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The position of the fertility counsellor in a fertility team: A critical appraisal

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Abstract
The ongoing evolution of reproductive medicine has revealed the complexity of emotional reactions of couples seeking to fulfil their desire for a child. The position of counselling is evaluated from three perspectives: the couple, medical staff and the individual counsellor. This leads to three proposed levels of counselling, as an integrated component of Assisted Reproductive Technology (ART).

Keywords: *Infertility counselling, psychotherapy, case conference, emotional support*

Introduction

There is overwhelming evidence in the scientific literature on reproductive medicine and from clinical workers in the different disciplines involved in fertility clinics, that an unfulfilled desire for a child provokes an emotional crisis for the women and men involved and a challenge for the quality of the marital relationship and for the psychological resilience of both partners (Greil et al., 2010). Generally, in clinical studies, women present themselves with more emotional distress (anxiety and depression) than men (Greil, 1997; Wischmann et al., 2001). Moreover, there is an enormous difference between both sexes in help-seeking behaviour (Schmidt et al., 2003). But this does not mean that men are free from distress during this period of unfulfilled desire for a child. Much psychosocial research in this 'field makes use of self-reported questionnaires in which socially preferred answers are quite common. Men frequently use socially accepted escape routes such as their career to hide possible (temporary) sexual dysfunctions (Wischmann, 2010b). These different emotional reactions between women and men may threaten the communication, intimacy and sexuality in the couple's relationship. Recent studies have found that the quality of marital relationship has a direct correlation with the influence of this crisis on both individuals (Verhaak et al., 2001).

Many couples seem to have sufficient resources to cope emotionally well with this infertility crisis without the use of professional help (Boivin et al., 1999). Today, they have different ways to share their experiences with their social network, as well as companions in the virtual world of the internet. These chat rooms are frequently visited and experiences are shared (Wischmann, 2008).

Nevertheless, most couple find it necessary to make use of fertility counsellors in the multidisciplinary team of the clinic; the knowledge and experience they can offer provides sufficient support. However, many couples do not use this service actively (Boivin, 1997).

Moreover, in the medical and political world, there is a consensus that a fertility counsellor must be part of the team as a part of the multidisciplinary approach to the fertility problem of every couple (van Empel et al., 2010). It is a clear message to the couple that not only is the medical part of their infertility being addressed, but also their quality of life and the way they cope with the unfulfilled desire for a child.

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Who is the fertility counsellor?

The counsellor in most fertility clinics, institutional or private, is a person with a scientific background in the humanistic sciences (psychology, social work, etc.). In most cases, the counsellors have followed a psychotherapeutic course that influences them in the theoretical framework of their counselling (Corrigan et al., 2002).

This means that their way of working with clients is based on a psychodynamic, client-centred, systemic or behavioural model (Boivin & Kentenich, 2002). These different models influence their counsellor's approach to the emotional difficulties of the patients they are confronted with during the counselling sessions. This also influences their position and their way of communicating within their team (Monach, 2003). Although the way to it can be different, the goal of the counsellor's work is the same: to take care of the emotional well-being of the couple and if necessary, to increase their psychological defences or resources. It is a matter of empowering the patient and his/her reproductive autonomy with different tools to help them to help them go through the Assisted Reproductive Technology (ART).

The policy of a fertility team is mostly worked out by fertility doctors within a medical model. This policy influences strongly the position, role and resposibilities of the fertility counsellor within the team. This can lead to broad variation in the availability of the counsellor: on referral of the doctor or on the initiative of the couples who seek contact. It is evident that the motivation of the second group differs from the first. The motivation of the couple to seek counselling is strongly influenced by the manner in which the fertility doctors motivate their patients. The consequences for the counsellor's field of work vary from a strictly limited or focused work task to a broad openness in discussing all issues (not only fertility issues) in the life of the patient or the couple. The motivation to ask for counselling can also differ within the couple and can extend beyond surface emotional conflicts to examine the dynamics of the intimate relationship.

