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## **Title**

The impact of a self-administered coping intervention on emotional wellbeing in women awaiting the outcome of IVF treatment: a randomised controlled trial.

## **Running title**

Effect of a self-administered coping intervention

## **Authors**

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## **Running title**

Effect of a self-administered coping intervention

## 26 **Abstract**

27 **Study Question:** The aim of this study was to investigate the effect of the Positive  
28 Reappraisal Coping Intervention (PRCI) on anxiety in women awaiting the outcome of an  
29 IVF/ICSI cycle.

30 **Summary answer:** Women willing to participate in the RCT reported significantly more  
31 anxiety during the waiting period than before treatment but the use of the PRCI did not  
32 significantly reduce anxiety during the waiting period.

33 **What is known already:** Waiting for the outcome of IVF/ICSI treatment after embryo  
34 transfer is one of the most stressful periods of fertility treatments. At present, no evidence-  
35 based coping interventions are available to assist women through this waiting period. The  
36 PRCI has been designed to address this unmet need by promoting positive reappraisal coping.

37 **Study design, size, duration:** A three-armed RCT evaluating the PRCI women undergoing  
38 IVF/ICSI. Data were collected between October 2010 and June 2012. Participants were  
39 randomised to receive either PRCI and emotional monitoring, emotional monitoring only, or  
40 routine care. Only the PRCI-monitoring group received the coping intervention, comprising of  
41 an explanatory leaflet and 10 statements to be read at least once in the morning and once in  
42 the evening.

43 **Participant, materials, setting, methods:** To capture the general impact of the PRCI all three  
44 groups completed questionnaires at three time points: just before the waiting period (Time 1:  
45 stimulation phase), on day 10 of the 14-day waiting period (Time 2: waiting period) and 6  
46 weeks after the start of the waiting period (Time 3: six-week follow-up). In addition, to  
47 capture the specific impacts of PRCI on the days of the waiting period the PRCI-monitoring  
48 and the monitoring-control group also rated daily, for the 14-day waiting period, their  
49 emotions and reactions.

**Main results and the role of chance:** Three hundred and seventy seven of the women who agreed to participate and met eligibility criteria were randomised. Study participants reported significantly more anxiety and depression during the waiting period than before treatment ( $p < 0.001$ ). Mean difference in anxiety between time 1 versus time 2 was 1.465 (95%CI 1.098 to 1.832). Mean difference in depression between time 1 versus time 2 was: 0.514 (95%CI 0.215 to 0.813). Use of the PRCI did not significantly reduce anxiety or depression, or daily negative emotions during the waiting period. However, patients randomised to PRCI reported significantly more positive emotions during the waiting period ( $p < 0.001$ ) than the monitoring-control group, and reported the intervention to be easy to use, and as having a positive psychological effect. No significant differences were found between groups in treatment outcome.

**Limitations, reasons for caution:** The lack of difference observed in the present study between the PRCI and the monitoring-control could have been due to the effects of monitoring itself or its ability to attenuate or obscure effects of the PRCI intervention in unknown ways. A randomised group of women that used only the PRCI without daily monitoring would provide more insight.

**Wider implications of the findings:** The PRCI was shown to help women reinterpret the demands of the waiting period in a more positive way. These results are consistent with previous studies showing that positive reappraisal coping is a useful strategy for unpredictable and uncontrollable situations represented by a medical waiting period. This simple low cost self-help coping intervention increases positive affect during the waiting period in an IVF/ICSI treatment.

**Study funding/competent interest(s):** The Women and Baby Division of the University Medical Centre Utrecht funded the study. The authors have no conflicting interest(s).

**Trial registration number:** The study is registered at the Clinical Trials.gov (NCT01701011).

75

76 **Key words**

77 Coping-intervention, Medical waiting period, Randomised Controlled Trial, Anxiety, Positive  
78 emotions

79

80 **Introduction**

81 In health-care patients often have to deal with different waiting periods that could be stressful  
82 because the outcome of that period cannot be predicted or controlled, and is often difficult to  
83 manage (Boivin and Lancaster, 2010; Lancaster and Boivin, 2008). Theory shows that patients  
84 who are waiting for the results of medical treatments or examinations should use meaning-  
85 based coping strategies to deal with negative anticipatory emotions (Folkman and Lazarus,  
86 1988). Although medical waiting periods are stressful, research on coping interventions to  
87 deal with waiting periods is limited (Phelps et al., 2012).

88 Meaning-based coping strategies can be helpful in situations that involve a prolonged period  
89 of unpredictability and uncertainty. Tedlie Moskowitz et al. (1996) and Folkman and  
90 Moskowitz (2000) observed that the use of the coping strategy positive reappraisal, by carers  
91 of partners in the final stage of AIDS, led to positive emotions. People who use this strategy  
92 try to reinterpret the meaning of the situation so that they can obtain some benefit. Folkman  
93 and Lazarus (1988) suggested that the effect of positive emotions is to stimulate people to go  
94 on in their efforts to deal with these enduring stressful situations.

