NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

# Infertility and Loss

Media Conference

Stress and Infertility

*Trainee Guide*

## Contributors

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## Learning Objectives

By the end of this module, trainees will:

1. Demonstrate the ability to analyze issues related to stress and infertility as portrayed in the lay media
2. Be able to locate and interpret relevant scientific literature as it relates to issues raised in the media
3. Be able to communicate accurately and thoughtfully with a lay audience regarding issues surrounding stress and infertility

## Overview

With the ubiquity of digital and portable technology, women are exposed everyday to stressors via social media. This, in addition to personal stressors, may exacerbate comorbidities such as depression and anxiety. As a trainee, it is necessary to develop the ability to address patient's questions that will inevitably emerge from being exposed to social media, mass media, and popular culture. A physician should possess the ability to sift through all of this information in order to evaluate and present only empirically supported claims. Specifically, trainees should be able to interpret and convey data and statistics presented in lay media in an accurate and clinically relevant manner. Thus, the goal of the Perinatal Loss and Infertility Media Module is to provide trainees with communication skills that will enable them to serve as knowledgeable and thoughtful representatives of reproductive psychiatry.

This section consists of three parts: 1) review of two videos from the popular media; 2) appraisal of medical literature; and 3) role-playing a psychiatrist/patient interaction about how to communicate this topic to a lay audience.

The aim of reviewing the medical literature is to compare its findings with the information portrayed in the media. For the purposes of this exercise, the most relevant parts of medical literature are the abstract, the introduction, and the discussion. The aim is not to have an in-depth analysis of the article (which is an important skill for residents to master elsewhere in their training), but rather to delineate in broad strokes the gaps between the information presented by the media portrayal and by the medical literature.

The media conference is tailored for PGY-4 psychiatry residents but can be modified for any resident trainee group. A small group setting with time and space to work within break-out groups is recommended. After review of the media items and the medical literature, the residents will divide up into pairs to role-play the clinical interaction.

## Resources required
1) A faculty moderator
2) Copies of samples from media and relevant articles (provided)
3) Copies of Trainee Guide (provided)
4) Computer (with internet access) and projector

## Structure of the session
1. Review of media items (15 minutes): Faculty and residents together will review the media items
2. Review of medical literature (15 minutes): Faculty and residents together will discuss the literature and its portrayal in the media pieces
3. Role-play with case example (15 minutes): Pairs of residents will role-play a psychiatrist/patient discussion
4. Large group discussion (10 minutes)
5. Wrap-up and Q+A (5 minutes)

## Presentation of Media Items
ABC Action News (2014)
https://www.youtube.com/watch?v=ufBcFvUKXZc

Fox7 Austin, TX (2014)
https://www.youtube.com/watch?v=6vtPeiHhZ88

## Critique of Media Coverage
1) What is the central claim of these media pieces and how do they differ?

2) How do these media pieces influence (and potentially bias) the lay reader?

3) What questions do you imagine a patient who is considering pregnancy might ask after viewing these media pieces?

## Appraisal of Scientific Literature
Lynch et al. (2014)
https://www.ncbi.nlm.nih.gov/pubmed/?term=infertility+and+stress+AND+2014+AND+amylase

1. What is the study design? What “level” would this study design be? What are the strengths and limitations of this study design?

2. What are the pros and cons of using salivary alpha-amylase as biological marker for stress?

3. What is the primary conclusion of this study? Do the findings support the hypothesis? What are the clinical implications?

## Role-playing Exercise

Trainees should separate into groups of two with one trainee playing the role of psychiatrist and one playing the role of patient

## Sample Clinical Case

Kristin L. is a 37 year-old married G0P0 woman who works as an EMT with a history of depression who previously consulted with you for a preconception counseling appointment regarding concerns about taking antidepressants during pregnancy. During the prior visit, she relayed the following history:

Kristin experienced her first episode of depression when she was 17 years old. At the time she was under a great deal of pressure preparing for college applications and started isolating. Over the course of three months her mood declined and she isolated to the point that she remained in bed, could not complete high school, neglected self-care, lost 20 lbs and experienced almost daily passive death wish (PDW). This episode resolved when she saw her primary care physician who prescribed citalopram (titrated to 40 mg daily). She remained on citalopram with complete remission of symptoms through her early 30s. At this time, she was engaged to her prior fiance and they elected to start trying for pregnancy. She consulted her physician who recommended tapering citalopram over the course of three months. After four months, Kristin experienced a relapse of depression; she again was not able to work, lost 15 lbs over the course of a month, broke up with her fiance and started experiencing increasingly severe

PDW and suicidal ideation. She self-presented to her local ED and was psychiatrically hospitalized for one week during which they started her on sertraline. She has continued on sertraline 150 mg daily through present day. Her family history is notable for a mother with recurrent, major depressive disorder which has responded well to fluoxetine 60 mg daily. Her mother did not receive treatment for her symptoms until her mids-30s after she was hospitalized following an episode of postpartum depression following birth to the patient's younger sister. She attempted suicide by overdose and was started on paroxetine, which she continued until her 50s. The patient's younger sister also has a history of anxiety and depression, but refuses to take medications.

During your first consultation with the patient, you recommended and she agreed that given her history of recurrent, severe MDD that she would remain on her sertraline during pregnancy. She returns now however, because she and her husband (Bill) have been trying to conceive for the past eight months without success. She called to schedule the appointment after hearing about recent evidence linking stress to infertility. She states, "I feel like my trouble getting pregnant is my fault. My mood is better, but my job is stressful, but I think I would feel more stressed if I quit my job and had financial problems. It makes me feel as though I should have chosen a different line of work. If my work stress is going to prevent me from getting pregnant it's not worth it!" During the exam, she otherwise denies any symptoms consistent with depression and in fact is thriving her job, marriage and recently started a knitting group called, "Knits and Giggles."

## Patient then asks a series of questions

1) Is there a way to get a similar blood test like alpha amylase to test my stress levels to see if this is what is causing my trouble becoming pregnant?

2) Should I increase my antidepressant dose to reduce my overall stress?

3) What recommendations do you have about my case?

## Wrap-up and Q+A

1) For the learner role-playing the reproductive psychiatrist: what was challenging about this interaction?

2) For the learner role-playing the patient: what was it like to be on the "patient" side of this discussion? Was there anything in particular that your partner did that helped you feel more comfortable in your decision-making?

## References

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