Integrative Systems Model For Infertility: Patient benefits and provider considerations

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Workshop Objectives

- Have a working understanding of the benefits of providing counseling in a medical setting, especially for patients impacted by infertility.
- Be able to identify the relationship between infertility and mood disorders and the impact it has on a woman throughout reproductive transition – from conception, pregnancy and into the postpartum period.
- Be able to discuss important considerations for treating patients with infertility throughout pregnancy, the postpartum period and loss.

"WE NEED A COMPREHENSIVE, INTEGRATED APPROACH TO SERVICE DELIVERY. WE NEED TO FIGHT FRAGMENTATION." - WHO DIRECTOR-GENERAL, 2007

Integrative Care
Integrative Care

- Integrating mental health and primary care services produce the best outcome and, proves the most effective approach to treat people with multiple healthcare needs.

- Some form of integration is generally understood to provide the best path to enhancing and improving (a) quality of care; (b) quality of life; (c) access to care; and (d) reduce costs over time.

Integrative Care Literature Review Summary

- Not as much research on integrative care embedded within OB/REI clinics
- Most studies looking at collaborative care models indicate positive outcomes for patients and providers
- Bryan, C.J. (2012) looked at data from 495 primary care patients, data showed 71.5% improved
- McFeature, B. (2011) 251 patients with mood d/o; given PHQ-9; 49.8% showed 50% improvement in scores, 80.5% showed improvement by at least 5 points. # of medical visits significantly decreased
- Torrence, N.D. (2014) Medical providers attitudes and perceptions about behavioral health clinicians 73-100% endorsed strongly agree or agree to benefits of having integrative services with behavioral health

Integrative Care

- Involves collaboration and care of multiple providers co-located within the same clinic.
- Regular and consistent communication and consultation between mental health provider and medical provider on patients care.
- Given the significant amount of medical appointments and needs of infertility patients, integrative care allows them to come to a "one-stop shop."
- Reduces barriers around the stigma of mental health and, in particular, with the infertility population, helps this to be considered a normal part of their routine care.
Reproductive Mental Health Collaborative Care

- Program started in 2006
- Referrals originate from both inpatient and outpatient clinics (family med, pediatrics, NICU, postpartum floor, OB clinics)
- Average 50+ referrals a month
- MFT first point of contact for all patients; then triaged to staff for authorizations and scheduling
- Most UCSD REI MD’s have integrated mental health into their initial appointment with patients so that it’s offered as a “normal part of their care”

Provider and Patient Perspectives: interviews with patients and providers
The Wide Reaching Impacts of Infertility

INFERTILITY: (N)
A MEDICAL CONDITION WHICH DIMINISHES SELF-ESTEEM, YOUR SOCIAL LIFE, AS WELL AS CHECKING AND SAVINGS ACCOUNTS. CAUSES SUDDEN URGES TO PEE ON STICKS, CRY, SCREAM, AND A FEAR OF PREGNANCY ANNOUNCEMENTS. TREATED BY A MEDICAL SPECIALIST WHO YOU PAY TO KNOCK YOU UP—THIS DOES NOT ALWAYS WORK. AFFECTS 1 IN 10 COUPLES.

Causes of Infertility

There Are Multiple Causes of Infertility

- Woman/couples are less likely to receive treatment for emotional distress despite need for treatment
- Limited financial resources, limited access to care
- Prevalence of psychological problems of the infertile couple is estimated to be 25-60% (Hasanpoor-Azghdy, 2014)
- Distress may play a role in patients’ desire to continue ART

Emotional Impact of Infertility
Impacts of Infertility: Individual

- Despite cause, infertility is almost always attributed to the woman
- High prevalence of Major Depression Disorder and Anxiety Disorders
  - 11% found to have MDD; 15% Anxiety Disorder (Volgsten, 2008)
- Grief and loss related to the hope of a family unit
- Other emotions such as stress, shame, anger, self-blame, isolation and loneliness

Impacts of Infertility: Couple

- Stress related to their sexual relationship
- Isolation from family and friends with children
- Financial stress
- Arguments about treatment decisions
- Fear of marriage ending or that partner will seek out someone who is not “baron”
- Less co-parenting playfulness in relationship after ART (Darwiche et al, 2015)

Impacts of Infertility: On Pregnancy and into Parenthood

- **What we know**
  - High levels of stress reduce chances of becoming pregnant (Lynch, C. et al., 2012)
  - Couples that conceive via ART have increased anxiety throughout transition into parenthood
  - Patients conceiving via ART have increased adverse perinatal outcomes (Reddy et al, 2007)
  - Untreated Anxiety/Depression in pregnancy can pose risk for PMADs
- **What we can assume**
  - Treatment for emotional distress will improve fertility outcomes and potentially offset PMADs
- **Limited research**
  - Further research needed due to “unknown cause”
  - Confounding factors, including the psychosocial strengths of those using ART may offset risk of PMADs
Treatment Considerations

“INFERTILITY IS A LOSS. IT’S THE LOSS OF A DREAM. IT’S THE LOSS OF AN ASSUMED FUTURE, AND, LIKE EVERY LOSS, IT WILL BE GRIEVED.”

-UNKNOWN

Fertility-Related Questionnaires

Handout to be provided at presentation

Counseling for Infertility

<table>
<thead>
<tr>
<th>Counseling</th>
<th>Treatment Focus</th>
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<tbody>
<tr>
<td>Implications Counseling</td>
<td>Addresses legal aspects of infertility / ART</td>
</tr>
<tr>
<td>Support Counseling</td>
<td>Develops coping mechanisms for stress associated with treatment</td>
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<tr>
<td>Therapeutic Counseling</td>
<td>Addresses bio-psycho-social aspects of treatment with both the individual and couple</td>
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The Role of the Therapist in an Integrative Model

- Therapist’s role to the patient
  - Education/normalization, empathy, advocacy, giving them permission to stop ART, safe association in the medical setting.
- Therapist’s role to the medical provider
  - Liaison, shared access to treatment for both MD/therapist, flexibility to support patient/provider during treatment, continuity of care, location

Case Study

- Patient is a 42 yo female. At her 5th office visit (Gyn Consult, Saline infusion sonogram, Pre-op visit, polypectomy, Post-op) she disclosed that the main problems impacting her and husband’s ability to conceive were: impotence, low frequency of intercourse and uncertainty if her partner (56 yo) wanted a subsequent child. Reproductive Endocrinologist made two referrals, one to a Urologist specializing in male fertility & one to the Reproductive Mental Health Counselor.

- Therapist called patient 2xs; Couple presented to session 1.5 months after referral was placed.

Case Study

- At intake, the patient reported that they have been together for 6 yrs; patient stated that she has been tracking her ovulation since their marriage 1.5 yrs ago, as having a child was very important to her – “I told him on our first date that not having children was a deal breaker.”
- Patient stated that she understood that husband had some medical issues that were impacting frequency of intercourse (erectile dysfunction, etc.) however, she did not understand why he would not take a sperm analysis.
- In session, husband disclosed for the first time, that he had a vasectomy 9 yrs prior.
Recommendations

- Counselors embedded in REI clinic
- If not, therapists are encouraged to:
  + Connect and collaborate with REI clinics
  + Educate REI providers of the psychological and emotional needs of the patient
  + Disseminate information and resources to REI clinics to improve patients access to care
  + When possible, have patients sign ROI to discuss role as a collaborator in infertility treatment

Resource and Reference List

Handout to be provided at presentation

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Questions?