Treatment Strategies for Third-Party Reproduction

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Case: Glenda (age 38 yr) and Ted (age 40 yr) partners for 5 yr; history includes 3 failed cycles of gonadotropin with intratubal insemination (IUI); Glenda wishes to undergo in vitro fertilization (IVF), but Ted wants to “try naturally”; Glenda thinks she should put pregnancy on hold for Ted; Ted thinks Glenda “is obsessed”

Conflict: ambivalence and discordance between partners create need for negotiations about treatment; partners may have different levels of enthusiasm for having children and different feelings about possibility of being childless; partners may experience different circumstances within their lives and careers that influence timing of treatments; tensions related to infertility may resurrect other difficulties in relationship; one partner may have delayed childbearing so that other partner can complete schooling or other activities, and may therefore feel resentful

Case 2: same-sex couple Britney (age 28 yr) and Hope (age 31 yr), both have normal levels of follicle-stimulating hormone and antimullerian hormone; each prefers to use other’s egg; couple wants counseling to discuss selection of donor but has already scheduled and cancelled 3 appointments

Working with same-sex couples: negotiations may need to address which partner carries pregnancy, which partner genetically involved, method to be used to achieve pregnancy, and career issues; ages of partners must be considered; simultaneous pregnancies in both partners may be inadvisable because mutual support may not be possible; role of counselor to help patients make decisions while considering full range of issues

Ambivalence: may cause couples to drop out of treatment; in sample of >21,000 patients, discontinuation of treatment associated with psychological burden and relational and personal problems; counseling may be instrumental in overcoming these problems; issues couples face vary depending on stage and type of treatment; mental health professional must tailor intervention to needs of couple; in meta-analysis of 39 studies addressing issues of couples, psychosocial interventions, including cognitive behavioral therapy, efficacious for reducing psychological stress; ambivalence may be related to cost, age, or health; in addition, unconscious factors may include ambivalence about relationship, readiness or capacity to parent well, or effects of treatment on health or partner’s health; therapist may assist by helping couples separate fears from facts

Gender and individual differences: brain activity and emotional processing may be influenced by individual differences in personality, dispositional affect, gender, and genotype; studies show brain activity correlated with emotional response and emotional memory; styles of coping (defined as controlling and regulating stress) vary by gender; women use proportionally greater amounts of confrontative coping, accepting responsibility, seeking social support, and escape or avoidance; men use proportionally more distancing, self-controlling, and planful problem solving; men often report feeling powerless to help themselves and their partners; in study of coping strategies of couples undertaking IVF, women more affiliative and therefore more likely to seek out friends, while men often used planful problem solving; couples may establish daily 15-min period of discussion for hearing one another’s points of view

Behaviors and attitudes: influenced by conscious and unconscious factors; pursuit of goals related to marriage and reproduction unconsciously influenced by social features and norms, communication with others, and media; changes in behavior difficult to achieve; techniques couples use to try to change partner may be directive, authoritative, or emotionally evocative and may include bullying, threatening, or ultimatums; one partner may disengage, have difficulty coping, feel abandoned, or interpret actions of other partner as lack of interest; couples commonly present for therapy when methods of coping (such as fear or intimidation) become ineffective

Discordance: therapist should help couples define success; success may take many forms, including making peace with inability to achieve successful pregnancy, parenthood, or genetic parenthood; therapist facilitates open discussion of each partner’s internal dialogue; in Swedish study, heterosexual women displayed decreased satisfaction with relationship in areas of personality, children, family, friends, egalitarian roles, conception of life, and conflict resolution; heterosexual men experienced decreases in relationship satisfaction related to some of same things and overall; after assisted reproductive technology (ART) with donor sperm, lesbian couples reported stable

Educational Objectives

The goals of this program are to improve management of third-party reproduction. After hearing and assimilating this program, the clinician will be better able to:

1. Identify potential areas of conflicts between partners undergoing infertility treatment.
2. Recognize common gender differences in styles of coping.
3. Determine whether discordant couples with infertility would benefit from referral to a therapist.
4. Create instructions for pregnant patients outlining situations requiring a call to the office.
5. Manage pregnancies in women who have participated in third-party reproductive services.

Faculty Disclosure

In adherence to ACCME Standards for Commercial Support, Audio Digest requires all faculty and members of the planning committee to disclose relevant financial relationships within the past 12 months that might create any personal conflicts of interest. Any identified conflicts were resolved to ensure that this educational activity promotes quality in health care and not a proprietary business or commercial interest. For this program, members of the faculty and planning committee reported nothing to disclose.
relationships and high satisfaction with relationships even when treatment unsuccessful; heterosexual couples reported differences in many assessments but did not report low relationship satisfaction; these findings suggest good outcomes possible even if objectives of infertility treatment not met.

