Fertility Problems: Complex Issues Faced by Women and Couples

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Approximately 8% of all couples in the United States with a woman of childbearing age experience fertility problems (Mosher & Pratt, 1990). In the past two decades, there have been dramatic advances in medical technology aimed at increasing a couple's chances of having children and in the number of couples who seek medical services for infertility (Office of Technology Assessment [OTA], 1988). Increases in use of services have been attributed to several factors, including the availability of new treatments, increases in public awareness of infertility, and increases in rates of infertility within certain age groups presumably attributable to delayed childbearing, exposure to environmental toxins, and increases in rates of sexually transmitted diseases (STDs; OTA, 1988). Currently, tens of thousands of attempts using in vitro fertilization (IVF) and similar technologies are made every year, resulting in the births of thousands of children.

Infertility is medically defined as the inability to conceive a pregnancy after one year of regular sexual intercourse without contraception (OTA, 1988). Despite the static nature of this medical definition, infertility is not a discrete event but instead an unfolding process. It typically begins unexpectedly, as a period of time of anticipating a pregnancy passes without success. For couples who seek medical treatment, estimates suggest that 50% are successful in achieving a pregnancy by one means or another (OTA, 1988). However, the process can take many years, it may involve extensive procedures and complex decisions, and any given treatment procedure usually has a limited chance of success. Eventually, unsuccessful couples explore options other than having a genetic offspring together, including donor sperm, donor eggs, or a surrogate mother; adopting a child; or not having children. It has become increasingly difficult for couples to know when it is time to accept the loss of their joint reproductive potential because they may feel that each new technological advance renews the possibility of success. Health care professionals who work with...

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1For a detailed description of diagnosis and treatment procedures for infertility, see Davajan and Israel (1991) or Taylor (1990).
individuals or couples with fertility problems are faced with many complex
tasks, including assisting them in dealing with the invasive nature of di-
agnostic and treatment procedures, helping with decision making regard-
ing treatment options, and identifying and offering counseling to those
who experience significant emotional distress.

In this chapter we present an overview of research on (a) the relation-
ship between psychological factors and the etiology of infertility; (b)
psychological reactions to infertility; (c) effects of infertility on couples; and
(d) psychological issues in the treatment process, with particular attention
to assisted reproductive technologies (ARTs). In this overview, we identify
some common misperceptions from the research literature. The overview is followed by an attempt to translate research findings into recommenda-
dtions for clinical practice.

Historically, infertility has been considered mainly a “women’s issue.”
As the medical causes of infertility have been identified, most estimates
suggest that the biological origin of infertility is equally likely to be male
as female (Speroff, Glass, & Kase, 1983). Although the research literature
has focused on women, men who want to be fathers are substantially af-
ected by infertility too. Therefore, throughout this chapter, we consider
fertility problems as they affect women, men, and the couple as a unit.
Nevertheless, there are still several compelling reasons to consider in-
fertility as an important women’s health issue: Women see having children
as being more important than men do (Berg, Wilson, & Weingartner,
1991), are more likely to seek treatment and make treatment-related de-
cisions (Greil, Leitko, & Porter, 1988), and are more likely to experience
distress (Leiblum, Kemmann, & Lane, 1987). Also, regardless of the bi-
ological cause, the vast majority of medical treatments for infertility are
aimed at the female partner; thus, they incur the medical risks and physi-
ical and emotional pain associated with the patient status more so than
do their male partners. Reproductive technologies also become a women’s
health issue when women seek to conceive as single parents or within
lesbian relationships. These women then may face the complex dilemma
of seeking medical assistance (i.e., donor insemination) within a sociopo-
itical system that questions their rights to make use of reproductive tech-
nologies (see Golombok & Tasker, 1994).