95 Woman undergoing fertility treatment, cope with an unpredictable and uncontrollable waiting  
96 period when they wait to find out whether or not treatment is successful. In a cross sectional  
97 study among 242 women undergoing fertility treatment, ten significant difficulties were  
98 identified like: monthly anticipation of treatment results (40%), lack of spontaneity in sexual  
99 relationship (30%), uncertainty regarding the future (29%), not being able to solve the

problem myself (17%) (Benyamini et al., 2005). Research shows that the most stressful parts  
 of a fertility treatment are the waiting period after embryo transfer (ET), doing a pregnancy  
 test and finding out treatment was unsuccessful (Boivin and Takefman, 1995; Eugster and  
 Vingerhoets, 1999; Merari et al., 1992; Verhaak et al., 2010; Yong et al., 2000). Although  
 women have increased anxiety and depressive symptoms during the waiting period after ET  
 (Boivin and Lancaster, 2010; Eugster and Vingerhoets, 1999; Lancaster and Boivin, 2008;  
 Yong et al., 2000) they often do not look for psychological support (Boivin et al., 1999; Van  
 Dongen et al., 2012). Arguments for not searching for professional support are perceived  
 difficulty of scheduling sessions, not knowing who to contact and potential cost of sessions  
 (Boivin et al., 1999). This lack of action occurs despite the fact that women often wonder  
 whether stress influences the outcome of their fertility treatment. Meta-analyses make  
 conflicting conclusions about the role of stress with a lack of effect on single cycles (Boivin et  
 al., 2011) but possible effects on multiple cycles of treatment (Matthiesen et al., 2011).  
 Narrative and meta-analytic reviews about the impact of psychosocial interventions on  
 anxiety, depression and treatment outcome are also inconsistent (Boivin, 2003; Hammerli et  
 al., 2009). Inconsistency in these reviews could be due to the fact that psychosocial  
 interventions are generally aimed at the entire fertility treatment and not on a specific stage  
 like the waiting period after ET. A review found that psychosocial interventions in infertility  
 which emphasized education and skills training that focused on specific targets were more  
 effective than more general interventions which emphasized emotional expression and  
 support (Boivin, 2003).  
 The Positive Reappraisal Coping Intervention (PRCI) is designed for medical waiting periods  
 such as waiting for the outcome of a fertility treatment. The PRCI consists of a card with ten  
 statements and an information leaflet about the coping strategy which was designed to  
 stimulate the use of positive reappraisal coping. The development of PRCI was in keeping

with the Medical Research Council framework for development of complex interventions: it used theory, integrated empirically validated determinants of behaviour, tested the acceptability and feasibility of the intervention and estimated effect size for future randomised controlled trials on effectiveness (Campbell et al., 2000; Craig et al., 2008). The development of PRCI is described in detail elsewhere (Lancastle, 2006; Lancastle and Boivin, 2008) but is briefly summarized here. Our goal was to develop a coping intervention that was theoretically derived, simple enough for untrained patients to use by themselves (whenever needed), sufficiently inexpensive to be made freely available, and generic so it could be adapted for other health contexts.

From these considerations PRCI was conceptualized using the cognitive model of stress and coping (Folkman, 1997; Folkman, 2011; Lazarus and Folkman, 1984) and the Velten positive mood induction procedures (Velten, 1968). The first pilot study generated the potential pool of statements for the PRCI card. Seventeen items with face validity as intervention items were selected from three existing coping scales (COPE questionnaire, problem-appraisal coping scale and Ways of Coping questionnaire). Two further items (“try to do something meaningful” and “try to do something that makes me feel good”) were adapted from a qualitative interview schedule designed to investigate the experience of positive meaningful events (Folkman and Moskowitz, 2000). Seven filler items were also added, each of which represented an alternative way of coping with stressful situations. In the first pilot study 36 patients waiting for assessment or treatment in the Accident and Emergency department were provided with a hypothetical scenario of a patient waiting for important medical test results and asked to imagine themselves in this situation and to rate (for all 26 selected reappraisal and filler coping strategies) whether they would use the strategy, find it helpful, and capable of making them feel more positive during this experience of waiting for important medical test results. The analysis showed discriminant validity with the capacity of positive

reappraisal items to make the patient feel more positive in this situation rated higher than for  
 filler items (i.e., other coping strategies, ( $t(35) = 2.13, p < .05$ ). As expected from theory, the  
 perceived helpfulness of the positive reappraisal items for this (unpredictable, uncontrollable)  
 medical waiting period was significantly higher than for the filler items (i.e., other coping  
 strategies). There was no gender difference in response to any items (all  $ps < 0.05$ ) and  
 internal reliability amongst all positive reappraisal items was high (Cronbach alpha 0.89 for  
 beneficial ratings). Given these results, the final selection of the ten PRCI statements was  
 based on optimising percentage of patients endorsing use of the item, correlation with other  
 items, perceived helpfulness and potential for improved positive mood ratings. A second pilot  
 study was conducted to further model the intervention. In this study the psychological  
 wellbeing of medical students who used the PRCI ( $n=19$ ) while they were waiting for seven  
 days to sit important exams was compared with a control group ( $n=20$ ) who did not receive  
 the intervention. Students who received the PRCI read the card as instructed (twice per day on  
 average), felt more optimistic about their exam results in the last three days before the exam  
 and reported marginally fewer physical stress reactions (e.g., racing heart, sweaty palms). The  
 acceptability and feasibility of the PRCI was explored in an RCT of 82 women undergoing  
 IVF who were randomly assigned to PRCI, a positive mood induction (PMI) control group ("I  
 feel good") or a daily monitoring control group. The RCT was additionally designed to  
 estimate effect sizes for PRCI effects on coping, appraisals and other psychological factors  
 related to the cognitive model of stress and coping (Lancastle, 2006). Women using PRCI  
 were found to appraise the waiting period as significantly more controllable ( $F(2, 79)=3.10, p$   
 $< 0.05$ ) and reported significantly more challenge appraisals ( $F(2, 79)=2.58, p < 0.05$ ) than  
 the positive mood induction group (Lancastle, 2006).



