Making room for men in infertility counseling

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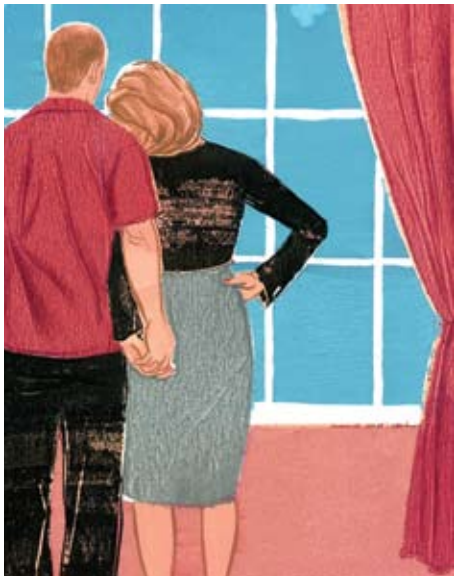
After 2 years of trying to conceive, Mrs S is referred to an infertility counselor by her reproductive endocrinologist. Mrs S has a history of grade III endometriosis and has undergone 2 intrauterine inseminations and 2 in vitro fertilization cycles in the last 12 months. She reports increasing anxiety and depressive symptoms after each unsuccessful treatment. Feeling helpless and wanting to do more, Mr S agrees to call the counselor to make an appointment for his wife. When he calls, Mr S is surprised to discover that after talking about their situation, he himself feels better. The counselor recommends that Mr and Mrs S attend the initial session together, explaining that the counseling process will (a) educate them on the physical and psychological impact of infertility; (b) explore the couple's typical coping strategies and whether they are as effective during infertility; (c) teach new techniques to reduce individual stress and decrease relationship conflict; and (d) include gender-specific discussion of the experience of infertility.

Although research has shown that infertile men typically suffer tremendous grief, a challenge to their identity, and interpersonal struggle related to their inability to have a biological child, mental health support continues to be sought by—and offered predominantly to—women.[1] Historically, responsibility for childbearing and infertility treatment were considered the biological imperative of women, regardless of which partner received a diagnosis of infertility. The prolonged effect of the "childbirth decree" is that many women continue to feel the primary burden of responsibility for infertility, while men are alternately marginalized and protected.[2]

Dr O'Donnell reports no financial relationship with any company whose products are mentioned in this article, or with manufacturers of competing products.



The evidence suggests that men can benefit from infertility counseling as much as women do, but that they require additional precounseling education and a more structured approach to this type of intervention.[3] Further, a counseling format that involves both partners of a couple—or a group of couples—may improve communication and alleviate relationship strain.[4] The challenge to clinicians and mental health professionals is (a) identifying who would most benefit from counseling services; (b) determining which type of service is most effective; and (c) presenting services to promote participation by couples rather than women only.[5]

Before ART: The value of patient preparation and education

The experience of infertility and its treatment provokes significant stress, which is modulated by prior mental health stability, intrapersonal and interpersonal characteristics, coping styles, sociocultural influences, and the length of time spent

trying to conceive. Differences in the way partners acknowledge and manage stress symptoms can strain the relationship and add to the sense of helplessness many couples experience.[6]

Couples who are educated early in the treatment process about what to expect, how best to support themselves and their partner, and where they can go for additional resources report feeling better equipped to handle the emotional fallout of infertility treatment and possible treatment failure.[7] Psychological distress continues to be one of the main reasons couples cite for discontinuing treatment; therefore, education and efforts to reduce distress have implications not only for patient well-being but also for patient retention.[7-9]

Women frequently attend their first consultative infertility appointment without their partner. Many men report that their initial exposure to gynecological medicine is as mysterious as their understanding of menstruation. They are neither prepared to know more nor comfortable being asked to contribute beyond the initial diagnostic sperm sample, and for many men this is where their desire for regular participation in infertility treatment is inclined to stop.[10,11] Women describe feeling increasingly isolated during this period, losing faith in their body and previously held beliefs about their life path, ability to be happy, and their relationship.[7]

When couples present for treatment they are often unaware of the pervasive impact that assisted reproductive technologies (ART) can have on their lives. Although it might seem appropriate to describe infertility as a "couple problem," men and women generally experience treatment as observer and participant, respectively. Studies demonstrating gender differences in response to fertility treatment highlight the need to educate individuals about ways to traverse these differences[6,12] and, in fact, it is often lack of preparation—rather than unwillingness—that inhibits the participation of the male partner.

Evidence shows that men who receive pretreatment educational brochures are more likely to attend infertility appointments than those who do not.[13] Along with clinical protocols, referral packets should include a description of available counseling services and an explanation of their potential benefits; literature that addresses the needs of couples as well as individuals may encourage the participation of both partners in counseling. Finally, preappointment telephone calls directed toward each partner establish the expectation that the consult is intended for the couple rather than the woman only, thereby setting a precedent for follow-up visits.