Responsibilities to the couple (see Thorn & Wischmann, 2009; Van den Broeck et al., 2010; Wischmann et al., 2002)

- Helping to clarify their possible ambivalent feelings as a result of being infertile as a couple,
- Helping to clarify their possible ambivalent feelings towards the technical aspects of their desire for a child,
- Helping to cope with confusing emotions as a reaction towards the bad news of a failed trial,
- Helping to make decisions during the fertility treatment, which include the possibility of ending treatment taking into account the emotional limits of one or both partners,
- Helping to communicate better as a couple about all these issues,
- Helping to cope with the reality of uncertainty and uncontrollability,
- Helping to clarify all the issues of the decision to third party reproduction,
- Helping to cope with traumatic experiences of pregnancy and loss (history of recurrent miscarriage, still birth etc.),
- Referral, if necessary, for more intensive psychotherapy.

Responsibilities to the team

- Helping the medical team to take into account the psychological suffering of the couple and to reflect on the influence this can have on the course of the medical treatment,
- Helping to teach the medical team to communicate adequately in this respect (if necessary with training in counselling), implying that every team member in the contact with the patient is a 'counsellor',
- Helping making decisions among the staff, if people are emotionally ready to start the next phase of their treatment.

This can lead to a conflicting situation because of the difference in expectations between medical staff and the couples.

The evaluation of the intervention work of counsellors in this field is embedded in the paradigm of reproductive medicine. Fertility clinics evaluate their work in terms of the number of treatment cycles, (un)successful treatments or the onset of pregnancies. Assisted Reproductive Technologiesare also frequently evaluated in the scientific literature in terms of the onset of new pregnancies. This means that all clinics count the number of initial pregnancies as a result of their assisted reproductive interventions. But how many fertility clinics publicise successful births of healthy babies (singletons), which is the final goal for the would-be parents (Wang et al., 2010)?

Counselling or psychotherapeutic interventions are also frequently evaluated in the scientific literature in terms of if, and how, they increase the number of onset of pregnancies according to the medical model. The effect of counselling or psychotherapy is evaluated only in quantitative terms. Psychotherapeutic interventions like cognitive behaviour therapy (individually or in group), couple therapy (psychodynamic or systemic) or hypnosis

are evaluated in terms of the increasing numbers of pregnancies started in a medical treatment protocol. By reducing anxiety or depression, this must lead to an increase of success in the medical treatment. This reflects exactly what the medical world expects. Until now, the results of scientific research could not provide clear-cut evidence that pregnancy rates are positively influenced by psychological interventions (Wischmann, 2008; Hämmerli et al., 2009). This leads to confusion about the role and the efficiency of the work of the fertility counsellor in the reproductive field. Nevertheless, from an evidence-based perspective, the factors leading to positive relieving effects of counselling across different approaches of psychotherapeutic background are clearly described in the literature (Boivin, 2006).

Doctors expect fertility counsellors to prepare patients emotionally for ART. For the medically schooled team members, the ideal couple is the one who adapts themselves to treatment without any annoying or disturbing emotional reactions. While most patients do not fit within this paradigm, it frequently depends on the personality or communicating qualities of the doctor as to how he or she deals with the emotional reactions of the couple. The consequence is that the reactions of the doctor frequently sound emotionally harder for the couple than is meant. Diagnosing azoospermia with the words 'Your count is zero' (Boyd, 1988) has a deep emotional impact on the man and his self-esteem. In this emotional reality, it has a different meaning for the doctor than for the couple. This kind of interaction between doctor and patient can reinforce or reduce the emotional burden of the couple. Well-intended advice turns out differently. Medical advice is not 'heard correctly' by the patient, and she risks receiving the etiquette reserved for the 'annoying' patient, which may reinforce a negative vicious circle.

