

## 4. Special questions in counselling

### 4.1 Pregnancy after infertility treatment

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#### Introduction

Patients' infertility history has an impact on the way they live through pregnancy and child-rearing. Infertility creates a crisis at the individual, relational and social levels. The transition from infertile patient to pregnant patient may be influenced by the individual fertility history of each patient, the way they have dealt with their infertility problem in the past, their sociocultural environment and the kind of treatment they have had.

#### Purpose

Infertile patients have had to go through tremendous efforts in order to have a child. The pregnancy represents an enormous investment of time, emotions, energy and often money. During the treatment patients focus on becoming pregnant. Patients have many fantasies about how extremely happy they will be once pregnant. However, when pregnant they have to deal with the possibility of complications and the risk of losing the pregnancy. This is especially problematic if they already have experience with reproductive loss. Clinical experience shows that anxiety and stress are increased during the pregnancy after infertility treatment.

Two extreme reactions in relation to the pregnancy might appear in some patients. Denial might occur in women who are not capable of developing an attachment to the fetus because of the anticipation or fear of negative events during pregnancy (e.g. miscarriage). Others may develop an exaggerated worry about each 'normal' physical event in the pregnancy (Covington and Hammer Burns, 1999). The fact that pregnant patients do not feel extremely happy about their pregnancy, as they feel they should, produces feelings of guilt and shame, which further reinforce feelings that may have developed when the infertility problem was first discovered.

Being pregnant introduces issues concerning the welfare and especially the health of the baby to be born. The patients' inability to conceive may have already produced a lack of confidence in their bodies and therefore might decrease the belief in their body's competence during pregnancy and delivery. Higher anxiety levels during the pregnancy are related to the IVF mother's concern for the well-being of the baby and

her fear of being separated from her baby after it is born (McMahon *et al.* 1997). Moreover, infertility patients have to deal with a lot of uncertainty about the quality of their future parent-child relationship and child-rearing practice. Becoming a parent has lost its naturalness. Patients often have the feeling that they have to prove that they will be worthy parents. Sometimes they even feel that they are not competent to be parents.

Patients who used donor gametes have a lot of worries and anxiety about the consequences of the use of donor material for the future father-child and mother-child relationship. Although most of them are counselled about matters such as anonymity of the donor and whether to tell the child about its conception, this discussion was mainly theoretical before the treatment started. Moreover, during pregnancy, anonymous material can introduce curiosity about the donor, anxiety about the donor's health and genetic background, anxiety about the physical characteristics of the baby and sometimes even a sense of alienation from the child to be born.

In all cases, counselling should also deal with the side-effects of assisted reproductive techniques such as multiple gestation, multifetal reduction and pregnancy risks due to a higher maternal age.

#### Objectives

The team should:

- (i) Facilitate the transition from infertility patient to pregnant patient. The patients must set themselves free from the infertility treatments and invest in the pregnancy. The patients must adjust to the pregnancy. They need to normalize the pregnancy and to develop an attachment to the fetus. Furthermore, they need to start an important role transition, i.e. the transition to parenthood. In clinics where obstetric and infertility teams differ, patients need to separate themselves psychologically from the infertility team and trust the obstetric team that will support them through the pregnancy and delivery.
- (ii) Reduce stress and anxiety levels, help patients to deal with their feelings of guilt and restore feelings of self-efficacy in order to help them to feel in control of their pregnancy.
- (iii) Reassure patients about the impact of the treatment on the health of their baby without underestimating the chance

of their having a baby with a congenital or genetic problem. Help them to deal with their fear of having a baby with a health problem.

(iv) Compare their anxieties and stress with those of patients who become pregnant by natural means: show the similarities and explain the differences resulting from the infertile situation. For every pregnant woman, pregnancy is a period of profound physical and emotional changes influencing body image, relationships with others and the identity of the pregnant mother. Moreover, the woman must share her body with another and develop an attachment with the baby. Some ambivalent feelings may occur during pregnancy. On the one hand, pregnant women develop a sense of accomplishment and a higher sense of self-esteem. Nevertheless, anxiety, self-doubt, lower self-confidence and distress about body competence can also occur in pregnant women, complicating adjustment to the pregnancy (Covington and Hammer Burns, 1999)

(v) Patients should be informed that some ambiguous feelings may exist towards the child. These feelings are often provoked by the idea that they have to be 'perfect' parents and that they may not meet this self-imposed standard. Moreover, transition to parenthood can be more difficult than they expected. Patients can also question the 'correctness' of their decision to have a child through IVF. Parents may worry that their child will be affected negatively if s/he is informed about her/his conception in a non-natural way. Continued counselling after the birth of the child should be available.

(vi) Cope with ambiguous feelings towards the fetus in third-party reproduction.

(vii) Counsel on matters such as secrecy and anonymity in third-party reproduction.

### Typical issues

The main problem encountered is that after the first ultrasound, performed at 7–8 weeks, pregnant patients and partners are often followed by obstetricians outside the infertility centre. From this point on, patients are considered by these teams to have a normal pregnancy. However, the majority of patients will feel differently with respect to their pregnancy than people who have never been infertile. In this context, previously infertile people do not allow themselves to have negative feelings and, therefore, deny any they experience. Only in interviews years after the child is born will patients recognize these feelings to some extent.

Moreover, the fertility team is often enthusiastic about the success of the treatment, forcing patients to react happily. Teams might show a lack of understanding for the doubts and uncertainties about the pregnancy of former infertile patients. Additionally, if patients have undergone multiple cycles of treatment before becoming pregnant, some physicians might become overprotective and overcautious.

IVF parents are more likely to have a multiple pregnancy. They should be counselled about the physical consequences and medical risks of multiple pregnancies and the stress involved in taking care of multiples.

### References

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