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PSYCHOLOGICAL DISTRESS OF INFERTILE COUPLES

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SUMMARY

The follow-up of the infertile couple is not limited to the diagnosis of the causes and the technical aspects of the treatments of medically assisted procreation. Dropping out of treatment is a major cause of pregnancy failure. Thus, taking care of emotional aspects and identifying couples at risk of psychological distress are therefore essential to prevent abandonment. Psychological counseling is considered at several levels. The gynecological team will focus on information, positive communication and the identification of couples who may benefit from stress management strategies. Finally, the liaison psychiatrist will take care of couples suffering from a pre-existing psychiatric pathology or who develop anxiety / depressive symptoms following treatment.

INTRODUCTION

Infertility is a disease of the reproductive system, defined as "the inability to conceive a pregnancy after 12 months or more of regular, unprotected sex." On average 10 to 15% of couples are affected and the prevalence increases significantly with the age of the woman. The cause remains unexplained (idiopathic) in 10-15% of cases after the assessment has been carried out.

Both the announcement of a diagnosis of infertility and the absence of identified causes, after various examinations carried out, represent a crisis in the life trajectory of couples. Awareness of an infertility problem often confronts the couple with an existential-type crisis calling into question their own psychological and physical integrity, the couple's relationship and the meaning of existence.

Distress and emotional repercussions are most often expressed in the form of feelings such as

helplessness, anger and / or frustration. These experiences can also be encountered later when the procedures and treatments are unsuccessful. The process of assisted procreation can often be associated with a long and painful experience of loss or bereavement: mourning for one's own fertility, maternity / biological paternity (recourse to a gamete donation), pregnancy (adoption), or the bereavement of the child (renunciation of treatment and / or child plan).[1]

More than 40% of women present with psychiatric disorders of the anxiety or depressive type, and the levels of anxiety and depression in infertile women are equivalent to those of women with chronic diseases such as heart disease, cancer or HIV status. During treatment, women appear to be more vulnerable than men and their reactions to treatment failures represent a risk factor for worsening emotional adaptive difficulties.[2]

I- Risk of abandonment of treatment in the context of infertility

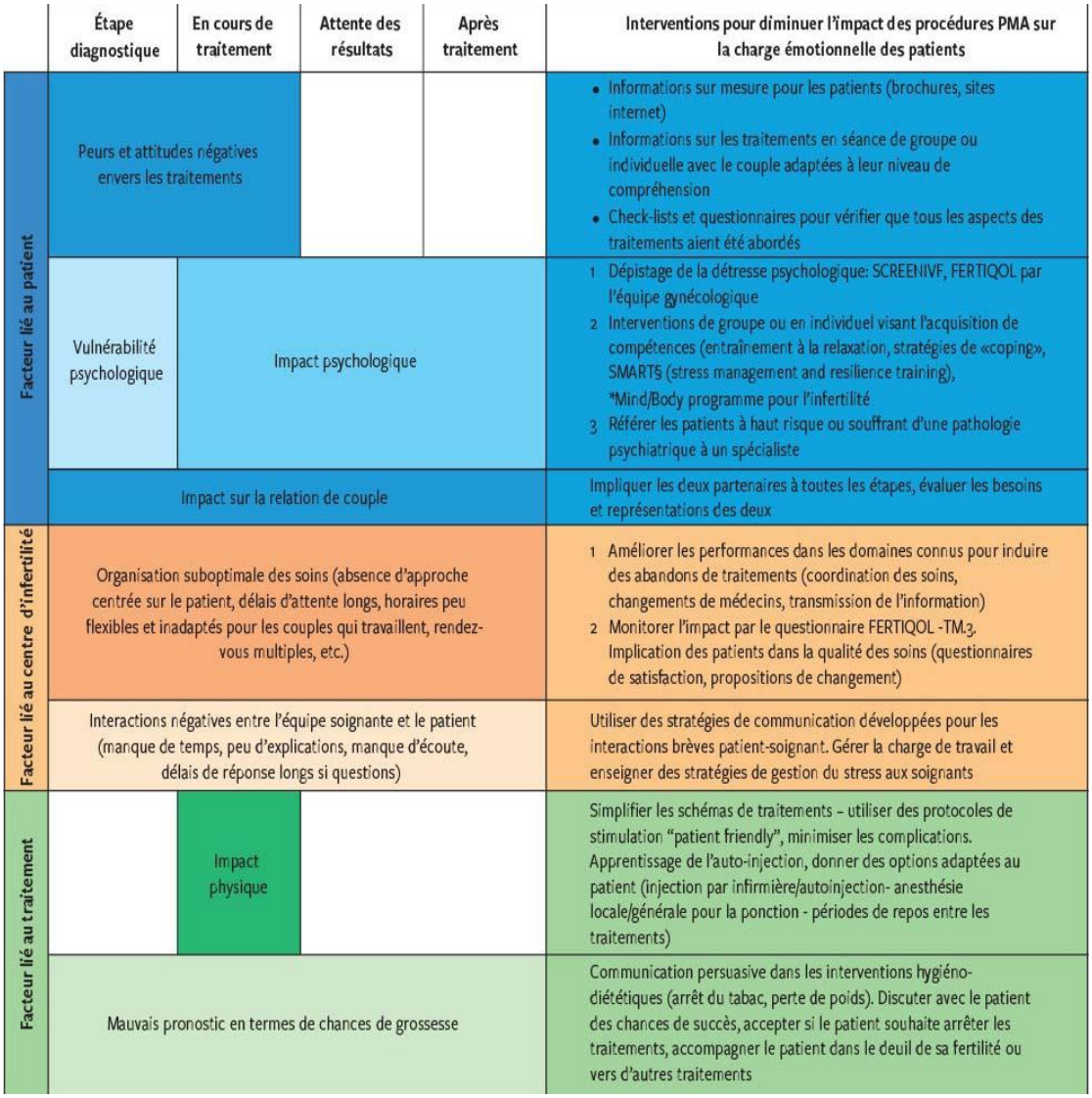
Most couples adapt well to the various phases of the assisted reproduction procedure, however it is estimated that 50% of infertile couples do not consult, that 20% wait more than two years before seeking medical attention and that a proportion not. negligible couples will not initiate treatment after the diagnostic phase.[3.4]