**Communication:** although couples may believe they communicate, true communication may not be taking place; assumptions about motivations of other person common; Gordon model assesses what speaker says, what listener hears, and what listener thinks speaker means; therapist may use “importance ruler” as tool to help couples rate importance of changing behaviors; for example, partners may rate importance of changing amount of time spent talking about infertility on scale of 1 to 10; therapist may then explore why they chose specific number; couples may be asked how ready they feel to undertake specific steps such as IVF, IUI, visiting physician for infertility, or having sex at right time of month; when positions of partners understood, therapist may help them negotiate, learn to respect legitimacy of needs of partner, and recognize possibility of gender differences in emotional processing; focusing on respect may be helpful; counseling can help couple negotiate, communicate honestly and clearly, and address fears and ambivalence.

**Pregnancy and Delivery for Third-Party Reproduction**

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**Comorbidities:** for reproductive endocrinology and infertility specialist, conception and pregnancy must be considered in light of risk factors (eg, advanced maternal age, medical problems including severe diabetes or hypertension); adjustments to care may be needed for patients undergoing ART.

**Prenatal care:** begins with usual history, physical, laboratory tests, and ultrasonography; provider should also offer anticipatory guidance; medical history encompasses genetics of family and health of surrogate; routine and optional laboratory tests and imaging procedures should be discussed.

**Optional procedures:** laboratory tests — tests such as quadruple screen (and now cell-free DNA) that offer estimates of relative risks for chromosomal abnormalities and spina bifida may be reasonable even if egg comes from young donor; compared with other patients, patients who have used ART equally likely to accept screening tests and termination of pregnancy for anomalies; ultrasonography — patients need only one ultrasonographic examination during pregnancy; 2-dimensional ultrasonography that assesses fetal anatomy adequate; patients who have had frequent ultrasonography in connection with ART may request more frequent and more complex imaging; however, frequent 3-dimensional ultrasonography not indicated for medical diagnosis.

**Additional prenatal care:** anticipatory guidance should begin during first visit; patients should know schedule of visits, reasons for calling, and common complaints during pregnancy; vaccinations should be checked; patients who have used ART accustomed to more frequent visits; postpartum visit important because patients with history of infertility or ART may be at higher risk for postpartum depression, and because contraception needed even for patients with history of infertility; emergencies — although patient may have spoken with infertility specialist daily, she now should be given list of reasons to call office emergently such as vaginal bleeding, blood pressure >160/100 mm Hg, absence of fetal movement after 28 wk of gestation, headache that does not respond to acetaminophen (eg, FeverAll, Panadol, Tylenol), or thoughts about wanting to harm self or others; less urgent problems — other reasons to call that do not constitute emergencies include decreased fetal movement after 24 wk, moderate elevations in blood pressure, or signs of preterm labor or rupture of membranes; patients should seek out social support for discussion of less critical problems such as swelling of feet, pain in back, hemorrhoids, constipation, fatigue, or sleep disturbance.

**Outcomes:** miscarriage — most pregnancies resulting from ART normal; miscarriage (loss of pregnancy before 20 wk of gestation) usually not treatable; when measures such as cerclage or antibiotics contemplated, risk-benefit ratios should be discussed; neonatal outcomes at early gestational ages and other possible outcomes such as maternal sepsis should be considered; discussion complicated when surrogate carrying pregnancy; fetal malformation — implications of some malformations difficult to determine until early in childhood; significance of known malformations may be discussed when anatomic ultrasonography performed in second trimester; preterm delivery — delivery between 22 and 37 wk gestation increased by 50% in women with multiple gestations, including twins; late-preterm or early-term deliveries (occurring between 37 and 39 wk of gestation) associated with increases in morbidity and time in intensive care nursery; delivery before 39 wk of gestation discouraged; twins may be induced at 37 to 38 wk (later than the previously used cutoff of 36 wk); major complications unlikely for late-preterm infants, but avoiding early birth may decrease probability of exposure to neonatal intensive care environment and reduce risks for infection, intubation, and pneumoperitoneum; each intervention creates potential for complications.

**Complications related to maternal age:** gestational diabetes and gestational hypertension or preexisting diabetes or hypertension more common in older and obese women; these disorders significantly increase risks for maternal medical complications; delivery (and sometimes premature delivery) often needed to resolve these problems; improving control of blood glucose or blood pressure increases chance for delivery at term.