TABLE 1

Fertility Problem Inventory

Scale	Sample Statements
Sexual concern	I feel like I've failed at sex.
Social concern	I feel like friends or family are leaving us behind.
Relationship concern	When we try to talk about our fertility problem, it seems to lead to an argument.
Need for parenthood	Having a child is not necessary to my happiness.
Rejection of a child-free lifestyle	It's hard to feel like a true adult until you have a child.

Score elevations detected with this tool are helpful in identifying elevated levels of infertility-related stress and in discovering areas of discrepancy between partners. Those differences are useful targets for education and counseling intervention. Used with permission from Newton CR, et al. *Fertil Steril.* 1999;72:54-62.

Strategies to successfully recommend intervention services

A couple's problem-solving skills might not be as effective as usual when dealing with infertility. It is possible that both fear and lack of "know how" in negotiating infertility's terrain underlie men's frequent reticence to engage in medical treatment or counseling: "I'm a guy, I don't really know all the ins and outs of it—just fix it and get back to me."

Physicians can offer couples a renewed ability to successfully manage the impact of infertility by referring them to resources that can teach new coping strategies, for example, listening to one's partner express their concerns rather than immediately offering advice. Information can go a long way in eradicating fear and enabling patients to successfully address the impact of infertility.

The Fertility Problem Inventory (FPI) provides useful baseline information for evaluating the level of difficulty that a

KEY POINT

Patient literature and preappointment calls directed at both partners promotes couple participation in infertility consults and counseling.

TABLE 2

The Stages of Change Model

Stages of Change	Associated Change Processes	Possible Interventions
Precontemplation	No perceived benefit to changing	Sharing evidence of benefit of education or counseling (suggested readings)
Contemplation	Assessing impact of distress on self and relationship	Review evidence of impact of infertility on life and relationships
Preparation	Considering effect of counseling support	Referral to resources, eg, introductory psychoeducational seminar
Action	Participation in counseling or supportive education	Group workshop, seminar, or couple counseling (cognitive behavioral or mind-body)
Maintenance	Reliance on learned skills	Ongoing application of learned skills

DiClemente CC, Prochaska JO. In: Shiffman S, Willis TA, eds. *Coping and Substance Abuse.* San Diego, CA: Academic Press; 1985:319-334.

KEY POINT

The Fertility Problem Inventory identifies the specific difficulties of an infertile couple, facilitating referral to appropriate mental health interventions.

couple diagnosed with infertility is experiencing.[14] This 46-item questionnaire measures perceived infertility stress on a 6-point Likert scale in 5 categories: sexual concern, social concern, relationship concern, need for parenthood, and rejection of a child-free lifestyle (TABLE 1). The FPI also includes an overall global stress score.

By highlighting specific problem areas, the FPI may be used as a reference point for offering interventions that match the stated difficulty. For example, couples for whom mutual support is a problem should be referred to programs that teach active listening skills.[14] Although the FPI was originally designed for use by mental health professionals, physicians may find the FPI helpful in promoting discussion of sensitive topics such as loss of desire, performance anxiety, and sexual dysfunction.

Couples facing reproductive challenges often report feeling stigmatized by an "invisible shame."[15] To diminish this effect, it is important that clinicians minimize the use of mental health labels. Emotional descriptions such as feeling sad or worried are more helpful to infertile patients than clinical labels such as depression and anxiety.[7] These distinctions are important because patients' perceptions of their emotions can drive the actions they are prepared to take to find help.

Men in particular may indicate that they believe they can overcome these feelings alone.[11] They report fear of being judged "deficient" and describe an unexpected burden at being unable to impregnate their partner. Men may view sharing their feelings about infertility as a conversation taboo: "If I told her how upset I was about not having kids…well, it would be like telling her she's fat—it's a cardinal sin." By discussing these feelings and assuring patients that their reactions are not unusual, clinicians can help alleviate a couple's discomfort and facilitate open and honest discussion.[11]

What type of intervention?