Research Overview

Psychological Factors and the Etiology of Infertility

As recently as two decades ago, emotional factors were presumed to be
the cause of 30–50% of infertility cases (OTA, 1988). Much of the literature
generated from these psychogenesis models was highly speculative, and
reviews of studies with more rigorous designs have concluded that the
preponderance of evidence is not in favor of psychogenesis models (see
Edelmann & Connolly, 1986; Stanton & Dunkel-Schetter, 1991). In addi-
The notion that adoption facilitates conception by relieving stress has now been refuted in research that shows no differences in the rates of pregnancy in couples with fertility problems who adopt and those who do not (Seibel & Taymor, 1982). Nonetheless, myths such as these may lead women to retreat from their social networks, and perhaps from receiving desired medical care, to avoid embarrassment and receiving unhelpful advice (see Abbey, Andrews, & Halman, 1991).

**Psychological Reactions to Infertility**

The heightened emotional distress experienced by many couples with fertility problems is better understood as a consequence rather than as a cause of having a fertility problem. In describing the experience of infertility, some authors have concluded that the experience is so profound that they have conceptualized it as a life crisis (e.g., Berger, 1980; Menning, 1980) and described a series of stages (i.e., shock, denial, anger) through which individuals are expected to pass. The life crisis conceptualization has helped to bring the psychological consequences of infertility into view and has led to the development of support groups aimed at helping couples manage the crisis. However, Stanton and Dunkel-Schetter (1991) have argued that this conceptualization is flawed in two important ways (see also Stanton & Danoff-Burg, 1995). First, crisis models do not fully recognize the substantial interindividual variability. Second, there is no evidence...
that individuals go through predictable stages in response to stress in general or in response to infertility in particular; instead, it appears that various emotions and reactions are experienced by different people at different points in the coping process (see Wortman & Silver, 1987). On the basis of an extensive review of the empirical and clinical literature, Dunkel-Schetter and Lobel (1991) concluded that although there seems to be a consensus that infertility is almost universally a difficult and emotionally charged experience, "methodologically rigorous research suggests that the majority of people with infertility do not experience clinically significant emotional reactions, loss of self-esteem, or adverse marital and sexual consequences" (p. 50).

Given these findings, Stanton and Dunkel-Schetter (1991) proposed that infertility may best be thought of as an important and ongoing source of stress that affects different people in different ways. They argued that a stress and coping framework (i.e., Lazarus & Folkman, 1984) may be a more useful model for understanding the effects of infertility. Research based on a stress and coping framework has identified certain factors that are associated with psychological adjustment. These include (a) characteristics of the stressor (e.g., length of time attempting to conceive before firm diagnosis; extent of diagnostic tests and treatments; gender of person diagnosed); (b) individual appraisal (e.g., degree of investment in the parent role as a source of self-fulfillment, feeling responsible for the fertility problem, and low perceived control over one's ability to get pregnant); (c) coping resources (e.g., positive reappraisal and seeking-support coping strategies); and (d) social environment (e.g., support from one's spouse, a good marital relationship, social network support). Other factors are under investigation.

Effects of Infertility on Couples

Infertility is unique among stressors because it typically confronts a couple as a unit as well as the individual partners. Medically, it is best treated as a characteristic of the couple regardless of which partner has the etiological factors. When one partner has a fertility problem, both partners find themselves unable to have a child. This is in contrast to many other medical problems, including some described in this book (e.g., cardiovascular disease, diabetes), that, although clearly affecting both partners, basically characterize only the afflicted partner.

There has been much concern that infertility is the cause of significant marital and sexual problems. However, on the basis of a review of the well-designed studies, Stanton and Danoff-Burg (1995) concluded that the evidence consistently reveals no impairment in marital functioning as a result of infertility. In fact, two controlled studies have shown that marital satisfaction is higher in couples who seek treatment for fertility problems than in control couples who have no fertility problem (Callan & Hennessey, 1989; Downey & McKinney, 1992). As with emotional distress, there is substantial variability in the impact of infertility on marital functioning,
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with some couples reporting significant marital problems and others reporting improvements as a result of "going through this together."

