ORIGINAL RESEARCH ARTICLE

# The Impact of the Follow-Up Care Model on the Resilience of Women Referring to the Infertility Clinic: A Quasi-experimental Study

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## Abstract

**Background** Resilience is a critical factor that can positively influence an individual's quality of life. Among infertile couples, resilience serves as a protective factor against psychological distress and feelings of helplessness. This study aimed to evaluate the impact of a follow-up care model on the resilience of infertile women.

**Methods** This quasi-experimental study included 90 infertile women referred to the infertility clinic of Bent Al-Hoda Hospital in Bojnurd, Iran. Participants were assigned to either the intervention group (n = 45) or the control group (n = 45) based on predefined inclusion criteria. Data collection tools included a demographic questionnaire and the Connor-Davidson Resilience Scale. The intervention was delivered according to the follow-up care model. Statistical analyses were performed with a significance level set at $p < 0.05$.

**Results** There were no statistically significant differences between the intervention and control groups in demographic characteristics. In the intervention group, all resilience subscales showed significant improvement following the intervention ($p < 0.05$). In contrast, no significant changes were observed in the control group. Post-intervention comparisons indicated a statistically significant effect of the follow-up care model on resilience ($p < 0.001$).

**Conclusion** The findings demonstrate that the follow-up care model effectively enhanced resilience among infertile women. It is recommended that health authorities develop and implement educational and support programs based on this model in infertility treatment centers to promote the mental health and resilience of this population.

**Keywords** Infertility, Female, Resilience, Psychological, Patient Care Management

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## 1 Introduction

According to the World Health Organization (2023), approximately one in six individuals, or 17.5% of adults, experience infertility. This underscores the urgent need for accessible, affordable, and high-quality fertility services.[1] A 2023 meta-analysis by Abanegah et al.[2]on the prevalence and contributing factors of infertility in Iran reported a lifetime infertility prevalence of 11.3%, with primary infertility at 18.3% and secondary infertility at 2.5%. The causes of infertility were distributed as follows: female factor, 32%; male factor, 43.3%; both partners, 12.5%; and unexplained causes, 13.6%.

Infertility represents a complex life crisis that is psychologically threatening and emotionally stressful. Some researchers have likened its psychological impact to general grief reactions.[3] Infertility and its associated factors are linked to psychosocial stress, decreased life satisfaction, increased marital difficulties, reduced self-confidence, and lower sexual satisfaction, with women typically experiencing more pronounced individual and social impacts.[4] The stress associated with infertility can negatively affect emotional and social well-being, decrease satisfaction with oneself and relationships, and may even lead to psychological imbalance, relationship breakdown, or divorce.[5,6] Among the factors that can mitigate these effects, resilience plays a critical role in improving individuals' quality of life.[7]

Resilience is a dynamic process through which individuals demonstrate positive adaptive behaviors when facing adversity.[8] It is considered an intrapersonal factor that facilitates adjustment to illness and supports mental health, as grounded in positive psychology.[9] In infertile couples, resilience serves as a protective factor against psychological distress and contributes to enhanced quality of life.[10] Resilience-based strategies help individuals recognize that while certain painful or uncontrollable events cannot be changed, they can influence their perception and response to these events. Such interventions encourage individuals to confront long-avoided aspects of their lives, acknowledge adverse events with courage, and understand that lasting security and constant happiness are unattainable, thereby promoting adaptive coping and well-being .[11]

The Continuous Care Model is an indigenous Iranian healthcare approach. It involves a systematic, ongoing process that fosters effective, interactive, and sustained communication between clients and healthcare providers. This model aims to identify clients' needs, support adoption of health-related behaviors, and enhance recovery and overall health outcomes.[12,13]

Previous studies have examined psychotherapy and resilience among infertile women. For instance, Jalili reported that participation in eight sessions of existential psychotherapy significantly increased resilience in infertile women.[14] Similarly, Jamasianmobarakeh et al. (2017) found that reality therapy-based training enhanced resilience and improved quality of life among infertile patients.[15] Given the importance of continuous care in promoting self-care, it is essential to identify a relevant and practical model that can effectively support education and communication with infertile women. However, to date, no study has specifically investigated the effect of the Continuous Care Model on the resilience of infertile women, and existing evidence shows inconsistent results.[14,15] Therefore, this study aimed to evaluate the effect of the Continuous Care Model on resilience in infertile women.

## 2 Methods

This quasi-experimental study was conducted on infertile women attending the infertility clinic at Bent Al-Hoda Hospital in Bojnourd, Iran, following approval from the relevant institutional ethics committee.

Sample size estimation was performed using G*Power software. A total of 90 participants were required, with 45 allocated to the intervention group and 45 to the control group. The calculation was based on a Type I error probability of 0.05, a study power of 80%, and an effect size of 0.6.