A feasibility study carried out in the Netherlands for the present study showed that 12/19 women (63%) undergoing IVF found the PRCI was suitable for this context and 17/19 (89.5%) rated PRCI as quick and easy (unpublished data).

These feasibility results suggest that PRCI could be useful for medical waiting periods and that there would be sufficient interest among patients to make feasible a full RCT within the two years available to do a trial. The aim of the present study was to investigate the effect of the PRCI on emotional wellbeing in women awaiting the outcome of an IVF/ICSI cycle. The primary outcome was general anxiety. Secondary outcomes were general depression, treatment specific positive and negative emotions, evaluation of the intervention and treatment outcome. It was hypothesised that PRCI would reduce general and treatment-specific negative emotions in infertile women waiting for the outcome of their fertility treatment compared to control conditions.

## **Materials and methods**

### **Trial design**

The PRCI was evaluated in a three-arm Randomised Controlled Trial (RCT). Participants were randomised to a PRCI-monitoring group or to one of two control groups: monitoring-control or routine care control group. To capture the general impact of the PRCI, all three groups completed anxiety and depression questionnaires at three time points: just before the waiting period (Time 1: pre-intervention), on Day 10 of the 14-day waiting period (Time 2: waiting period intervention) and 6 weeks after the start of the waiting period (Time 3: post-intervention). Mobile phone text reminders were sent to patients regarding completing the Time 1 and Time 3 questionnaires (if necessary) and all patients received a reminder just prior to the Time 2 assessment on the ninth day of the waiting period.

To capture the specific impacts of PRCI on the days of the waiting period, the PRCI-monitoring and the monitoring-control group also rated daily, for the 14-day waiting period, their treatment specific emotions and reactions. Daily monitoring has previously been shown to be an efficient and sensitive way of evaluating emotional reactions during fertility treatment, including the waiting period (Boivin and Takefman, 1995; Boivin and Lancaster, 2010) and to be sensitive to intervention effects during Assisted Reproductive Technologies (ART) (de Klerk et al., 2005). One potential drawback of this method of assessment is that it may impact on the reporting of emotions itself. For example, habituation or sensitisation to monitoring per se may decrease or increase reporting of anxiety compared to groups that do not monitor (Cohen et al., 1995). Due to this potential reactivity the monitoring-control group also monitored emotions and reactions daily during the waiting period. The routine care control group did not receive the intervention and did not monitor daily their reactions, but completed questionnaires as per the other groups.

## **Participants**

The RCT was conducted over a period of twenty months in a fertility clinic at a university hospital in the Netherlands. The sample size calculation for the three-arm RCT was based on the following parameters. To test the difference in psychological wellbeing between three groups with a power of 95%,  $\alpha=0.05$  and a medium effect size ( $f=0.25$ ), a total of 297 participants was required (99 patients per group) (Polit and Hungler, 1999; Polit and Beck, 2008). Taking into account a 20% attrition rate at least 124 women had to be recruited in each group. Effect size and attrition were derived from Lancaster and Boivin (2008). The inclusion criteria were woman undergoing a stimulated or cryopreserved IVF/ICSI treatment cycle. Women not speaking the Dutch language were excluded.

## **Intervention and control group**

The PRCI-monitoring group received the PRCI. The PRCI is a small card that contains ten positive reappraisal statements and a leaflet with a detailed explanation about this coping approach. See Figure 1 for the PRCI card (contact author JB for complete intervention, including PRCI leaflet). **Permission was obtained from Cardiff University to reproduce the PRCI card.** The leaflet instructed women to read the PRCI at least twice a day, once in the morning and once in the evening as well as at any other time they felt the need, and to think about how each statement applied to them personally. The other groups did not receive the PRCI.

## **Materials**

Data were obtained with self-reported questionnaires, daily monitoring and from the medical records. The following self-report measures were used:

The Background Information Form (BIF) is a 16-item self-report questionnaire designed to obtain demographic (e.g. age, educational status), medical (e.g. previous illness) and gynaecological (e.g. infertility diagnosis, previous infertility treatment) characteristics. This form was completed by all groups pre-intervention (Time 1).

