most women, infertility and its treatments were “the most upsetting experience” of their lives
  
Infertility: Psychological Impact in Men

- Although **Men** & **Women** equally likely to contribute to a couple’s fertility problems, most of psychological literature focuses on **Women**

- Infertility potentially cuts into a man’s feelings of Masculinity → shame & embarrassment → secrecy surrounding diagnosis to the point that the woman takes the blame for the couple’s infertility
- Men with fertility problems very often worry about their inability to continue their family’s genetic line

- 12 months after unsuccessful fertility treatment:
  - decreased mental health
  - increased physical stress reactions
  - increased negative social stress
  → Involuntary childlessness is difficult for all Men

Infertility – Psychiatric Impact

- Incidence of Depression: 15 - 50%
  - Women with a history of depression are twice as likely to develop a recurrence of depression during infertility, reproductive treatment.
  - High prevalence rates of depression in infertile women are comparable across nations and cultures.
  - Grief & bereavement reactions are common but pathological grief is rare.
    (Dyer SJ et al - Hum Reprod – 2005)

- Anxiety D/O: 8 - 28%
  - Exacerbation of pre-existing conditions: GAD, phobia, OCD
  - Initial full-blown anxiety D/O
  - Greatest levels of anxiety D/O in 1st and last treatment cycles.
Psychological State & Pregnancy rate

- High levels of cumulative stress associated with recurrent depression/anxiety → early decline of ovarian function → cause for infertility? (Harlow et al – Arch. of Gen. Psych. – 2003)


- Pregnancy rates: 55% in CBT compared to 20% in control group (Domar A – Health Psychology – 2000)

- Meta-analysis of psychological interventions in infertility: no effect on mental health but positive effect on pregnancy rates (Hammerli K. – Hum Reprod Update- 2009)

- Complex relationship between Stress, Mood Disorders and ART outcome: psychological factors have to be taken into account
Fertility Treatments

- **Hormone treatments:**
  - Induced ovulation & Endometrial support

- **Assisted Reproductive Technologies – ART:**
  - Intrauterine insemination: IUI
  - Intracytoplasmic sperm injection: ICSI
  - In Vitro Fertilization: IVF

- **Alternative Treatment Plans:**
  - Use of donor oocyte, sperm or embryo
  - Use of gestational carrier or surrogate mother
Drug Use & MH effects

- Bromocriptine
  - Hyperprolactinemia
  - Depression, somnolence, anorexia, psychosis

- Clomifene
  - Ovulation induction
  - Irritability, anxiety, mood changes

- Leuprolide acetate (GnRH)
  - Hypothalamic downregulation
  - Depression, cognitive Pbs

- Progesterone
  - Endometrial support
  - Depression, decreased libido, irritability

- Estradiol
  - Endometrial support
  - Antidepressant, induce rapid cycling
Infertility Tts & Emotional Impact

- Infertility Tts = Tts of a chronic illness:
  Extensive appointments, frequent testing, several medications, surgical interventions, drug side-effects
  Depression level same as depression in patients with chronic medical conditions (hypertension, diabetes...)

- Feelings of frustration & impatience, fear of failure, concerns about daily injections
  Relationship difficulties with partner & anxiety surrounding sex
  Strained relationships with family & friends

- After unsuccessful infertility Tts, women with a sustained child-wish had more adjustment problems than the women who had managed to refocus their lives (Mac Dougall K. - Human Reproduction – 2012)
Infertility Tts & MH Impact

- All children born in Denmark in 1995 – 2003 with follow-up until 2012
  3,139 children conceived after fertility treatment

- The widely used IVF/ICSI techniques are quite safe for the mental health of the developing offspring:
  - Small increased risk of autism, hyperkinetic disorders, conduct, emotional or social disorder, and tic disorders, but the absolute risks are low
  - Overall long term development of children born after IVF/ICSI is comparable with that of children conceived spontaneously

- Sub-fertility itself has an important role in adverse effects in singletons born after medically assisted reproduction
  (Bay B. et al – BMJ – 2013)
Infertility Tts & MH Impact

- In Denmark 124,384 children born to women with registered fertility problems, were followed up for psychiatric disorders.