One part of the role of the fertility counsellor in the team could be to demonstrate the impact of the doctors', nurses' and the lab staffs' behaviour on the emotional life and cognitive processes of the couple. Joint case-conferences provide a good framework to achieve this aim (see Figure 1).

Emotionally preparing couples for fertility treatment is not a matter of black and white: the couple are ready 'to go' or not. Standing still, doing nothing from an ART perspective feels uncomfortable when you are convinced you have to move forward. However, taking the time for accurate listening to the expression of the couple's emotional reactions when confronted with their infertility, the diagnosis and the indications for treatment, gives sometimes a clear and sometimes an ambivalent picture of what the couple is holding on to. While ambivalence is a normal emotional reaction for couples involved in this process, ambivalence does not always fit in the medical approach of the fertility problem.

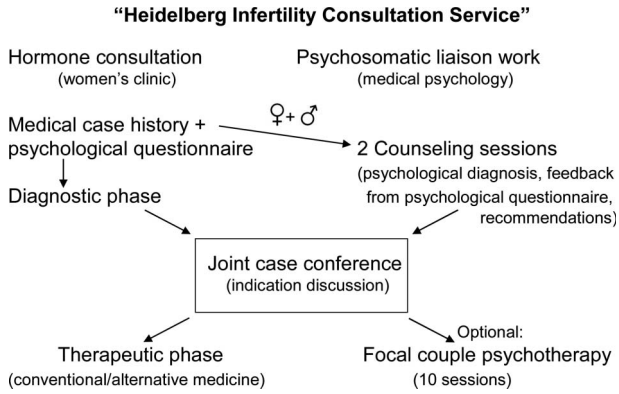

Figure 1. The Heidelberg infertility consultation service (reproduced by permission of *Involuntary Childlessness* by Bernhard Strauss, ISBN 0-88937-198-9, p 127–149, © 2002 Hogrefe & Huber Publishers, available at: www.hogrefe.com).

Does it mirror what couples expect of a fertility treatment?

A recent study (Bunting et al., 2010) shows once again the ambivalence of these couples. On the one hand they expect medical treatment that will be successful and safe without long-term physical effects. On the other hand, they are worried about long waiting lists or are afraid of possibly scary examinations and medical techniques and short-term physical and emotional effects.

Couples have the same expectations and goals as doctors: getting pregnant as soon as possible in order to become parents. Just as they will do 'everything' – some doctors are neglecting ethical and/or psychological limits to reach this goal as a consequence of their feeling of 'omnipotence' in life matters (e.g. achieving pregnancies above the age of 50 years) - and their notion ''Everything (is) conceivable'' (Mundy, 2007). Some patients learn quickly to talk the same medical or almighty language. At the beginning of the counselling, they state that they will do everything to become pregnant. This even includes a consultation with a counsellor or a psychologist. For most of them, this is something they never intended or expected to do. These patients do not realise by behaving this way, they reinforce the medical paradigm. And last but not least, they enhance the psychological pressure on themselves, increasing the risk of an emotional burden; a reality they try to avoid. They often expect only one thing from the counsellor; to help them get pregnant. There are many couples who are convinced that this is the only missing link to their having a happy life. Therefore, in their fantasies, there is no place for failure. But when the medical world fails in helping them conceive, they feel

obliged to visit a counsellor. This emotional attitude demeans the work of fertility counsellors; it reflects the couple's ambivalence towards a psychological approach to their difficult situation. They know you cannot get pregnant by talking and do not 'see' how counselling can work. But at the same time, they strongly hope it does, because they have knowledge of cases where counselling has led to pregnancy by resolving psychological issues. They try to convince themselves they can be one of the exceptions. The resolution 'I must give up my desire to have a child in order to conceive' can be considered psycho-dynamically as an – albeit paradoxically – attempt to influence positively the ultimately uncontrollable situation of a fertility disorder by consciously relinquishing control. Once again they will then reinforce psychological pressure on themselves and increase the risk of an emotional burden, struggling to control the uncontrollable reality (Wischmann, 2003). It is the responsibility of the fertility counsellor to make them conscious about these mechanisms putting themselves under pressure and to help them to find healthy coping styles to diminish this emotional pressure and to prevent an emotional burden. This goes frequently together with bringing in a smooth way the exposure to a life without children in the life scope of the couple, the neglected plan B.