Several studies have looked at this phenomenon, called drop-out , either abandonment during treatment or prematurely before having even started treatment. The importance and impact of the emotional burden on the outcome of assisted reproduction has been documented in the literature.[3]

Indirect links were noted between psychological factors and the premature abandonment of procedures. Some studies thus highlight the relationship between the psychological impact and the ongoing drop-out of treatments, when the emotional repercussions linked to the treatments (emotional “burden”) and their psychological impact are too great.[4]

The management of couples in infertility and the medical course are thus complex. It is suggested to act upstream on three distinct levels: with patients (information, screening, support / follow-up), within the PMA care center (organization, coordination of care, caregiver-patient relationship), as well as level of treatment (simplification of treatment schedules, individualization of treatments, offering options, related hygieno-dietetic measures).

Impact of infertility management at different stages and possible interventions.



	Étape diagnostique	En cours de traitement	Attente des résultats	Après traitement	Interventions pour diminuer l'impact des procédures PMA sur la charge émotionnelle des patients
Facteur lié au patient	Peurs et attitudes négatives envers les traitements				• Informations sur mesure pour les patients (brochures, sites internet) • Informations sur les traitements en séance de groupe ou individuelle avec le couple adaptées à leur niveau de compréhension • Check-lists et questionnaires pour vérifier que tous les aspects des traitements aient été abordés
	Vulnérabilité psychologique	Impact psychologique			1 Dépistage de la détresse psychologique: SCREENIVF, FERTIQOL par l'équipe gynécologique 2 Interventions de groupe ou en individuel visant l'acquisition de compétences (entraînement à la relaxation, stratégies de «coping», SMART§ (stress management and resilience training), *Mind/Body programme pour l'infertilité 3 Référer les patients à haut risque ou souffrant d'une pathologie psychiatrique à un spécialiste
	Impact sur la relation de couple				Impliquer les deux partenaires à toutes les étapes, évaluer les besoins et représentations des deux
Facteur lié au centre d'infertilité	Organisation suboptimale des soins (absence d'approche centrée sur le patient, délais d'attente longs, horaires peu flexibles et inadaptés pour les couples qui travaillent, rendez-vous multiples, etc.)				1 Améliorer les performances dans les domaines connus pour induire des abandons de traitements (coordination des soins, changements de médecins, transmission de l'information) 2 Monitorer l'impact par le questionnaire FERTIQOL -TM.3. Implication des patients dans la qualité des soins (questionnaires de satisfaction, propositions de changement)
	Interactions négatives entre l'équipe soignante et le patient (manque de temps, peu d'explications, manque d'écoute, délais de réponse longs si questions)				Utiliser des stratégies de communication développées pour les interactions brèves patient-soignant. Gérer la charge de travail et enseigner des stratégies de gestion du stress aux soignants
Facteur lié au traitement		Impact physique			Simplifier les schémas de traitements – utiliser des protocoles de stimulation "patient friendly", minimiser les complications. Apprentissage de l'auto-injection, donner des options adaptées au patient (injection par infirmière/autoinjection- anesthésie locale/générale pour la ponction - périodes de repos entre les traitements)
	Mauvais pronostic en termes de chances de grossesse				Communication persuasive dans les interventions hygiéno-diététiques (arrêt du tabac, perte de poids). Discuter avec le patient des chances de succès, accepter si le patient souhaite arrêter les traitements, accompagner le patient dans le deuil de sa fertilité ou vers d'autres traitements

