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# INFERTILITY AND IN VITRO FERTILIZATION. ARGUMENTS TO SUPPORT PROPER COUNSELING

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## Abstract

Infertility is a growing problem worldwide, with significant medical, psychological, social, ethical, and legal implications. In vitro fertilization is a procedure of medically assisted human reproduction which aims at solving the consequences of infertility and not treating it. The conception of a child using in vitro fertilization is a complex medical undertaking which on the one hand involves several people (the woman who seeks to become pregnant, the infertile couple, the family, the medical staff, etc.) and which, on the other hand, can generate an array of psychosocial issues that are difficult to cope with. In this paper, the authors review the psychological and social consequences of infertility and the failure of the in vitro fertilization procedure and support a proper counseling of people suffering from infertility who resort to in vitro fertilization, to prevent or control the psychological reactions generated by the potential failure of this procedure and by the inability to procreate.

**Keywords:** infertility, in vitro fertilization, psychological aspects, social aspects, counseling

## Introduction

Infertility is defined as the failure to reach pregnancy after 12 months of regular, unprotected sexual intercourses (Vander & Wyns, 2018). The category of infertile women also comprises those who can become pregnant, but are confronted with recurrent abortions (Deka & Sarma, 2010).

The World Health Organization considers infertility as a condition that generates disability or an alteration of the good functioning of affected individuals (Vander & Wyns, 2018)

Infertility is a growing problem (Deka & Sarma, 2010) which affects between 8 and 12% of the couples of reproductive age worldwide (Vander & Wyns, 2018) and, according to certain authors, this percentage reaches values of 10-15% (Deka & Sarma, 2010). Thus, some authors estimate that at a global level, approximately 72.4 million couples are confronted with infertility issues (Gurunath, Pandian, Anderson & Bhattacharya, 2011). The prevalence of infertility at women of reproductive age is estimated at approximately 1 in 7 couples in Western countries and 1 in 4 couples in developing countries, reaching 30% in certain parts of the world, such as South Asia, Sub-Saharan Africa, Central and Eastern Europe and Central Asia (Vander & Wyns, 2018).

Infertility affects almost equally men and women, being diagnosed in a proportion of 55% in women and 45% in men (Katz, Teloken & Shoshany, 2017).

A study conducted in our country by the Association for Human Reproduction in Romania, in April-May 2018 on a group of 3331 subjects of fertile age (women aged 25-45 and men aged 25 to 60, in a relationship with a partner from the appropriate age segments) showed that 16.8% of the studied population were or are in an infertility situation (ARUR, 2018).

The etiology of infertility is complex and includes various pathologies, environment factors or factors related to the lifestyle. However, the most important negative predictive factor in reaching pregnancy is the older age of women at conception (Vander & Wyns, 2018). In Romania, for instance, according to the data of the National Statistics Institute, the age of mothers at the birth of the first born child has increased from 23.1 in 1997 to 27.1 in 2017, reaching 28.7 in the urban areas and 30.3 in Bucharest (ARUR, 2018).

Secondary infertility is the most frequent form of female infertility around the world, with a higher prevalence in the regions that record high rates of abortions in improper conditions and deficiencies in maternal care, which lead to post-abortive or postpartum infections (Vander & Wyns, 2018).

The last years have witnessed a worldwide increase of the number of couples requesting treatment for infertility, especially due to a postponement of procreation by women, but also due to an improvement of the medical techniques designed to treat infertility and to an increase of the population's awareness regarding the availability of such medical services (Deka & Sarma, 2010).

In this paper, the authors review the psychological and social consequences of infertility and of the failure of the in vitro fertilization procedure and show the need for a proper counseling of people suffering from infertility who resort to in vitro fertilization, to prevent or control the psychological reactions generated by the potential failure of this procedure and by the inability to procreate.

### **Psychological and Social Problems Related to Infertility**

Infertility and in vitro fertilization may become chronic, hard-to-manage stressors, with negative long-term psychological and social consequences (Schmidt, 2009), mainly due to the importance of the parent status in the life of an adult (Deka & Sarma, 2010). A major challenge infertile individuals are confronted with is the proper management of infertility and its treatment at a personal level, within the couple, but also within the personal and professional relationships (Schmidt, 2009).

The impossibility of having a child has repercussions on a psychological level, generating emotional problems such as: anger, depression, anxiety or feelings of uselessness, reflected both at a personal level and at the level of the couple (Deka & Sarma, 2010).