**Intrapartum care:** birth setting — contraindications to home birth include high-risk patient, preterm pregnancy, nonvertex presentation, and lack of preparation on part of patient; although absolute risk associated with home birth small, risk for each individual pregnancy significantly elevated; patients encouraged to deliver in hospital, especially if older or overweight, carrying multifetal gestation, or has medical complication; birth attendant — choice of physician or midwife depends on preference of patient; many patients for whom beginning of pregnancy “medicalized” opt for midwife care; support — social support for patient challenging when space in delivery room limited; additional room may be needed for surrogates because >2 parents involved; labor difficult without support system; single mothers may benefit from working with doula; method of delivery — vaginal delivery associated with best outcomes; maternal risks associated with cesarean delivery include pain, bleeding, anemia requiring transfusion, development of scar tissue, need for subsequent cesarean delivery, and deep venous thrombosis; infants born by cesarean delivery at higher risk for admission to intensive care nursery; in surrogate birth, decisions complicated because additional people may wish to be involved in decisions; cutting umbilical cord — choosing individual who cuts cord may engender conflict; family members may be reassured that other opportunities available to share in care of infant; intrapartum complications — women at both extremes of gestational age at risk for arrest of dilation, arrest of descent, and maternal hemorrhage.
Anxiety and sexual stress in men


Postpartum: breastfeeding — patients should be informed that breast milk best nutritional choice; however, not all babies breastfed, and caregivers should not obsess about this issue; contraception — patients should understand that history of infertility does not preclude use of contraception; even if patient wants another pregnancy soon, she should be counseled that rates of preterm delivery and other complications increased when births occur <18 mo apart

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Suggested Reading


"Suggested Reading"
1. A lesbian couple wants 2 children and presents to discuss insemination. Both women are interested in carrying a pregnancy, and they are contemplating simultaneous pregnancies. Which of the following should the obstetrician recommend?

   (A) Suggest one pregnancy at a time and inseminate the oldest partner first
   (B) Inseminate both partners simultaneously
   (C) Ask the partners to return when they have decided which partner should be inseminated first
   (D) Recommend consultation with a therapist

2. In a sample of >21,000 patients treated for infertility, the major reason for discontinuation of treatment was:

   (A) Psychological burden
   (B) Fear of health problems in the future
   (C) Cost of treatment
   (D) Advanced maternal age

3. Which of the following styles of coping with stress is most strongly associated with male gender?

   (A) Accepting responsibility
   (B) Self-controlling
   (C) Escape or avoidance
   (D) Confrontative

4. When a couple has discordant approaches to infertility, the primary role of the therapist is to:

   (A) Suggest possible unconscious influences on attitudes
   (B) Explore how the couple would feel if they remained childless
   (C) Determine whether the relationship will be unnecessarily strained by infertility therapy
   (D) Facilitate open discussion of each partner’s internal dialogue

5. A study of couples in Sweden who used assisted reproductive technology (ART) found which of the following?

   (A) Lesbian couples became unsatisfied with their relationships after unsuccessful treatment
   (B) Heterosexual couples reported low relationship satisfaction after use of ART
   (C) A and B
   (D) Neither A nor B

6. Which of the following statements about antenatal screening is true of patients who have used ART to achieve pregnancy?

   (A) They are more likely to undergo such screening tests than other patients
   (B) They are less likely to undergo such screening tests than other patients
   (C) They are equally as likely to undergo such screening tests as other patients

7. In general, patients who have used ART to achieve pregnancy should be screened for anomalies with which of the following?

   (A) One 2-dimensional ultrasonographic examination
   (B) Two or more 2-dimensional ultrasonographic examinations
   (C) One 3-dimensional ultrasonographic examination
   (D) Two or more 3-dimensional ultrasonographic examinations

8. A pregnant patient should be instructed to call the office emergently for which of the following?

   (A) Blood pressure of 150/90 mm Hg
   (B) Headache that does not respond to acetaminophen
   (C) Decreased fetal movement at 25 wk of gestation
   (D) Back pain

9. What is the earliest gestational age at which induction of labor should be performed in a woman carrying a healthy twin pregnancy?

   (A) 36 wk
   (B) 37 wk
   (C) 38 wk
   (D) 39 wk

10. Contraception should be recommended at the postpartum visit for patients with a history of infertility who desire additional children.

    (A) True
    (B) False

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