The relation of stress to infertility is long-standing and ambiguous. Credible evidence supports the connection between stress hormones and menstrual dysfunction, but the precise mechanism of action of stress on fertility remains unclear.[16] Psychogenic infertility[17,18] has fallen out of favor as an explanation for infertility,[19] placing a pall on the use of the word "stress" in association with reproduction. Some researchers have documented a clinical relationship between trait versus episodic anxiety and depression rates in pregnancy outcome and in vitro fertilization, while others demand caution in attributing a causal relationship between psychological characteristics and fertility.[20-22]

When referring patients for infertility counseling, clinicians can discuss how cognitive-behavioral and mind-body approaches to mental health treatment have demonstrated a benefit to individuals and couples experiencing infertility.[4,20,23] These interventions are designed

to address the complex physiological variability that accompanies infertility. They employ strategies that help to interrupt excessive rumination or fatalistic thinking, aim to instill and maintain realistic hope, and assist participants in recognizing their own physical and emotional manifestations of stress. Meditative and body-awareness techniques, such as breathing and progressive muscle relaxation, are used to facilitate greater identification between emotional distress and its impact on physical and physiological function.[24] Men have reported using deep-breathing techniques in particular to help slow their reaction time, decrease irritability, and reduce muscle tension during periods of stress and emotional arousal from infertility as well as other causes.[7]

More cost-effective than individual sessions, group interventions offer the benefits of peer support, decreased isolation, collaborative sharing, and an opportunity for role modeling or imitative learning among group members.

Promoting couple participation

Psychoeducational interventions that teach couples what to expect at the beginning of treatment and provide fundamental strategies for coping are highly valuable; they help to improve and maintain relationship integrity and equip couples with the communication skills to navigate unpredictable terrain.[4] A recent research project designed to evaluate a 1-day mind-body workshop for women and couples facing infertility revealed an important difference in several parameters between women who attended the workshop alone and women who attended as part of a couple. Couples who attended together reported higher levels of relationship conflict pre-workshop and improved interpersonal communication post-workshop; they were more likely to be using mind-body techniques a year later; and they had higher pregnancy and live birth rates.[7] Although this study was not large enough to suggest a cause-and-effect conclusion about the effect of individual versus couple participation, it does support the need to look more closely at this variable in treatment outcome.

Engaging men in counseling

Mental health outreach directed toward men is a severely neglected field.[25] Men are usually not socialized to seek professional help for emotional difficulties, and they tend to be particularly resistant to group activities that attempt to address mental health issues. With escalating treatment costs and a diminished ability to predict whether the physical and emotional investment will guarantee a successful pregnancy, couples—and men in particular—tend to ask how a given intervention might contribute to achieving a viable pregnancy. This is especially true of counseling, which is viewed by many men as ineffective, a sign of personal weakness, or simply, an elusive commodity.[5,25]

When assessing the readiness level of individuals to accept mental health interventions, physicians may find it helpful to keep in mind the Stages of Change Model (TABLE 2).[26] It is likely that women and men arrive at these stages at different points during their infertility experience. Typically, patients in a precontemplative stage of change will see less benefit to counseling than someone who is at a later stage in their desire to transform behavior. Women, who typically struggle with intervention schedules and medication protocols, may feel that they live with their body under a form of continual physical and emotional siege. They are far more likely than their male partner to discuss their difficulties with other women, friends, and relatives, and they may more readily perceive counseling as a part of the support they need.[4]

It may be possible to influence men to participate in seeking mental health support earlier in the course of ART treatment by providing patient handouts with prominent testimonials from men that convey the experience of infertility in a way with which male patients can identify. Men who have benefited from this type of service report a willingness to share their insights with other men who are considering participation (SIDEBAR).[7]

Conclusion

After attending counseling with his wife, Mr S reports that he is better able to understand how ART is affecting her, both physically and emotionally. He has also

KEY POINT

Body-awareness techniques focus patients on the connection between their stress and physiological function.

In Their Own Words

A woman's testimonial

I know I need to get the emotional support first. My heart has been broken....I learned through the workshop is that infertility is grieving. I don't believe anybody who already has a child could ever understand not having a child. I mean, my husband sees the sadness in me but he doesn't know what to say. Work is tainted beyond belief because I have had to tell people. I could have made up some other health problem, but people know about my infertility, people I never wanted to know. I feel so violated that I despise them. I feel embarrassed to go to work. —*Hillary*

Testimonials from men in counseling

I was looking for an answer or a solution when I first came. I was really judgmental, like, "How are they going to help me with my problem?" I saw by the end of the class it is not just me—it's lots of people who have the same problem....After the workshop, I have opened up more, talked to people about it. —*Howard*

The experience was eye-opening...hearing other people's perspectives on what they were going through, how they handled it. Picking up a new method to deal with it was good. When you start facing infertility, you are trying to tackle a problem and may not be doing it well. —*Graham*

KEY POINT

Testimonials that reflect typical male concerns about counseling may encourage men to seek mental health support.

gained new awareness of how ART has affected him. Because Mr and Mrs S attended a group therapy session, he was reassured to see that their interpersonal difficulties were not unusual. Mr S says, "I felt when we left the workshop, we left with something else."