It also is important to put the experience of infertility in the broader context of couples' lives and consider how the experience of infertility compares with the experience of becoming new parents. Abbey, Andrews, and Halman (1994) have shown that compared with women who did not become parents over the 2-year course of the study, women who became parents reported more positive life quality but also less intimacy in their marital relationship. Thus, couples who are not successful in having children may experience less overall life satisfaction than those who have children, but it does not appear that the continued experience of failure to conceive results in significant marital problems. In fact, any negative effect on the marriage appears to be, on average, less than that of becoming parents.

Given the large variability in effects of infertility on marital relationships, an important question is what factors are associated with a greater likelihood of relationship problems. The descriptive literature has suggested that differences between husbands and wives in their responses to a fertility problem are an important source of marital problems (e.g., Mahlstedt, 1985; Salzer, 1991). For example, consider the situation in which one spouse feels that the only way to cope with the pain associated with infertility is to talk about it and share feelings, and the other spouse feels that talking only makes the problem worse. As a result of this difference, communication between partners may be characterized by demanding, stonewalling, blaming, and attacking (see Pasch, 1994). Couples who encounter this type of problem may find that their inability to communicate effectively begins to affect the overall functioning of their relationship, and they may benefit from couples' counseling, as discussed later in this chapter.

Psychological Factors in the Use of ARTs

IVF is the most widely used of the ARTs, with an average success rate (defined as live births) for a given treatment cycle (e.g., ovary stimulation, egg retrieval, fertilization, transfer) of about 15% (Society for Assisted Reproductive Technology, 1994). Research has shown that individuals attempting ARTs tend to overestimate their chances of success and have unrealistic expectations about how they will be affected (Callan & Hennessey, 1988; Johnston, Shaw, & Bird, 1987). This tendency to overestimate likelihood of success and minimize risks has been the cause of significant concern, under the assumption that overly optimistic expectations will lead to a difficult adjustment to failure. Some authors have suggested that this overestimation occurs as a result of the availability heuristic (Adler, Keyes & Robertson, 1991; Johnston et al., 1987). Media reports of successful new procedures, plus pictures of babies conceived through IVF posted in physicians' offices, may lead to many more examples of success stories than failures, thus leading couples to overestimate the likelihood
that they will be successful. In addition, Adler et al. (1991) have argued that given the emotional and physical demands of these treatments, coupled with the high financial cost, individuals may have a psychological need to bolster hope to justify going through the experience. Physicians and medical staff also may contribute to unrealistic expectations, not so much out of an attempt to intentionally mislead patients, but they may be overly optimistic out of a desire to justify both their work and putting the couple through so much stress and to foster hope in patients who are distressed by continued failure.

What is known about psychological reactions to the stress of undergoing ARTs? There is little doubt that the use of ARTs is highly stressful. Women report that egg retrieval and the waiting period after embryo transfer before it is known whether a pregnancy has occurred are the most stressful components of the treatment (Callan & Hennessey, 1988; Seibel & Levine, 1987). Emotional reactions appear to vary dramatically over the course of treatment (Newman & Zouves, 1991). The psychological process associated with ARTs has been described as an "emotional rollercoaster" because it is characterized by so many different emotions in so short a time (Stewart & Glazer, 1986).

The availability of ARTs also presents couples with a complex dilemma: If they attempt this treatment, it will involve significant disruption of their lives, many office visits, physical pain for the woman, high financial costs, and a high likelihood of failure, whereas if they choose not to attempt it, they may find themselves regretting their decision not to try everything possible and will always wonder whether it would have been successful. Most couples who achieve a pregnancy using one of these procedures do so after more than one treatment cycle. Thus, the decision-making process may occur over a period of months and years, with anticipation and disappointments, followed by the difficult decision of whether to try again.