II- Screening of couples at psychological risk.

The link between drop-out and psychological experience mentioned here raises an important question: the benefit of being able to detect patients and couples who are more psychologically vulnerable at an early stage in order to offer them appropriate care, aimed at improving adaptation. psychological and thus reduce drop-outs during treatment. The identification of psychological vulnerabilities by the reproductive medicine team is therefore crucial. To do this, specific psychometric tools make it possible to screen couples at psychological risk before and / or after treatment and to assess the areas impacted by infertility itself and by the treatments.

FertiQol (www.fertiqol.org) is a tool for measuring the quality of life of infertile couples, developed and validated in many languages including French. This questionnaire assesses the difficulties in the following areas: self-perception, emotions, couple, family, social relations,

work and projection into the future. The second part of this questionnaire is a grid of 10 questions which assesses the impact of infertility treatments on the individual's quality of life.[1]

SCREENIVF[8]

is a questionnaire for screening individuals at risk of psychological distress during and after treatment. This questionnaire developed in Dutch, translated into English (but not validated in English, nor translated and validated in French) uses elements of several questionnaires validated in the fields of anxiety ((10 items of the State-Trait Anxiety Inventory), of depression (7 items from the Beck Depression Inventory), social involvement (5 items from the Inventory of Social Involvement (ISI)), acceptance / impotence in relation to infertility problems (12 items from the 'Illness Cognition Questionnaire (ICQ)). According to the team that developed SCREENIVF, this tool correctly identifies 75% of patients as being at risk for emotional distress after treatment, with a negative predictive value of 89% and a value of 48% positive predictive The identification of individuals / couples at risk is essential to individualize and adapt care.

III- Psychological care

Psychological care, or counseling, can take place at several levels and be provided by several professional bodies, as established by the work of Peterson.[9]

Counseling is not compulsory, but nevertheless seems essential, especially for couples at emotional / psychological risk.

The first level of intervention is provided by the team of gynecologists and specialist nurses on the front line. Their mission will be to provide information on the possible causes of infertility and on existing treatments, either individually or in groups. This information, called psycho-educational, will aim to reduce fears and negative attitudes about the treatments offered. At this level of intervention, the identification of couples at emotional risk by the gynecological team, using the specific tools described above, is also an important issue.

The second level of care will consist of addressing the desire for a child and the experience of infertility within the couple and individually. At this stage, it is then a preventive approach which makes it possible to create an alliance that can facilitate a resumption of contact and

the establishment of a subsequent psychological-psychotherapeutic follow-up if necessary. Counseling can also be a place to acquire skills in the area of stress management, relaxation, and coping strategies.[10,11]

Third line, some couples require psychiatric / psychotherapeutic type of care in connection with psychological distress or in the presence of psychiatric comorbidities.

In general, it is essential for the medical team to be able to recognize and validate the psychological suffering of couples coming to consult in assisted reproduction and to refer them to a specialist (liaison psychiatrist, specialist in psychology / psychotherapy), working in close collaboration with the gynecology team.

CONCLUSION

The management of infertility does not stop with the technical and specific treatment of the identified cause only but is addressed to the couple taken into account together and individually. The infertility clinic therefore offers a global approach of the person offering on the one hand, complete information and then support tailored to the couple's needs for managing stress and reactive psychological distress. The global approach thus aims to ensure the best possible quality of life for the people being followed and to give the couple's project as much as possible, the aim being to reduce drop-outs during the procedure.

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