The Hospital Anxiety and Depression Scale (HADS) was used to measure general anxiety and depression (Zigmond and Snaith, 1983). The HADS consists of 14 items (7 items for each subscale) that are rated on a 4-point Likert scale. The total score is the sum of the 14 items, and for each subscale the score is the sum of the respective seven items (ranging from 0–21). Scores on each scale can be interpreted in ranges: normal (0-7), mild (8-10), moderate (11-14)

and severe (15-21) anxiety and depression. The Dutch version of the HADS has been shown to be a valid and reliable instrument, including in the IVF/ICSI context (de Klerk et al., 2005). All groups completed the HADS at Time 1, Time 2 and Time 3.

The Daily Record Keeping (DRK) form was used to rate positive and negative emotions daily during the 14-day waiting period (PRCI-monitoring and monitoring-control groups only) (Boivin and Takefman, 1995). The DRK was developed for use in fertility treatment and comprises 46 possible reactions to the IVF waiting period, including the 20 positive and negative emotions used in the present analysis. Women endorsed each of the reactions provided on the DRK (e.g., happy, sad, anxious) according to whether, and to what extent, they had felt that way in the previous 24 hours. Emotions were rated on a scale from 0 to 3, with higher scores representing more emotion. These ratings were summed to compute positive and negative emotion subscales that Folkman and Lazarus (1985) proposed to be the emotional counterparts of particular appraisals of a situation. Negative emotions comprised threat (e.g., tense, worried) or harm emotions (e.g., sad, discouraged) whereas positive emotions referred to challenge (e.g., hopeful, positive) or benefit emotions (e.g., content, happy) (Folkman and Lazarus, 1985).

The DRK has been used in numerous treatment studies with the Cronbach alpha for the emotional subscale in the range of 0.76 to 0.82 for subscales (Boivin, 1997). The DRK item on vaginal bleeding (i.e., spotting) was also used and was rated in the same way. This item referred to light bleeding or spotting which occurs during the waiting period in approximately 30% of patients (De Sutter et al., 2006). Vaginal bleeding is not consistently associated with pregnancy outcome (De Sutter et al., 2006) but may nevertheless affect daily emotional reactions due to patient perceptions of the meaning of this symptom. The DRK was translated and used in a Dutch study that showed good correspondence between the original and Dutch

version, and acceptable convergent and discriminant validity with other measures of anxiety and depression (de Klerk et al., 2005). Participants were instructed to complete the DRK at the end of the day and for the PRCI-monitoring-group at least one hour after reading the PRCI card to limit the chance of DRK ratings being artificially and transiently influenced by completing the DRK. The PRCI-monitoring and the monitoring-control groups completed the DRK daily during the two-week waiting period from the day of ET until the day before the pregnancy test. Women also noted on the DRK the number of times per day they read the PRCI.

The Intervention evaluation form (IEF), a 23-item questionnaire developed to assess perceptions of intervention, was used to assess PRCI in previous research (Lancastle and Boivin, 2008). It measures the following aspects of the intervention: practicality (6 items), acceptability (4 items), endorsement and feasibility (4 items), perceived psychological effects (7 items) and perceived duration of intervention effects (2 items). The response scale varies by item. The PRCI-monitoring group completed the intervention evaluation form at Time 2.

A medical chart review at the end of treatment was used to obtain data about treatment outcome: clinical pregnancy and clinical pregnancy with fetal heartbeat. Clinical pregnancy is a pregnancy diagnosed by ultrasonography of one or more gestational sacs or definitive clinical signs of pregnancy (Zegers-Hochschild et al., 2009). Clinical pregnancy with fetal heartbeat is a pregnancy diagnosed by ultrasonography or clinical documentation of at least one fetal with heart beat (Zegers-Hochschild et al., 2009). The medical chart of all groups was examined at six-weeks follow-up.

## **Procedure**

296 The ethical committee of the University of Utrecht provided ethical review and approval for  
297 this study. The opt-in method was used to recruit participants as per requirements of the  
298 Ethics Committee. Participants were sent an invitation to the trial and if interested asked to  
299 contact the research team using the reply form or email address provided. A researcher  
300 contacted patients interested in the study to give more information about the study and answer  
301 any questions. Those who decided to participate were sent a written information sheet and a  
302 consent form to return in a pre-addressed stamped envelope. During their first visit to the  
303 hospital, more information was given about the logistics of the study, as needed, but all  
304 patients were given the same information according to a written protocol.

305 A computer-generated table of random numbers was used to achieve the stratified  
306 randomisation of the 372 women who met the eligibility criteria. The type of treatment  
307 (stimulated or with use of own cryopreserved embryos from a previous cycle) stratified the  
308 population because emotions and expectations relative to a stimulated IVF/ICSI may differ  
309 from a cryo-preserved treatment (Provoost et al., 2010; Svanberg et al., 2001). Randomisation  
310 took place after the first assessment (Time 1: pre-intervention) between follicle aspiration and  
311 ET. An independent researcher was responsible for the randomisation. Participants were not  
312 told what intervention was being evaluated, whether it was the intervention card or  
313 monitoring form or psychological questionnaires. The independent researcher had no contact  
314 with participants after randomisation. All women received written information about group  
315 assignment on the day of the ET. They received instructions for the waiting period in an  
316 opaque sealed envelope after the ET. The clinical staff that performed the ET was blinded to  
317 the content of the envelope. After the ET, there was no further contact between the clinical  
318 staff, other patients, or the researcher during the 14-day waiting period. An independent  
319 research assistant verified random data input for accuracy of the database.