How individuals react to failed IVF has been a major concern. Evidence has shown that although most men and women seem to cope with the distress adequately and are satisfied with having attempted IVF, a sizable percentage experience short-term but clinically significant depression and anxiety (Baram, Tourtelot, Muechler, & Huang, 1988). Studies that have included men reveal that they are clearly affected, although women tend to be at higher risk for negative reactions to failed IVF than are men, especially those who have no previous children (i.e., Leiblum et al., 1987). The few follow-up studies that exist reveal no long-term negative effects of failed IVF; however, attrition rates make it impossible to draw firm conclusions (Baram et al., 1988).

Translating Research Into Clinical Practice

Given the lack of longitudinal research, researchers do not yet know the long-term impact of continued unsuccessful infertility treatment. Also, researchers know little of the experience of couples with fertility problems
who do not seek treatment at all, either because of lack of financial resources or otherwise, or those who terminate treatment. Furthermore, there is a clear need to include individuals from ethnic minority groups, individuals in lower socioeconomic groups, and single and lesbian women in research on both fertility problems and reproductive technologies.

Attention to the potential for negative psychological effects of the experience of infertility and its treatment, and ways to avoid negative effects, should be central in the minds of all health care professionals who work with individuals with fertility problems. Clearly, attending to and implementing ways to avoid negative effects is easier said than done, and even well-intentioned professionals may have difficulty. For example, consider the physician who does not acknowledge to patients the stressful nature of fertility treatment (perhaps because of a belief that it is best to keep medical and emotional issues separate). This may leave patients feeling that their emotional reactions are unacceptable or indicative of serious psychological problems.

The research literature can provide some guidance on how health care professionals working with individuals with fertility problems can be most helpful. Broadly, health care professionals must play a delicate balancing act. Given that researchers know that emotional reactions to the stress of infertility are common and are not usually indicative of psychological problems, health care practitioners should avoid treating patients as weak and should not pathologize emotional responses. Instead, emotional responses can be seen as part of a normal reaction to highly distressing circumstances. Simultaneously, health care practitioners should be continuously sensitive to their patients’ level of vulnerability and should allow patients the opportunity to bring emotional responses into the realm of treatment planning yet not require that they do so.

Managing Patient Distress

Emotional responses. It is extremely important to acknowledge to patients from early in the infertility investigation that there are several common emotional responses, such as feeling sadness, anxiety, and feeling out of control and that there is considerable interindividual variability in the experience of these. This is particularly important if ovulation-inducing agents (i.e., Clomid, Fergonal) are prescribed because these drugs have common mood-altering side effects. Also, the health care professional should point out that it is typical for a given person to experience fluctuations over time in their emotional responses, with the testing and diagnostic period often involving particularly distressing emotions and the treatment period possibly being more hopeful. Psychological theory and research indicates that the patient should never be told to expect predictable stages of emotional response (Wortman & Silver, 1987).

Coping strategies. Although certain coping strategies are associated with better or poorer adjustment, it is not typically useful to “prescribe”
any strategies or to warn against the use of others. First, it may be that coping strategies are used as a result of the level of distress as opposed to being capable of changing the level of distress. Second, there is little evidence to suggest that an individual's natural coping style can in fact be altered, although it may be useful to offer patients the option of a broader coping repertoire, leaving the choice up to the individual. Furthermore, the consequences of spontaneously implementing a particular coping strategy may be much different from those that result when a coping strategy is adopted at the suggestion of others (Dunkel-Schetter & Stanton, 1991).

Reducing stress. Treatment facilities should focus on reducing the controllable aspects of the stress associated with infertility treatment. First, reducing treatment-related stress may lead to a lower risk of excess psychological distress among patients. Second, stress-induced cognitive processing deficits (see Janis, 1993) may lead couples to make poor treatment-related decisions. Poor decision making, in turn, has many costs, as discussed later in this chapter.

