Assuring provision of mental health care to the most vulnerable patients: a renewed call for integrative care

Huang et al. (1) surveyed 463 women who had initiated at least 1 cycle of in vitro fertilization (IVF) using autologous oocytes. The primary objective of the study was to characterize the experiences of women in their older reproductive years to facilitate better counseling and support for this patient population. The investigators noted that the success rates using autologous oocytes in IVF with women aged ≥ 42 years are known to be universally low, and their goal is to better understand patient expectations and identify modifiable factors that impact decision regret.

The investigators found that among the women who were unsuccessful in their cycle, 40% reported moderate or severe regret in their decision to undergo IVF. In this group of patients, the perceived adequacy of information/counseling and emotional support were the strongest predictors and protective factors that influenced their level of regret. The investigators noted that, in their own clinic, there is no structured emotional support that is routinely offered as part of IVF treatment. They described that patient referral to a mental health provider is given by a physician if the patient is deemed in need of emotional support or when patients seek it out themselves. The investigators concluded that “early proactive inclusion of mental health specialists would be beneficial as part of this patient population’s treatment program.”

I am a clinical psychologist, and I have devoted my entire career (almost 20 years) to the field of reproductive psychology as a clinician, researcher, and educator. I was not surprised that the patient perception of emotional support mediated decision regret. I commend the investigators on conducting this important research. My hope is that the results of this study lead to more women accessing the mental health services that they need. I also hope that the findings lead to changes at the center where this research was conducted. This would be particularly important for women who, given their age at the time of treatment, have little chance of conceiving using their own oocytes but are not routinely offered mental health support.

I found myself thinking that maybe this will be the study that moves the needle and that, finally, the wealth of data that we already have regarding distress in patients who undergo IVF and the importance of mental health treatment will spark movement toward a truly integrative model of patient-centered care. We now have decades of research on the psychological distress that patients with infertility experience. We know that women who are unsuccessful in their IVF attempts experience the highest levels of distress. We also know that participants in this study had little chance of success using autologous IVF because of their advanced reproductive age. Yet, none of these women are being routinely screened for psychological distress, and none of them are being offered structured mental health support unless they pursue services on their own or a physician determines they need it. This is problematic because there are some data that suggest that even women at the highest risk for psychological distress after IVF treatment are not being referred to a mental health professional or even given information about mental health services (2).

Over the years, societies such as the American Society for Reproductive Medicine (formerly The American Fertility Society) and European Society of Human Reproduction and Embryology have developed multiple guidelines and opinions regarding the importance of and the need for mental health support for patients. By the definition provided by the American Society for Reproductive Medicine in the current ethic committee opinion on fertility treatment, when prognosis is very poor or futile, the women in this study would, at best, have a prognosis of “very poor” (1% to <5% chance of achieving a live birth) (3) and some may even be characterized as having a “futile” prognosis (<1% chance of achieving a live birth). In this same ethics document, the committee opines that in cases in which the chances of success are <1%, “psychological consultation is highly recommended for couples and individuals prior to undertaking treatment in such situations.”

I struggle with the seeming lack of attention paid to the multitude of studies that recommend psychologically screening high-risk patients or providing in-house psychological support, to say nothing of routine dissemination of mental health resources. For example, the study by Pasch et al. (2) is one of the only known studies to examine the extent to which patients and their partners are both receiving information about mental health services and engaging with mental health services. Pasch et al. (2) summarized what is often a common argument against recommending routine mental health care for all fertility patients: many patients cope with the stress of treatment on their own. The collective consensus appears to be that mental health care should be targeted toward those at risk; however, there is no evidence to suggest that the most vulnerable patients are being identified and referred appropriately.

Pasch et al. (2) investigated 352 women and 274 men across 5 reproductive endocrinology practices over 8 locations. The results were consistent with previous research in this area: most patients and their partners experienced clinically significant levels of both anxiety and depression. Yet, mental health services were not used by most patients, even those experiencing the most distress: there was no difference in the use of mental health services between distressed and nondistressed patients. Therefore, although patients who are unsuccessful in treatment are likely going to struggle more emotionally, they were clearly not identified or offered care and support. In addition, most egregious (to me) was that most of the patients in the study reported that their respective clinics had not provided them with any information about mental health services.

Fertility and Sterility published an article in 2013 that discussed what optimal IVF treatment would be like by

2020 (4). The investigators stressed the need to minimize the psychological burden of IVF and noted that psychological distress is one of the main reasons why patients drop out of treatment. The article provides clear guidance on the need to identify vulnerable patients through evidence-based screening before treatment. They noted the need for appropriate mental health referrals and suggested using a flowchart that would identify the stages of treatment where psychological support should be provided. I am disappointed that we have not achieved reasonable implementation in a more routine and consistent way across treatment programs.

A number of articles and book chapters have been written that provide clear guidance on how mental health care can be routinely implemented in treatment programs. There are a number of highly successful models across the United States and a recent study by Sax and Lawson (5) that overview a number of options that may be implemented, some at no significant cost to a clinic or practice. Given the mass movement toward tele-mental health as an acceptable form of intervention, it seems even clearer that there are few reasons not to include care that is extremely critical to the well-being of fertility patients.

This brings me back to the article that we are discussing. I would argue that the women represented in the study by Huang et al. (1) are among the most vulnerable of fertility patients for several reasons. It is likely the “last chance” to attempt to have a child using one’s gametes; and if unsuccessful (which most patients will be), there will be a host of complex psychological issues that will emerge. One is the grief over a failed cycle and, very possibly, the grief of realizing that one will never have a child who shares a genetic connection with the mother. There will be complex decisions to consider: whether this is the end of treatment, whether donor gametes may be used, and whether adoption is an option. These are complicated issues for which there is a lot of research evidence to show that involving mental health is of great benefit to patients.

Given that, going into treatment, the odds of a poor prognosis are almost certain for these women because of advanced reproductive age, this is a high-stakes psychological situation. I commend these investigators on reiterating the need to provide care in a proactive way. My hope is that this is the study that changes the course of mental health care in our field. If we, as a society, are committed to patient-centered care, then we must revisit the ever-growing need of using an integrative care model that includes routine mental health screening and services to patients undergoing fertility treatments.

Mary P. Riddle, Ph.D.
Department of Psychology, The Pennsylvania University,
State College, Pennsylvania

https://doi.org/10.1016/j.fertnstert.2022.04.007

F&S **DIALOG:** You can discuss this article with its authors and other readers at https://www.fertstertdialog.com/posts/35048

REFERENCES

1. Huang D, Jaswa E, Ransohoff A, Boscardin WJ, Pasch LA, Cedars M, et al. Decision regret after failed autologous in vitro fertilization in women ≥42 years of age. Fertil Steril 2022;117:1301–8.
2. Pasch LA, Holley SR, Bleil ME, Shehab D, Katz PP, Adler NE. Addressing the needs of fertility treatment patients and their partners: are they informed of and do they receive mental health services? Fertil Steril 2016;106:209–15.e2.
3. Ethics Committee of the American Society for Reproductive Medicine. Fertility treatment when the prognosis is very poor or futile: an Ethics Committee opinion. Fertil Steril 2019;111:659–63.
4. Gamerio S, Boivin J, Domar A. Optimal in vitro fertilization in 2020 should reduce treatment burden and enhance care delivery for patients and staff. Fertil Steril 2013;100:302–9.
5. Sax MR, Lawson AK. Emotional support for infertility patients: integrating mental health professionals in the fertility care team. Women 2022;2:68–75.