Not all couples are caught in this medical paradigm. They expect other work from the fertility counsellor. Some ask help and support in their trying to cope with the burden of all bad news they received until now. Some ask help to improve quality of communication within their partner relationship. Some ask help for making difficult decisions in the treatment process. Realising the limits of the fertility treatments and of the doctors and realising their personal emotional limits, they dare to ask questions.

- When and how do we stop with medical treatment without regretting this decision in the future?
- Do we have to go further with treatment even when we cross frontiers we set for ourselves before we started any medical treatment?
- How do we cope with a third party reproduction technique?
- How can we live without children or can we evaluate if adoption could be an acceptable alternative perspective?

These are difficult emotional questions that influence the future life perspectives of these couples. A fertility counsellor can support and guide these couples to find answers for themselves to these questions by mirroring their emotions and ambivalences of both partners (Wischmann et al., 2002). A fertility counsellor can also pay attention to the influence of this searching process on the psychodynamics within the partner relationship.

Who could benefit from counselling?

From a counsellors' perspective, all couples who contact a fertility centre need a form of psychosocial care. Other words for it are *information gathering and analysis* and *implications and decision-making counselling* (Strauß & Boivin, 2002; see Figure 2). This includes transparent information about the reasons of reduced fertility or infertility, about the possibilities of treatment including counselling, what they can expect from treatment and how this treatment might interfere with their daily life. This need of the couples is also mirrored in the searching behaviour on the internet for information, not only on technical aspects but especially how others did experience such interventions (Tuil et al., 2009). Psychosocial care is more than just giving accurate information to the couples. Psychosocial care also means that the counsellor evaluates how couples cope with all this in the first place, technical information. It is not only a matter of understanding medical reasons of decreased fertility and medical techniques. First of all, due to being emotionally upset by the negative news on their fertility capacities, the couple reads with emotional *glasses* all this information. The way they read, capture and understand this information is a *reflection* of the way they cope with their emotions individually or as a couple. This psychosocial care could be done by any team member, who has skills in guiding conversations on this topic (Corrigan et al., 2002).

When this trying to cope runs emotionally difficult, some couples may benefit from *support counselling* by the counsellor team member. This counsellor helps them do deal on a healthy way with their emotions, doubts and questions they have. This can be on a short or long term during every phase of fertility treatment depending on the needs of the

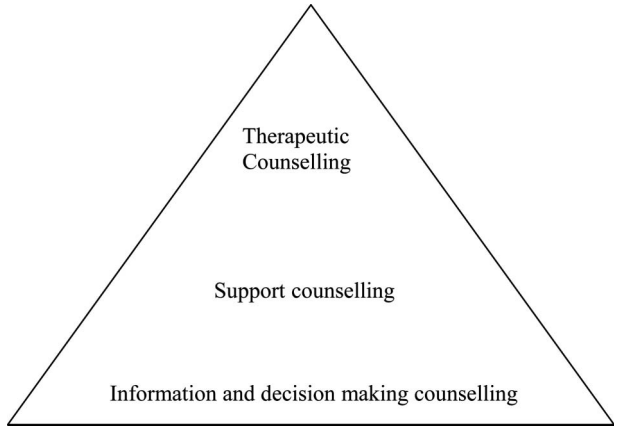

Figure 2. Hierarchy of counselling interventions.

couple. This emotional process must be geared towards the medical treatment.

When individuals or couples are really blocked on emotional issues during the treatment, which could be an indication of the onset of deeper individual or relationship difficulties, *therapeutic counselling* or even more intensive psychotherapy can be indicated to resolve these emotional conflicts (Verhaak et al., 2010). During this stage, it is not uncommon that the fertility treatment is temporarily at the background, to give space and time to the couple to intensify working on their emotional issues.