Eligible participants provided written informed consent prior to enrollment. Convenience sampling was employed to recruit participants according to the following inclusion criteria: women aged 20–45 years; a confirmed diagnosis of infertility based on physician evaluation and medical records; infertility attributed to female factors; duration of infertility ≤5 years; no participation in resilience-related educational programs in the preceding six months; absence of psychiatric disorders; no experience of traumatic or stressful events within the past six months; and at least basic literacy skills. Exclusion criteria included becoming pregnant during the study, unwillingness to continue participation, or missing any educational sessions.

Data were collected using two instruments. The first was a demographic questionnaire, which recorded participants' age, spouse's age, education level, spouse's education level, place of residence, occupation, spouse's occupation, economic status, number of marriages, duration of infertility, family history of infertility among relatives, and previous unsuccessful infertility treatments. The second instrument was the Connor-Davidson Resilience Scale (CD-RISC), which assesses psychological resilience across multiple dimensions.

The intervention was delivered through the Continuous Care Model, consisting of eight educational sessions, each lasting 30–45 minutes. Sessions were structured to provide ongoing support, enhance adaptive coping

strategies, and strengthen participants' resilience in the context of infertility. The control group received standard care without the additional structured intervention.

### Measurement of Resilience

Resilience was assessed using the Connor-Davidson Resilience Scale (CD-RISC), which comprises 25 items scored on a 5-point Likert scale ranging from "never" to "always." Higher scores indicate greater resilience, with total scores ranging from 0 to 100 .[16] The face and content validity of the CD-RISC were previously verified in Iran by Khoshuei et al.[17] who reported a Cronbach's alpha of 0.89. In the present study, the test-retest method was employed to assess reliability, yielding a Cronbach's alpha of 0.89, confirming the tool's suitability for this population. The CD-RISC includes five subscales:

- Perception of personal competence (items 10, 11, 12, 16, 17, 23, 24, 25)
- Trust in instincts and acceptance of negative emotions (items 6, 7, 14, 15, 18, 19, 20)
- Positive acceptance of change and healthy relationships (items 1, 2, 4, 5, 8)
- Control (items 13, 21, 22)
- Spiritual influences (items 3, 9)

### Continuous Care Model Intervention

The Continuous Care Model consists of four interconnected stages: familiarization, sensitization, control, and evaluation.[18] Before the intervention, both groups completed the resilience questionnaire. The control group received standard care, which included midwife-led education on paraclinical procedures, self-care, and medication adherence. The intervention group received ongoing training and care based on the Continuous Care Model.

### Session 1: Familiarization Stage

This 15–30-minute session introduced the care providers to participants, clarified participants' situations, outlined medical staff expectations, and identified the women's expectations and concerns. Scheduling of in-person or phone follow-ups and explanation of communication goals were conducted. Family participation was required during this stage.[12]

### Sessions 2–3: Sensitization Stage

The aim was to engage the client and her family. Participants were informed about the nature of infertility, potential complications, limitations, and their educational and skill-based needs. Key topics included diet, medication adherence, physical activity, stress management, and strategies to optimize daily functioning. Training was delivered in small groups of 4–5 participants through lectures and Q&A sessions, lasting 30–45 minutes per session, depending on client tolerance. This stage also emphasized adherence to medical instructions and the importance of regular physician visits.[19]

### Sessions 4–8: Control Stage

This stage focused on internalizing and maintaining health behaviors. Activities included reviewing acquired skills, assessing stability of health behaviors, identifying emerging needs, reinforcing positive actions, and problem-solving with client and family participation. Education, follow-up counseling, and re-sensitization were conducted weekly via phone or in-person sessions as needed. Each session lasted approximately 15 minutes, scheduled according to participants' preferences. The sessions emphasized personalized educational content, problem-solving, and ongoing support to maintain health-promoting behaviors.[20]

### Evaluation Stage

The evaluation stage assessed the overall effectiveness of the model. This involved analyzing resilience questionnaire results, clinical and paraclinical findings, participant feedback, and the sustainability of health behaviors. The resilience questionnaire was re-administered to all participants, and outcomes were compared between the intervention and control groups. [20]

### Statistical Analysis

Data were analyzed using SPSS version 18. Descriptive statistics included means, standard deviations, percentages, and proportions. Inferential analyses employed t-tests and analysis of covariance (ANCOVA) for quantitative variables, and Chi-square or Fisher's exact tests for qualitative variables. Statistical significance was set at $p < 0.05$.

## 3 Results

A total of 90 infertile women referred to the Infertility Clinic of Bent Al-Hoda Hospital in Bojnourd participated in this study, with no sample attrition. The Chi-square and Fisher's exact tests showed no statistically significant differences in demographic characteristics between the intervention and control groups (Table 1).