Infertility is perceived as a major crisis in life – the infertility crisis, which involves emotional reactions that cover four stages: the initial stage, characterized by shock, surprise, denial; the reactive stage, manifested by frustration, anxiety, guilt, pain, depression, isolation; the adaptive stage, which leads to acceptance and finally the resolution stage, when the individual seeks and plans solutions for the future (Menning, 1980; Volgsten, Skoog Svanberg & Olsson, 2010). The individual reactions during this crisis are varied, being influenced by the event that had caused the situation, the pre-existing personality, cultural factors and the support provided by family and friends (Caplan, Mason & Kaplan, 2000; Volgsten, Skoog Svanberg & Olsson, 2010).

Infertility may be considered as a loss, concretized in loss of fertility, of the capacity to procreate and have biological children (Menning, 1980; Volgsten, Skoog Svanberg & Olsson, 2010). Under these circumstances, grief is a natural, often self-limiting reaction (Lindemann, 1994; Volgsten, Skoog Svanberg & Olsson, 2010). There are, however, situations in which grief becomes complicated, when it extends for more than 2 months,

without falling into the defining criteria of major depression. Apart from pain as an expression of grief, infertile individuals may experience feelings of excessive guilt, devaluation, as well as suicidal thoughts (Volgsten, Skoog Svanberg & Olsson, 2010).

Infertility has an important psychological impact for the infertile individual, but also for their partner. In time, a couple may become anxious regarding the attempts to conceive a child, which creates perturbations in their sexual life and makes them prone to social isolation. Infertile couples may also experience stigmatization, feelings of loss and low self-esteem, all these leading to dysfunctionalities in the couple's life (Deka & Sarma, 2010). There are, nonetheless, situations when infertile couples consider that infertility strengthens their relationship and makes them closer to one another. However the consolidation of the relationship despite the incapacity to procreate is conditioned by open communication with the partner concerning the problem of infertility. Thus, the use of the partners of assessment-oriented coping strategies may alleviate the stress caused by the infertility problems, while an avoiding- evading coping type affects the physical and psychical well-being of the individuals (Schmidt, 2009).

The psychological stress of infertile people is mainly generated by three factors: paternity as a major objective in life, the role of women in society associated with social pressure to procreate and the effect of infertility on sexual life (Deka & Sarma, 2010).

In general, infertile women who try to procreate have higher levels of grief than their partners, recording rates of clinical depression similar to women suffering from heart diseases or cancer. When the infertility has a male cause, men experience levels of grief close to women's, and emotional stress and conjugal challenges are more important (Deka & Sarma, 2010).

A subject of scientific debate is the role of psychological disorders in the genesis of infertility. Certain mechanisms have been suggested that could explain such causality. Thus, depression could directly generate infertility through a high level of prolactin, the perturbation of the hypothalamus – hypophysis – adrenal axis and through thyroid dysfunction. Depression is also associated with deficiencies in regulating the luteinized hormone, which has a regulating role in ovulation. On the other hand, depression and anxiety favor certain negative behaviors, such as smoking or alcohol consumption and decrease libido which, in turn, may negatively impact the procreation capacity (Deka & Sarma, 2010). On the other hand, there are studies that infirm the hypothesis of the involvement of psychological factors in the genesis of infertility (Anderson, Sharpe, Rattray & Irvine, 2003).

### **Psychological and social problems associated with in vitro fertilization**

Approximatively 30–40% of couples who resort to in vitro fertilization treatment will not have children by the end of such treatment and repeated failures of these procedures may render the infertility crisis chronic (Volgsten, Skoog Svanberg & Olsson, 2010).

The process of assisted reproduction is associated with increased levels of anxiety, depression, and stress. The incidence of depression in couples resorting to infertility treatment is significantly higher than in fertile couples, and anxiety is significantly higher compared to the general population (Deka & Sarma, 2010).

Women who experience repeated failures of the in vitro fertilization show a higher rate of depression compared to those who perform this medical procedure for the first time and the psychological disorders are important predictors of treatment abandonment. On the other hand, psychological factors may in turn negatively influence the outcome of the infertility treatment, stress being associated with a decrease of the success rate in reaching pregnancy (Deka & Sarma, 2010). Infertile women, even if they manage a good long-term adjustment, perceive the absence of children as a major theme in life, which persists for years after the finalization of the infertility treatments (Schmidt, 2009).