320

## Statistical methods

IBM SPSS Statistics 20 was used to perform the statistical analysis. Descriptive statistics for means and standard deviations were used to describe baseline variables and outcome of the intervention evaluation. Equivalence of baseline measures between groups was examined by one-way analyses of variance (ANOVA) for normally distributed variables on interval or ratio level and chi-square for variables on nominal level. If the groups were not comparable on demographics, medical history, or gynaecological variables, those variables were employed as covariates or factors in subsequent analyses. The onset of menstrual bleeding during the waiting period could differ between women and therefore vaginal bleeding (i.e., spotting) was used as a covariate in analyses. A mixed model for repeated measures was used to examine the differences between the three groups over time for the primary outcome anxiety and secondary outcomes depression and treatment-specific positive and negative emotions. All models were estimated by the method of restricted maximum likelihood (REML) and the Compound Symmetry covariance structure was chosen for the repeated measures. For the DRK analysis, with 14 repeated measures, we used time as a continuous variable with a linear contrast. **The parameter of the convergence criteria was set at 0.000001(absolute).** Results for this outcome will be presented as slope over time and differences in slope between groups when a group by time interaction is analysed. The analysis was performed according to intention to treat. The main effect of time indicated change over time (regardless of group), the main effect of group indicated overall differences between groups (regardless of time) and the group by time interaction indicated differences between groups at each time point. One sample t-tests were used to test whether evaluations of the intervention within the PRCI-monitoring group were significantly different from the 'no effect' rating.

## Results

## Recruitment, participant flow and baseline data

Figure 2 shows the study flow chart. In the 20 months of recruitment, between October 2010 and June 2012, 1445 letters were sent to women with an invitation to the trial. Of the 565 women who replied via a letter or email, 188 (33%) were not eligible. See Figure 2 for the main reasons of non-eligibility. The remaining 377 women were randomised and the 349 who had an embryo to transfer (n=119 PRCI-monitoring, n=117 monitoring-control, n=113 routine care control) received an opaque sealed envelope after transfer with detailed instructions of the study procedures during the waiting period. The number of questionnaires returned at Time 2 was 79% (n=100) in PRCI-monitoring, 90% (n=114) in monitoring-control and 82% (n=102) in routine care control. The number of questionnaires returned at Time 3 was 72% (n=92) in PRCI-monitoring, 81% (n=102) in monitoring-control and 73% (n=90) in routine care control group.

Baseline characteristics of the participants are shown in Table I. The three randomised groups were similar on these baseline characteristics except previous use of counselling for infertility, which was more frequent ( $p=0.009$ ) in the PRCI-monitoring (21.4%) and monitoring-control groups (27%) than in the routine care control group (11.3%). This variable was used as a covariate in subsequent analyses. Participants were also similar on highest education achieved, duration of fertility treatment, child with current partner, child with previous partner, other medical problems, previous experience of miscarriage, abortion, ectopic pregnancy, stillbirth and perinatal death.

## Outcomes

All women used the PRCI. Women read the PRCI on average twice a day with a mean of 1.97 (SD: 0.63) and a range from 0.29-4.50. The percentage of women who read PRCI between 1



and twice per day was 47.5%. The percentage of women who read PRCI twice or more a day was 52.5%.

### **General anxiety**

The final model had a random intercept for subject and fixed effects for groups and time with adjustment for the baseline variable previous counselling for infertility and baseline anxiety. For the models for Anxiety and Depression, respectively 4.9% and 4.2% of the studentised residuals were outside the -2 to +2 range. Further, the maximum Restricted Likelihood Distance (ranged 1.0 and 1.3) and the covratio (0.80 to 1.10 and 0.70 to 1.10 for Anxiety and Depression respectively), all indicated no influential observations. The results for HADS-A anxiety indicate a significant main effect of time ( $F(2, 670)=47.37, p=0.000$ ), but no significant main effect for group ( $F(2, 373)=2.09, p=0.125$ ) or group by time interaction ( $F(4, 670)=1.79, p=0.129$ ). The contrast for the significant main effect of time revealed that for all groups the anxiety level was significantly higher during Time 2 (waiting period intervention), than Time 1 (pre-intervention) or Time 3 (post-intervention) (see Figure 3). The mean difference between time 1 versus time 2 was: 1.465 (95%CI 1.098 to 1.832). The mean difference between time 2 versus time 3 was: -1.783 (95%CI -2.175 to -1.392).

### **General depression**

The final model had a random intercept for subject and fixed effects for groups and time with the adjustment for the baseline variables previous counselling for infertility and baseline depression. The results for HADS-D depression indicate a significant effect of time ( $F(2, 673)=7.04, p=0.001$ ) but no significant main effect for group ( $F(2, 379)=0.32, p=0.728$ ) or group by time interaction ( $F(4, 673)=1.38, p=0.241$ ). Contrasts for the significant main effect of time revealed that the depression score was significantly lower at Time 1 (pre-

intervention), compared to Time 2 (waiting period intervention) and Time 3 (post-intervention (see Figure 4). The mean difference between time 1 versus time 2 was 0.514 (95%CI 0.215 to 0.813). The mean difference between time 1 versus time 3 was 0.457 (95%CI 0.148 to 0.766).