Because loss of control often is cited as a key element in the stress of fertility treatment, treatment programs might focus their efforts to reduce stress on increasing the patient's perceived control. Outlining a diagnostic plan, and later a treatment plan, with both members of the couple is particularly important in this regard, as is explaining what the couple can expect when undergoing various procedures. A reasonable attempt should be made to help couples understand the rationale underlying the treatment plan, and partners should be given the opportunity to ask questions and discuss their feelings. Providing patients with the opportunity to make use of various books, pamphlets, and videotapes pertaining to various aspects of treatment is useful. Patients who do not understand the reasoning behind the treatment plan may be inclined to try to increase their sense of control by going from one doctor to another, attempting various treatments. This is costly, emotionally and physically draining, and wasteful because tests are often repeated and more invasive procedures attempted before less invasive ones.

It also is critical to tailor the evaluation and treatment plan to be responsive to the couple's particular needs. For example, although research has shown that many fertility patients want information and involvement in treatment planning, some patients may prefer to play a less active role and defer to the physician. These individuals may feel overwhelmed by too much information about possible risks and benefits (see Burger, 1992) and may experience undue stress if they are given too much control. Additionally, ethnic and cultural variations may affect the amount of control desired as well as the acceptability of various procedures and treatments. Such factors (i.e., individual, cultural) must be thoroughly considered.

Couples will have an easier time coming to the decision to terminate treatment if a realistic, well-defined, individually tailored treatment plan has been developed (Taylor, 1990). This allows couples who are not successful to have some degree of comfort in concluding that all realistic op-
tions have been exhausted in order to begin to pursue other options. Patients who have not progressed through a carefully structured treatment plan may have considerably more difficulty coming to the decision to terminate treatment.

In addition to advocating that treatment facilities adopt a focus on the reduction of stress, we urge that they not place the burden for stress reduction on the patient. This responsibility creates a danger that women (who are typically the patients) will come away with the message that they are responsible for the success of treatment (e.g., "If only I had been less stressed, I would be pregnant by now"). Many patients cite their own level of stress as a reason for their IVF failure (Callan & Hennessey, 1988), and patients who believe they had a role in the failure tend to experience more distress (Litt, Tennen, Affleck, & Klock, 1992).

Working With Couples as a Unit

It is extremely useful for health care professionals to remember that infertility usually affects the couple as a unit as well as the individual patient. For the physician, this means that when an individual seeks help for a fertility problem, diagnostic and treatment plans can be developed in the presence of both partners. Failure to include both partners in treatment planning can lead to a member of the couple participating in a treatment protocol that he or she finds objectionable. It also may lead to nonadherence with the protocol. Unfortunately, eliciting the participation and cooperation of both partners is not always easy. As described earlier, there often are gender differences in responses to infertility, with men on average being somewhat less invested in treatment and less willing to become involved in treatment. The physician and other medical staff can encourage the participation of a partner who shows minimal interest by making it clear, sensitively and nonjudgmentally, that his or her opinions and reactions are as important as the other partner's and that he or she will be included in the decision-making process should he or she choose to participate.

As discussed earlier, although infertility does not usually lead to serious marital problems, some couples experience significant distress. For couples who seek marital counseling, there are well-established techniques for communication skills training that may help the couple reach a mutually acceptable solution (see Jacobson, 1986). However, couples who seek counseling often are experiencing so much conflict that they can no longer openly discuss the problem. In this case, it may be helpful for the counselor to first try to promote acceptance of each other's views (see Christensen, Jacobson, & Babcock, 1995). This can be achieved through detailed discussions of the nature of the conflict and each spouse's point of view. Through these discussions, the counselor can help the couple to see that although their problems may occur as a result of differences between them, each spouse's view is understandable and not originally intended to hurt the other. For example, the counselor might help the hus-
band see that his wife does not continually ask him for support to annoy him and that his lack of responsiveness has made her feel alone. Similarly, the counselor can help the wife to see that her husband does not distance himself from the fertility problem to make her feel alone but instead perhaps because he feels overwhelmed by the enormity of the situation.