A study conducted in Great Britain, which involved couples with a history of infertility of minimum 12 months and who resorted to in vitro fertilization, showed that the subjects generally reported low levels of emotional grief, especially manifested through anxiety. In this study, women reported significant levels of depression and concerns related to infertility and its impact on personal life (Anderson, Sharpe, Rattray & Irvine, 2003).

Grief is often experienced by childless women, 2 years from the end of a failed in vitro fertilization treatment (Johansson & Berg, 2005).

In a study conducted in Sweden on a group of men and women three years after the finalization of the in vitro fertilization treatment showed that most participants had not adapted to the idea of remaining childless, which indicated that the grief process had not ended. Women who took part in that study described the set in of depression, manifested through a lack of self-esteem and a feeling of uselessness. Although these women partly managed to accept rationally the fact that they would not have their own children, acceptance is not reflected at an emotional level, which generates a vulnerability factor for depression (Volgsten, Skoog Svanberg & Olsson, 2010).

Men and women tend to react emotionally to the failure of the in vitro fertilization depending on typical gender roles (Boden, 2007; Volgsten, Skoog Svanberg & Olsson, 2010), such as the man's role of support. Women describe a loss of control and a feeling of guilt for not having children, which were not reported by men (Volgsten, Skoog Svanberg & Olsson, 2010). The feeling of guilt and loss of control constitute vulnerability factors after a failed in vitro fertilization treatment (Litt, Tennen, Affleck & Klock, 1992; Volgsten, Skoog Svanberg & Olsson, 2010). For certain couples, the failure of in vitro fertilization may even lead to temporary separation or divorce (Johansson & Berg, 2005; Volgsten, Skoog Svanberg & Olsson, 2010).

### **The role of psychosocial support in the approach of infertility**

The important psychosocial problems associated with infertility and in vitro fertilization show that infertile individuals and couples need support and counseling both prior to, during and after the finalization of the in vitro procedure (Volgsten, Skoog Svanberg & Olsson, 2010). Nevertheless, although the in vitro fertilization procedures have witnessed spectacular progress in the last decades, the process of counseling required has failed to register the same rhythm of development (Schmidt, 1998; Volgsten, Skoog Svanberg & Olsson, 2010).

The medical team involved in the in vitro fertilization should also include a specialist who needs to evaluate the couples who resort to this procedure, to facilitate the process of grief and pain, which is normal after the failure of the treatment, as well as to avoid the abandonment of the treatment (Volgsten, Skoog Svanberg & Olsson, 2010). The emotional support through an efficient professional counseling provides infertile couples the opportunity to reflect and to consider future treatment options and to optimize their success chances (Verberg et al, 2008; Volgsten, Skoog Svanberg & Olsson, 2010).

Providing explanations regarding infertility, its etiology, as well as the feasible treatment alternatives during a consultation after the finalization of the in vitro fertilization may help infertile people adequately process the fact that they cannot have children, decreases the risk of developing depression and supports couples in taking decisions for the future (Lalos, Lalos, Jacobsson & von Schoultz, 1986; Volgsten, Skoog Svanberg & Olsson, 2010)

At the same time, the social support from the family and friends may be a beneficial element in accepting infertility. People who actively seek social support and express their negative feelings have better results with regard to mental health compared to those who deny

their negative feelings and fail to seek or accept support in their social relationships (Caplan, Mason & Kaplan, 2000; Volgsten, Skoog Svanberg & Olsson, 2010).

The screening for identifying infertile patients with significant levels of psychological disorders and social dysfunctionalities is essential for their proper approach in view of reducing emotional stress (Anderson, Sharpe, Rattray & Irvine, 2003). Thus, health professionals should differentiate clearly between normal grief and complicated grief in order to identify those people showing a higher risk of developing depression after the failure of the in vitro fertilization and to provide adequate support for their clinical condition (Williams & Zappert, 2006; Volgsten, Skoog Svanberg & Olsson, 2010).

## Conclusions

Infertility and in vitro fertilization generate important psychosocial problems at the level of the individual and of the couple, which take the form of a so-called infertility crisis and which may turn chronic, with a major impact on the individual's and couple's well-being.

The psychosocial problems generated by infertility and in vitro fertilization are diverse and influenced by the pre-existing personality, cultural factors, and by the support provided by the social group.

The in vitro fertilization procedure should be provided by a team of professionals who should ensure, beside medical assistance, the screening of individuals and couples to identify and properly approach the psychosocial problems they are confronted with.

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