### **Treatment-specific negative and positive emotions**

The final model for the daily monitoring data had a random effect for subjects and fixed effects for groups and time with adjustment for vaginal bleeding (spotting). Influential observations for the final models were identified through the distribution of studentised conditional residuals. Only 4.2% of these residuals were outside the -2 to +2 range both in the models for both positive and negative affect. Further, the maximum Restricted Likelihood Distance (1.25 and 1.7) and the covratio (0.90 to 1.15 and 0.85 to 1.10 for positive and negative affect respectively), all indicated no influential observations.

Results for the DRK positive emotions indicated a significant main effect of time ( $F(1, 2669)=322.06, p=0.000$ ) and a significant group by time interaction ( $F(1, 2652)=16.15, p=0.000$ ) with a non-significant group main effect ( $F(1, 285)=1.44, p=0.231$ ). The significant main effect of time showed that the overall slope of positive emotions per day was -0.041 (95% CI -0.046 to -0.037) and the significant group by time interaction showed that the slope of positive emotions per day in the PRCI-monitoring group was higher (0.016, 95% CI 0.008 to 0.024) than in monitoring-control group.

Results for the DRK negative emotions for the two groups indicated a significant main effect of time ( $F(1, 2672)=73.93, p=0.000$ ) but no significant main effect of group ( $F(1, 292)=1.17, p=0.281$ ) or group by time interaction ( $F(1, 2655)=3.38, p=0.066$ ). The significant time effect showed the slope of negative emotions per day was 0.018 (95% CI 0.014 to 0.022). See Figure 5.

## Intervention evaluation

Women perceived that the stress of waiting would have been significantly higher without PRCI: mean (SD): 7.04 (2.27), then with PRCI, 6.27 (2.05), PRCI ( $t(101)=-7.20$ ,  $p=0.000$ ). Other aspects of the acceptability, feasibility and perceived helpfulness and benefits of PRCI were all significantly different from the ‘no effect’ point on the item response scale (all  $P$ s < 0.001). The effect of reading the PRCI was rated as lasting  $\leq 20$  minutes by 64.4%, mean (SD): 1.62 (1.02), which on average women perceived as long enough, 3.04 (1.41). PRCI was rated as helpful, 3.54 (1.26) and women would use it again, 3.73 (1.56), recommend it to friends, 4.01 (1.34) or recommend it for other medical waiting periods (e.g., genetic testing), 3.66 (1.22). Furthermore the psychological effect of the PRCI was perceived to be in helping to see things more positively, mean (SD): 4.78 (0.93), feeling more positive, 3.40 (1.34), and sustaining coping, 3.05 (1.45). PRCI was less perceived to be a distraction, 2.89 (1.60), and helping in making future plans, 2.36 (1.47). Practicality was good. PRCI was rated as suitable, mean (SD): 3.97 (1.25), for the waiting period, quick, 4.61 (1.18), and easy, 4.81 (1.07), to use. PRCI fitted in with the daily routine, 4.55 (1.19), and was not perceived to be a hassle to read, 1.89 (1.23). Women could memorise statements, mean (SD): 3.73 (1.31), but thought it was difficult to remember to read the card, 3.08 (1.61).

## Treatment outcome

No significant differences were found between groups on clinical pregnancy ( $p=0.83$ ) and clinical pregnancy with heartbeat ( $p=0.76$ ) (see Table II).

## Discussion

Waiting for the outcome of an IVF/ICSI treatment cycle was stressful with anxiety and depression levels during the waiting period significantly higher than before treatment. Women who used the PRCI intervention during the waiting period of IVF/ICSI reported significantly more positive affect but not significantly less anxiety, depression or negative treatment-specific emotions. Nevertheless, women evaluated the PRCI as acceptable, practical and they perceived a psychological benefit to its use. PRCI had no effect on treatment outcome. Overall, the pattern of results suggests that the main impact of PRCI was to make the stress of the waiting period seem more tolerable rather than in taking away the negative emotions waiting produces. This simple low cost self-help coping intervention can be offered to women to increase positive affect during the waiting period of fertility treatment.

Waiting for the outcome of treatment was perceived to be stressful and was associated with an increase in general anxiety and depression and negative emotions specific to treatment. These results are consistent with those of numerous studies on ART (Boivin and Takefman, 1995; Boivin and Takefman, 1996; Yong et al. 2000) that show that women appraise the waiting period as a potential threat and as causing related anticipatory negative emotions (e.g., feelings of worry, tension, nervousness). According to cognitive stress theory, the factors that make waiting periods stressful are the unpredictability and uncontrollability of the outcome (Lazarus and Folkman, 1984). Rumination about the outcome arrests the coping process because coping strategies would differ depending on whether one outcome (pregnant) or the other outcome (not pregnant) was most likely (Lancastle and Boivin , 2008). These results reinforce the need for effective coping interventions that help women manage the strains of medical waiting periods, such as waiting for the pregnancy test in IVF.