**Providing Help With Treatment Decision Making**

The health care professional must help patients with treatment-related decisions under conditions of extreme uncertainty. In light of evidence that patients tend to overestimate the likelihood of success, we agree with Leiblum et al. (1987) that it is "critical that IVF personnel understand the tendency of couples to display both overoptimism and denial with respect to success probability so that they do not reinforce these feelings and inadvertently contribute to the tremendous disappointment that accompanies failure to conceive" (p. 174). Medical staff should be alert to the manner in which they portray risks, benefits, and success rates and should be aware that how facts are framed (i.e., as likelihood of success vs. failure) can affect how information is used in the decision-making process. Patients should be informed of the success rates for the particular treatment facility and for cases similar to theirs before they consent to treatment.

On the basis of the assumption that overly optimistic expectations will lead to more difficulty coping with failure, some authors have concluded that health care professionals must monitor patients' level of expectations throughout the process and repeatedly remind them of the typically low success rates (Callan & Hennessey, 1988; Leiblum et al., 1987). We argue that it would be inappropriate to intervene in an individual's natural coping process without clear evidence that such interventions would have the desired effect. On the contrary, Adler et al. (1991) have argued that, based on social psychological principles, the appearance of unrealistic expectations may be a reasonable and adaptive stress management technique in some cases. Reformulating one's own estimates of the likelihood of success in one's mind may give one more justification for undergoing such a difficult procedure, making it easier to cope with the stress. This hypothesis was supported by the results of Litt et al. (1992), who found that women who were pessimistic about their chance of success and who were distressed before the IVF were more distressed after failure than women who were optimistic about their chances and less distressed before the IVF.

The following are our tentative conclusions about how to approach patient expectations. Individuals considering ARTs should be given clear, straightforward information regarding success rates and risks. Any misperceptions identified during the evaluation period can be corrected and patients counseled sensitively concerning realistic expectations. However, once a decision has been made, medical staff should not interfere with the psychological process of overoptimism because it may reduce stress. Instead, medical staff should pay special attention to the distress levels of those who appeared pessimistic and distressed at the start of the cycle.
Another major issue is how patients should be helped to decide whether to pursue options such as ARTs after initial options have failed and how to help unsuccessful couples decide to terminate treatment or elect to use donor sperm, an egg donor, or a surrogate mother. Given the complexity and uncertainty of new reproductive options, and the emotional nature of the procedures themselves, there is a need for the development of decision-making aids for couples faced with fertility treatment decisions. This could be achieved using videotapes that provide information regarding particular procedures and outline some of the positive and negative aspects of choosing a procedure. These videotapes might contain the stories of couples who have undergone (and of some who have chosen not to undergo) the procedure, with various outcomes.

**Psychological Intervention**

Many authors have advocated the provision of professional counseling as a component of infertility treatment programs (i.e., Dennerstein & Morse, 1988), and it is now considered a required component for participation in some IVF programs (Seibel & Levine, 1987). Also, many couples undergoing infertility treatment, particularly IVF, report that they would welcome the opportunity for counseling (Baram et al., 1988), although a small minority make use of services when they are offered on a voluntary basis (Reading, 1991).

Although the availability of counseling in conjunction with treatment is clearly important, research to date does not suggest that psychological counseling is necessary for everyone, nor should all couples making use of ARTs or other fertility treatments be required to have counseling. Yet, offering counseling on a purely voluntary basis can lead to underutilization. Thus, this concern must be balanced with the danger that making counseling a requirement of participation in a treatment program may contribute to an individual's sense of loss of control by forcing him or her into yet another patient role. Women may be at particular risk in this way because they are more often the designated patient and therefore the most likely target of psychological interventions.