Table 2 presents the comparison of total resilience scores before and after the intervention in both groups. In the control group, the mean total resilience score was 51.22 (SD = 20.69) before the intervention and 50.74 (SD = 20.54) after the intervention, showing no statistically significant difference ($p = 0.20$). In contrast, in the intervention group, the mean total resilience score increased from 70.13 (SD = 10.61) before the intervention to 80.88 (SD = 11.63) after the intervention, indicating a statistically significant improvement ($p < 0.001$).

**Table 1** Comparison of the demographic characteristics of the participants

| Variables | | Intervention group (n, %) | Control group (n, %) | Sig. |
|---|---|---|---|---|
| Patient Education | Below diploma | 17 (37.8%) | 21 (46.7%) | $X^2 = 2.026$, p = 0.363* |
| | Diploma | 13 (28.9%) | 16 (35.5%) | |
| | University | 15 (33.3%) | 8 (17.8%) | |
| Husband's Education | Below diploma | 17 (37.8%) | 16 (35.6%) | $X^2 = 0.849$, p = 0.654* |
| | Diploma | 14 (31.1%) | 18 (40%) | |
| | University | 14 (31.1%) | 11 (24.4%) | |
| Economic Status | Poor | 12 (26.7%) | 8 (17.8%) | $X^2 = 1.286$, p = 0.526* |
| | Moderately acceptable | 27 (60%) | 30 (66.7%) | |
| | Good | 6 (13.3%) | 7 (15.5%) | |
| Smoking | Yes | 2 (4.4%) | 1 (2.2%) | F = 0.508, p = 0.595** |
| | No | 43 (95.6%) | 44 (97.8%) | |
| Underlying Disease | Yes | 8 (17.8%) | 9 (20%) | $X^2 = 1.268$, p = 0.260* |
| | No | 37 (82.2%) | 36 (80%) | |
| Number of Marriages | Once | 36 (80%) | 41 (91.1%) | F = 0.828, p = 0.504** |
| | More than once | 9 (20%) | 4 (8.9%) | |
| Patient age | Under 30 years | 24 (53.3%) | 25 (55.6%) | $X^2 = 0.029$, p = 0.864* |
| | 30–40 years | 21 (46.7%) | 20 (44.4%) | |
| Husband's Age | Under 30 years | 17 (37.8%) | 22 (48.9%) | $X^2 = 2.082$, p = 0.149* |
| | 30–40 years | 28 (62.2%) | 23 (51.1%) | |
| Place of Residence | Urban | 32 (71.1%) | 35 (77.8%) | $X^2 = 0.014$, p = 0.907* |
| | Rural | 13 (28.9%) | 10 (22.2%) | |
| Patient's Occupation | Housewife | 38 (84.4%) | 42 (93.3%) | F = 0.906, p = 0.464** |
| | Employed | 7 (15.6%) | 3 (6.7%) | |
| Husband's Occupation | Worker | 22 (48.9%) | 17 (37.8%) | $X^2 = 3.343$, p = 0.188* |
| | Employee | 8 (17.8%) | 4 (8.9%) | |
| | Self-employed | 15 (33.3%) | 24 (53.3%) | |
| Duration of Infertility | 5–10 years | 30 (66.7%) | 30 (66.7%) | $X^2 = 0.068$, p = 0.795* |
| | 10–15 years | 15 (33.3%) | 15 (33.3%) | |
| Previous Treatment Failure | Yes | 21 (46.7%) | 23 (51.1%) | $X^2 = 0.214$, p = 0.643* |
| | No | 24 (53.3%) | 22 (48.9%) | |
| Family History of Infertility | Yes | 11 (24.4%) | 5 (11.1%) | $X^2 = 0.760$, p = 0.383* |
| | No | 34 (75.6%) | 40 (88.9%) | |
| History of Mental Illness | Yes | 5 (11.1%) | 3 (6.7%) | F = 0.090, p = 1.000** |
| | No | 40 (88.9%) | 42 (93.3%) | |

* Chi-square test
** Fisher's exact test

Moreover, based on the paired t-test results, all resilience subscale scores in the intervention group showed statistically significant improvements after the intervention ($p < 0.05$). In contrast, none of the subscales in the control group demonstrated significant changes ($p > 0.05$). Because the mean resilience scores and subscale values differed significantly between the intervention and control groups at baseline ($p < 0.05$), analysis of covariance (ANCOVA) was employed to examine the effect of the Continuous Care Model on resilience while controlling for pre-test differences. Prior to conducting ANCOVA, its assumptions were evaluated. The homogeneity of regression slopes was confirmed ($p > 0.05$), and Levene's test indicated that the assumption of homogeneity of variances at the post-test stage was also met ($p > 0.05$). Therefore, the use of ANCOVA was deemed appropriate.