PRCI produced the effects for which it was designed, namely to help women reinterpret the demands of the waiting period in a more positive way. Women who used PRCI reported significantly more positive emotions (e.g., encouraged, content, confident) during the waiting period than did women assigned to the control group. In addition, patients perceived PRCI to have benefit in helping to manage the stress of fertility treatment, even though PRCI use was not associated with a significant reduction in negative emotional reactions (general or treatment-specific). The generation of challenge emotions (encouraged, confident) is in line with original development data that showed that women using PRCI made more challenge appraisals and perceived the waiting period as more controllable than women using a control intervention (Lancastle, 2006). We have collected further data (to be reported separately) on the effects of PRCI that shows that PRCI is associated with a greater use of positive reappraisal coping compared to the controls groups. Our results support other research showing that positive reappraisal coping is a useful strategy for unpredictable and uncontrollable situations like the medical waiting period (Boivin and Lancastle, 2010). Fredrickson (1998) proposes that positive affect can undo the after-effects of negative emotions. Positive affect may restore autonomic inertness following negative emotional arousal (Fredrickson, 1998). According to Folkman (2011) positive reappraisal and the positive emotions it produces, can allow “psychological respite” during the waiting period, which helps sustain coping during stressful situations. It should be noted too that the PRCI items although originally culled from positive reappraisal measures such as the ways of coping and COPE questionnaire may also tap into other related forms of meaning-based coping (e.g., benefit-finding). Future research needs to consider the extent to which cognitive efforts to redefine the situation and/or derive benefit act synergistically or independently to generate psychological benefits in uncontrollable and unpredictable situations like the waiting period.

493

494 We expected that the beneficial effects of PRCI (i.e., generation of positive emotions,

495 perceptions of helpfulness) would reduce the burden of waiting. However, women using

496 PRCI did not report lower day-to-day negative emotions during the waiting period (anxiety,

497 tension, nervousness), or lower general anxiety and depression during and after treatment.

498 Why the intervention only had an effect on positive affect is unclear but there could be a few

499 explanations. There is still an on-going debate about the importance of positive and negative

500 affect, and how they relate to each other (Folkman and Moskowitz, 2000; Folkman 2011).

501 The results of the present study indicate that feeling positive does not necessarily mean one

502 feels less negative. Cognitive reappraisal may play a more definite role in the ability to

503 regulate positive emotions whereas other types of coping (e.g., distraction, acceptance) may

504 be more central in the regulation of negative affect and symptoms of anxiety and depression

505 (Andreotti et al., 2013). The results suggest that interventions may need to comprise multiple

506 modes of coping beside positive reappraisal to help women deal with anxiety and depression

507 during treatment.

508

509 Research has demonstrated that positive affect is associated with better physical health and

510 lower risk of mortality, independent of negative affect (Folkman and Moskowitz, 2000;

511 Folkman, 2011). However, in the present study the use of PRCI was not associated with any

512 advantage for treatment outcome. This result is consistent with another study that showed that

513 positive affect was not related to pregnancy rates in fertility treatment (de Klerk et al., 2008)

514 but inconsistent with a study that found that enhanced positive affect was associated with

515 lower probability of failed treatment in IVF (Klonoff-Cohen et al., 2001). Our study differs

516 from the prospective study of Klonoff-Cohen et al. (2001) in the eligibility criteria and the

517 questionnaires and time points used for measuring positive affect. Past reviews and meta-

analytic studies on the impact of psychosocial interventions on treatment outcome are inconsistent (Boivin, 2003 ; de Liz and Strauss, 2005; Hammerli et al., 2009). Further our sample size calculation was not based on effect sizes for treatment outcome and therefore may be underpowered for this outcome.

The results need to be considered in light of the strengths and limitations which should also be considered for future evaluations of the PRCI tool. Feasibility studies had previously been carried out to determine key uncertainties like attrition, recruitment, effect size, acceptability and compliance of the intervention in the present (Lancastle, 2006; Lancastle and Boivin, 2008). Attrition was 20% (at Time 2), similar to that observed in previous studies (Lancastle and Boivin, 2008) but was about 30% at Time 3. The use of mixed or multilevel modelling (MLM) allowed analysis of partial response whilst maintaining power (Hoffman and Rovine, 2007). However, maximum likelihood estimation has been shown to provide unbiased and efficient estimates only when the data are missing at random (Hoffman and Rovine, 2007).

We contend this to be the case but it is possible that attrition was due to some unknown systematic cause. An important aspect of intervention evaluation is to ensure that the intervention is delivered consistently across participants and this is often achieved by manualising the intervention (e.g., manual for lifestyle intervention in infertility, see Ockhuijsen et al., 2012). As a self-administered tool the PRCI comes with a two-page leaflet that describes the rationale for the intervention, including the recommendation that it should be read PRCI twice daily. On average women complied with this recommendation (mean number of times read daily 1.97) but a proportion of women used it less frequently. Lower frequency could reflect that women became less interested in using the tool which could impact on PRCI effects.