The role mental health professionals should play and the best psychological interventions for individuals with fertility problems are major unresolved issues. Pretreatment assessment is one role that psychologists and social workers have been asked to perform in the ART process. There is some ambiguity about whether this is a gatekeeper role, intended to deny access to treatment to certain patients (e.g., because of emotional instability), or simply a support and troubleshooting role, so that efforts can be taken to treat any problems (i.e., major depression) that might result in undue stress over the course of treatment. We believe that mental health professionals should be wary of the gatekeeper role for several reasons. First, there is limited research evidence to guide these decisions, and thus they are likely to result in unfair discrimination (see Humphrey, Humphrey, & Ainsworth-Smith, 1991; Sparks & Hamilton, 1991). Second,
as pointed out by Stanton and Danoff-Burg (1995), the psychological consequences of denying access to reproductive technologies to those who desire to use them are not known. In addition, ambiguity about the purpose of the initial assessment may lead patients to hide concerns or emotional problems, fearing that revealing any problems might lead to their rejection from the program. Therefore, when pretreatment assessments are used, we recommend that the purpose be made clear to patients.

Approaches to psychological interventions described in the literature include remnants of the psychogenesis model of infertility (i.e., psychoanalytic psychotherapy aimed at uncovering conflicts over the maternal role) as well as treatments such as crisis intervention, grief counseling, supportive counseling, stress management techniques, cognitive–behavioral therapy, and more. Little controlled research has been conducted to assess the usefulness of any type of psychological counseling for patients with fertility problems (however, see Connolly et al., 1993).

There appear to be three key arenas for psychological intervention, each with a different set of goals. First, it appears that the majority of fertility patients could benefit simply from an opportunity to discuss their fears, anxieties, and frustrations with a knowledgeable and supportive person (Adler et al., 1991). The goal of this intervention would be to provide support, access to information, and the opportunity to vent distressing emotions and discuss relationship issues. This intervention may be particularly important for patients undergoing ARTs and can be offered by many health care professionals (e.g., psychologists, social workers, nurses). This supportive function may be achieved through group interventions that are well established (i.e., RESOLVE, a national support group network for individuals facing fertility problems). This type of intervention is distinct from most conceptualizations of psychotherapy, in that there is no assumption that the patient has a psychological problem that must be solved through acceptance of the patient role.

The second arena for psychological intervention is the provision of help with decision making. Here, trained health professionals can work closely with couples in choosing the options that best fit their needs and goals. This function could be similar to that of the genetic counselor, who is adept at presenting information and choices. The third arena for psychological intervention involves those patients (or partners) who present for treatment with preexisting psychiatric disorders or who experience clinically significant levels of psychological distress as a result of coping with treatment. It may be difficult for the health practitioner to identify when a patient's level of distress is so high that intervention is warranted because, as we have indicated, some level of emotional response to infertility is expected in most cases. Some possible indicators of extreme reactions are (a) major depressive reactions (particularly when accompanied by suicidal ideation or social withdrawal); (b) severe relationship problems, particularly those involving physical or psychological abuse, or those involving a stalemate between partners (e.g., one insists on continued treatment and the other refuses to continue); (c) sexual dysfunctions beyond common temporary reactions to the stress of fertility treatment; and
(d) serious ruminative or obsessive reactions, such as preoccupation with getting pregnant leading to going from one doctor to another or trying numerous exploratory treatments. Couples with these responses may need referral to qualified mental health professionals who can work in conjunction with medical staff in treatment planning according to the patient’s desire.

Conclusion

The purpose of this chapter has been to focus on psychological issues faced by women and by couples during the period of time defined medically as infertility. Considerable research provides a foundation for drawing several conclusions, discarding some myths, and developing psychological interventions. Nevertheless, more research is needed to better understand and treat psychological responses to infertility in couples and individuals.

Nature, not culture, prescribed that women be childbearers. Thus, it is not surprising that the bulk of responsibility for many reproductive issues, including infertility, falls on women. In all likelihood, women will continue to bear the greater burden of the patient role in infertility treatment. However, they need not be held solely responsible for cause or solution. Health care professionals can have an important, positive influence on the adjustment process by creating an environment in which men feel comfortable being involved in the diagnosis and treatment process. In addition to reducing the emotional burden on women, more equal sharing of the responsibility could result in a greater sense of efficacy and control among men. As understanding of and solutions to infertility continue to grow, we hope that health care professionals can maintain an accepting and not a pathologizing approach in working with individuals with fertility problems.

References