Nevertheless, the question can be asked if in a multidisciplinary team all members could be counsellors in terms of facilitating emotional support and empathising the emotional struggle the couple is going through. This implicates that all team members must be able to give psychosocial care to all patients before, during and after any treatment trial. Each member of the team should be aware of his or her limits: the limit of time as well as the limit of empathy. Here again conjoint case-conferences may help in reflecting communication processes, resources and deficits within the fertility team.

A fertility team can use different methods to improve the uptake of fertility counselling for their patients. Primary, the possibility of psychological support can be presented and explained in different ways (website or leaflets) at first before the medical approach is explained. Second, infertility counselling should be mandatory offered as an integral component of ART, and this should become evident for all patients right from the start of any infertility treatment. Third, the doctor who does the intake must be aware of making sufficient personal and direct contact with his patient. And finally, low-threshold psychological support must be offered to all couples, regardless their cause of infertility and regardless the way they (do not) express their emotional quality of life (Wischmann, 2010a).

This means the fertility team can also benefit from the work of the counsellor. While several studies (Malizia et al., 2009; Van den Broeck et al., 2009; Domar et al., 2010) have shown that there is a large number of drop out after the first-failed IVF trial, providing counselling on a good quality level to all these couples can help them to deal with this failure in a healthy way. This can lead to a change in the drop-out rate. During the counselling sessions, the couple can make a free and a conscious emotional well-balanced choice to continue or to finish medical treatment.

How do counsellors see their position within the fertility team?

The primary goal of a fertility counsellor is to evaluate the quality of the emotional life of the couple and to the threats for the personal and marital stability, provoked by this infertility crisis. Second, a fertility counsellor might identify the couple-specific concerns regarding undergoing treatment. For the couple, their emotional life and their future are threatened by the unfulfilled desire for a child (Burns & Covington, 2006). At the surface, they are initially convinced that only the reality of a pregnancy and a child can increase quality of life and bring back calm in their emotional life. For the counsellor, it is important to look at the ambivalences and resources of the individuals and of the couple they have to cope with and which they can activate and utilise to cope with this crisis. The strong and weak points of the individuals and of the relationship can play a role in the course of the treatment process. Mostly during an emotional crisis, the vulnerable spots of the individuals come to the surface and are enlarged. It is the responsibility of the fertility counsellor to guide the couple around the emotional pitfalls ('emotional roller-coaster', Menning, 1980) of the medical treatment. This can sometimes provoke conflict between the counsellor's approach and the urge of the couple to fill in their need of being pregnant. This can also be in conflict with the medical team that becomes inpatient and wants to do something to help the couple. It is sometimes hard to understand at a certain moment of treatment that it is better for the team not to be active instead of planning a medical intervention. Acting here and now is based on a short-term vision. Sometimes it is overlooked that becoming parents is an unchangeable lifetime responsibility. Not acting immediately by building in a period of rest is on the long run frequently more helpful and fruitful for the emotional balance of the couple. Creating sufficient space and sufficient time to resolve ambivalences and emotional problems make the couple free of emotional turbulences for accepting their child in an open and non-conflicting way. The counsellor should encourage the couples both to respect the influence of infertility on their emotional life and to limit its influence (Diamond et al., 1999).

Conclusions

All members of a fertility team who have a counselling function have to validate with respect the emotional experience of the couples. From this perspective, emotional reactions can be normalised. Psychological counselling should in different ways be offered to all couples in medical treatment, regardless of their individual diagnoses or stage of medical treatment and independent of treatment. This is only possible if infertility counselling should be an integral component of ART. It is the responsibility of the fertility team that this should

become evident for all patients right from the start of treatment. Although many countries in Europe have psychological guidelines in counselling, the reality shows that practice is sometimes far away from the good theory.

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