It is possible to successfully support a woman or couple through infertility even if they do not achieve pregnancy. Future research will better explain the stress effects of infertility and provide evidence-based protocols that are more directly linked to pregnancy outcome. Until that time, clinicians should be aware of the research that does demonstrate the significant psychological and relationship strain that can result from infertility and consider the potential added benefit to medical treatment that mental health support can provide. ■

References

1. Gannon K, Glover L, Abel P. Masculinity, infertility, stigma and media reports. *Soc Sci Med.* 2004;59:1169-1175.
2. Pfeffer N. *The Stork and the Syringe: A Political History of Reproductive Medicine.* Cambridge, UK: Polity Press; 1993.
3. Ogrodniczuk JS. Men, women, and their outcome in psychotherapy. *Psychotherapy Res.* 2006;16:453-462.
4. Schmidt L, Tjornhoj-Thomsen T, Boivin J, Nyboe Andersen A. Evaluation of a communication and stress management training programme for infertile couples. *Patient Educ Couns.* 2005;59:252-262.
5. Englar-Carlson M, Shepard DS. Engaging men in couples counseling: Strategies for overcoming ambivalence and inexpressiveness. *Fam J: Counsel Ther Couples Fam.* 2005;13:383-391.
6. Petersen BD, Newton CR, Rosen KH, Schulman RS. Coping processes of couples experiencing infertility. *Fam Relat.* 2006;55:227-239.
7. O'Donnell E. Facing infertility: Design and evaluation of a mind-body program for providing effective emotional support [dissertation—mixed method, pilot study]. Cleveland, OH: Urban Education, Cleveland State University; 2006.
8. Domar AD. Impact of psychological factors on drop out rates in insured infertility patients. *Fertil Steril.* 2004;81:271-273.
9. Rajkhowa M, Mcconnell A, Thomas GE. Reasons for discontinuation of IVF treatment: A questionnaire study. *Hum Reprod.* 2006;21:358-363.
10. Throsby K, Gill R. It's different for men: Masculinity and IVF. *Men Masculinities.* 2004;6:330-348.
11. O'Donnell E. Hearing his voice: Men's experience with infertility. Cleveland State University; 2005:1-62.
12. Mindes EJ, Ingram KM, Kliewer W, James CA. Longitudinal analyses of the relationship between unsupportive social interactions and psychological adjustment among women with fertility problems. *Soc Sci Med.* 2003;56:2165-2180.
13. Pook M, Krause W. Stress reduction in male infertility patients: A randomized, controlled trial. *Fertil Steril.* 2005;83:68-73.
14. Newton CR, Sherrard W, Glavac I. The fertility problem inventory: Measuring perceived infertility-related stress. *Fertil Steril.* 1999;72:54-62.
15. Whiteford LM, Gonzalez L. Stigma: The hidden burden of infertility. *Soc Sci Med.* 1995;40:27-36.
16. Wilson JF, Kopitzke EJ. Stress and infertility. *Curr Women Health Rep.* 2002;2:194-199.
17. Benedek T. Infertility as a psychosomatic defense. *Fertil Steril.* 1952;3:527-541.
18. Bickers W. Uterine contraction patterns: Effects of psychic stimuli on the myometrium. *Fertil Steril.* 1956;7:268-275.
19. Wischmann TH. Psychogenic infertility—Myths and facts. *J Assist Reprod Genet.* 2003;20:485-494.
20. Domar AD, Friedman R, Zuttermeister PC. Distress and conception in infertile women: A complementary approach. *J Am Med Womens Assoc.* 1999;54:196-199.
21. Eugster A, Vingerhoets AJJM, van Heck GL, Merkus JMWM. The effects of episodic anxiety on an in vitro fertilization and intracytoplasmic sperm injection treatment outcome: A pilot study. *J Psychosom Obstet Gynaecol.* 2004;25:57-65.
22. Pook M, Tuschen-Caffier B, Kubek J, Schill WB, Krause W. Personality, coping and sperm count. *Andrologia.* 2005;37:29-35.
23. Tarabusi M, Volpe A, Facchinetti F. Psychological group support attenuates distress of waiting in couples scheduled for assisted reproduction. *J Psychosom Obstet Gynaecol.* 2004;25:273-279.
24. Gard G. Are emotions important for good interaction in treatment situations? *Physiotherapy Treat Pract.* 2004;20:107-119.
25. Rochlen AB, Hoyer WD. Marketing mental health to men: Theoretical and practical considerations. *J Clin Psych.* 2005;61:675-684.
26. DiClemente CC, Prochaska JO. Processes and stages of change: Coping and competence in smoking behavior change. In: Shiffman S, Willis TA, eds. *Coping and Substance Abuse.* San Diego, CA: Academic Press; 1985:319–334.