- 33% greater overall risk of any defined psychiatric disorders, which was statistically significant:
  - 27% higher risk of schizophrenia and psychoses,
  - 37% higher risk of anxiety and neurotic disorders,
  - 28% greater risk of learning difficulties
  - 22% higher risk of mental development disorders, including autism

- Increased risk associated with factors related to the mother's infertility (genetic or biological) or to its treatment?
Fertility Treatments & Mental Illness

- The drugs used in infertility treatment & psychotropic medications:
  - both metabolized by the liver:
  - both impact pituitary functions and hormones
  - Influence on medication bioavailability
  - Affect on infertility and psychiatric treatments

- Patients with a history of pre-existing psychiatric disorders, who are currently taking psychotropic medications, and who are undergoing infertility treatment should be assessed carefully.
In-Dignity in Fertility Clinics

In the traditional model of doctor-patient interaction, a physician’s job is to provide information regarding a disease and a patient’s role is to comply with the physician’s advice.

- Trauma, humiliation and loss of dignity for the patient who dares not state that what is being done is incorrect or unnecessary.

A woman seeking infertility treatment is often portrayed as emotionally distraught and desperate: the "desperate woman" stereotype denies women's ability to critically assess the health risks and life benefits of fertility treatments.

- Perpetuates emotional paternalism.
- Undermines the dignity, autonomy, and capacity of infertile women.
Clinical psychological and psychiatric research that acknowledges a link between infertility and emotional distress does not correlate distress and incompetence

(Madeira J. - Maurer School of Law: Indiana University - 2012)
In-Dignity in Fertility Clinics in Lebanon

- Currently, in Lebanon, there are **no legal or credentialing requirements** for physicians performing the ART, nor for any of the technical staff, the embryologist or the andrology laboratory.

- Those ART centers have **no professional guidelines** and the clinical outcomes are not audited, so the **consumers are not provided factual information** on the pregnancy rate, or on the hazards associated with ovarian hyper stimulation and the risks of multiple pregnancies to the mother and her newborns.

- The multiple ethical and legal issues emanating from ART are **dealt with arbitrarily**, often influenced by pharmaceutical manufacturers or medical supplies providers, and certainly by financial inducements  

Dignity in Fertility Clinics

- Need for a Patient-centered care: biopsychosocial approach towards diagnosis and management in order to assess patient’s psychological needs and decide for psychosocial interventions.

- Need to see the patient as an autonomous agent capable of making medical decisions based on personal values and beliefs → respect for Autonomy.

- Need to respect patient’s fundamental individual right to either have or avoid having children → Procreative Liberty is a basic personal right (Robertson J.: Am. Jour. Law & Med.-2004)

- Need for Educational interventions to address patient fears, and to better prepare patients for the demands of treatment and the emotions that they may experience.
Recommendations

- Make infertility care accessible to as many people as possible, and integrated into existing reproductive health settings:
  - Use services for basic infertility investigations (to determine cause of infertility)
  - Use simple forms of infertility treatment (such as ovulation induction and artificial insemination)
  - Use less potent and cheaper drugs to stimulate oocyte development
  - Require minimal monitoring
  - Use simplified culture systems and less technologically advanced equipment

Recommendations (ctd)

- Mental health professionals should be integrated at fertility clinics in order to take care of the psychosocial consequences of infertility and fertility treatment.

- There should always be an awareness of the patient’s vulnerability factors (prior depression, neuroticism) when counselling and supporting infertile couples.

- Treatment protocols should be made more patient-friendly (such as less complicated treatment regimens with fewer injections) in order to improve patient well-being and reduce the stress and burden associated with treatment.

- Organize support groups: sharing experiences and learning from others who are also struggling to conceive.
How can we speak of all, most, or even many infertile patients as "desperate" or "obsessed" instead of determined, optimistic and courageous?

Thank you for your kind attention