542 The PRCI was designed to help women reinterpret the demands of the waiting period in a  
543 more positive way and we used the DRK, a measure of treatment specific reactions, to capture  
544 the daily effects of PRCI during the waiting period. However, because daily monitoring itself  
545 may have an impact on the reporting of emotions (Cohen et al., 1995) we added a monitoring-  
546 control group to disentangle between this methodological artefact and genuine effects of  
547 PRCI. We considered this control as a strength of the RCT though this may not be the case.  
548 In a parallel study, interviews among women with miscarriage showed that the use of the  
549 DRK was affecting emotions, as if the DRK itself was an intervention (unpublished data). If  
550 daily monitoring is perceived to be an intervention then the lack of difference observed in the  
551 present study between the PRCI and the monitoring-control group could have been due to  
552 active effects of monitoring or the possibility that active effects attenuated or obscured effects  
553 of the PRCI intervention in unknown ways. Further, the PRCI benefits may be due to an  
554 interaction between PRCI and monitoring. The use of a monitoring-control could thus be a  
555 weakness of the study because assessment and intervention were confounded. A randomised  
556 group of women that used only the PRCI without daily monitoring would provide more  
557 insight. We collected such data (n=110) and it would seem that daily monitoring attenuates  
558 the effects of PRCI on anxiety and the pregnancy rate. However, only a randomised trial  
559 could definitely identify the benefits of PRCI when it is administered on its own.

560 Another methodological limitation worth considering is the use of the opt-in method to recruit  
561 participants. In this method patients indicate a willingness to be included the study (opt-in)  
562 instead of the more conventional approach where all patients are enrolled in the trial unless  
563 they have indicated a willingness to be excluded (opt-out). Although the opt-out method  
564 produces a larger pool of eligible participants at recruitment, ethical committees often do not  
565 approve of this method, as was the case in the present RCT, because it requires repeated  
566 contact which may be burdensome for participants (Junghans et al., 2005; Treweek et al.,



2010). In an RCT designed to evaluate the effects of the opt-in compared to opt-out recruitment strategies, patients in the opt-in arm were healthier on clinical indicators (e.g., fewer risk factors, symptoms of disease etc) than patients in the opt-out arm, presumably because they could better manage the demands of the study (Junghans et al., 2005; Treweek et al., 2010). In the present study, it is likely that mainly women who were interested in psychological interventions opted-in to participate. Indeed, the overall percentage of past users (19.7%) of infertility counselling in the present sample was higher than previously reported in a British sample (8.5%) (Boivin et al., 1999). It could be that previous use of more in-depth psychological interventions had an impact on study results. Although numbers were too few in the present study to examine this issue fully it warrants consideration in future trials using the opt-in method. Overall readers should consider these limitations as they may affect generalizability.

Although PRCI was not associated with benefit on the psychological questionnaires it was on the intervention evaluation form. Positive evaluations on the intervention form could be due to demand characteristics. However, patient and researcher were not connected in any way, and the medical staff did not have access to any study responses, which makes this possibility unlikely. A discrepancy between outcome measures and intervention evaluations has been reported in previous research (Bird et al., 2011; Emery et al., 2003). In a qualitative study, 15 trial participants and five staff members were interviewed at the end of a trial evaluating a rehabilitation programme that had previously been highly rated by patients (Bird et al., 2011; Emery et al., 2003). Although no scientific evidence was found for the efficacy of the rehabilitation programme, participants and staff members continued to have strong views about the benefit of the intervention. During the interview one of the staff members suggested that "the trial had killed the intervention". Their perspective was that because the pilot phase

had in their opinion been a success, then the process of the RCT must have affected the intervention in such a way as to take away from its benefits. This too may have been an issue for the PRCI trial with, as noted, the addition of monitoring potentially impacting PRCI effects. Bird et al. (2011) recommended that the views and experiences of staff and participants be taken before and after conducting the RCT to evaluate the impact of investigative process on perceptions and we concur with this recommendation. Future research on PRCI could also identify for whom the intervention works best and whether the PRCI could be made more or less effective with change to the item list.

The pattern of results, theoretical, empirical and methodological considerations, all point to the main impact of PRCI as being to make the stress of the waiting period more tolerable than in taking away the negative emotions waiting produces. If PRCI was expensive or difficult to administer one might consider the costs and modest (mainly perceived) benefits of PRCI to argue against a recommendation for the waiting period. However, PRCI is self-administered, comprises a sheet of A4, and can be implemented at a time when patients are not in contact with the medical team or other patients for more interpersonal forms of support. As such we contend that the positive emotions and sense of being helped that PRCI generates are sufficient for it to be offered singly or in combination with other interventions to help women manage the demands of the ART waiting period. Future research should investigate whether PRCI helps to make other medical waiting periods more tolerable.

## **Authors roles**

H.O. designed the trial, monitored data collection for the whole trial, wrote the statistical analysis plan, cleaned and analysed the data, and drafted and revised the paper. A.H. designed the trial, drafted and revised the paper. M.E. cleaned and analysed the data. N.M. initiated the project, designed the trial and revised the draft paper. J.B. designed the trial, designed

intervention and data collection tools, cleaned and analysed the data, and drafted and revised the paper.

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## **Conflicts of interest**

None declared

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