Table 3 presents the ANCOVA results. After controlling for pre-test scores, the difference in post-test resilience between the intervention and control groups was statistically significant ($p < 0.001$), indicating a positive effect of the Continuous Care Model on participants' resilience.

**Table 2** Comparison of the mean resilience scores between the control and intervention groups

| Dimensions of Resilience | | Control group (mean, SD) | Intervention group (mean, SD) | Independent t-test p-value |
|---|---|---|---|---|
| Perception of Personal Competence | Before intervention | 15.87 (7.27) | 22.25 (4.79) | < 0.001 |
| | After intervention | 15.83 (7.28) | 26.15 (4.30) | < 0.001 |
| | Paired t-test results | 0.16 | 0.00 | - |
| Trust in Instincts and Tolerance of Negative Emotions | Before intervention | 12.87 (5.81) | 18.23 (3.49) | < 0.001 |
| | After intervention | 12.72 (5.65) | 21.78 (3.54) | < 0.001 |
| | Paired t-test results | 0.24 | 0.00 | - |
| Positive Acceptance of Change and Secure Relationships | Before intervention | 11.24 (4.08) | 14.10 (2.85) | < 0.001 |
| | After intervention | 10.91 (4.09) | 16.23 (2.48) | < 0.001 |
| | Paired t-test results | 0.20 | 0.00 | - |
| Sense of Control | Before intervention | 6.13 (2.99) | 8.90 (2.05) | < 0.001 |
| | After intervention | 6.13 (2.98) | 9.65 (2.06) | < 0.001 |
| | Paired t-test results | 1.000 | 0.05 | - |
| Spiritual Influences | Before intervention | 5.11 (2.01) | 6.65 (1.51) | < 0.001 |
| | After intervention | 5.15 (1.89) | 7.08 (1.16) | < 0.001 |
| | Paired t-test results | 0.68 | 0.05 | - |
| Total Resilience Score | Before intervention | 51.22 (20.69) | 70.13 (10.61) | < 0.001 |
| | After intervention | 50.74 (20.54) | 80.88 (11.63) | < 0.001 |
| | Paired t-test results | 0.20 | 0.00 | - |

**Table 3** Results of the ANCOVA analysis on the effect of the continuous care model on resilience

| Source of Variation | Sum of Squares | Degrees of Freedom (df) | Mean Square | F Value | Significance Level (p-value) |
|---|---|---|---|---|---|
| Pre-test | 19530.183 | 1 | 19530.183 | 341.619 | 0.160 |
| Group | 2714.657 | 1 | 2714.657 | 47.484 | 0.000 |
| Error | 4745.061 | 87 | 57.169 | - | - |
| Total | 404331.000 | 90 | - | - | - |

## 4 Discussion

This study evaluated the effect of the Continuous Care Model on the resilience of infertile women. Consistent with our findings, Jalili et al. reported that existential psychotherapy positively influenced resilience in infertile women.[14] Similarly, Jamasian Mobarakeh et al. found that reality therapy improved resilience subscales, aligning with our results showing that the Continuous Care Model also enhanced these dimensions. However, unlike our findings, their study reported no effect of reality therapy on the "spiritual influences" subscale of resilience.[15] Fadaee et al. demonstrated that implementing the Continuous Care Model improved quality of life among infertile women, particularly in social and emotional domains,[19] which complements our finding that this model effectively increases resilience. While Fadaei et al. focused on quality of life, the present study applied the model specifically to enhance resilience.

Mirzaei et al., in a correlational study, examined mental health and marital burnout among infertile women and found that family resilience mediated these relationships.[4] Similarly, Wang et al. reported that family resilience was associated with infertility stigma, positive coping, and individual resilience, supporting the relevance of resilience in coping with infertility.[21] Additionally, a cross-sectional study by Ha and Ban found that resilience significantly affected quality of life in infertile couples. Their study employed the Wagnild and Young Resilience Scale and was conducted on couples rather than individual women,[22] whereas the present quasi-experimental study focused specifically on infertile women using the CD-RISC.

Evidence from other clinical contexts also supports the efficacy of continuous care interventions. Baghaei et al. found that implementing a continuous care plan improved anxiety, pain, and hospital readmissions in heart failure patients.[23] Similarly, the present study showed that the Continuous Care Model effectively enhanced resilience among infertile women. In a comparative study, Jebraeili et al. used the CD-RISC to assess resilience, meta-emotional beliefs, and psychological well-being in fertile and infertile women. Their results indicated significant differences in all resilience subscales between groups,

which aligns with the observed improvements in the intervention group in the present study.[24]

To our knowledge, this is the first study to examine the effect of the Continuous Care Model on resilience among infertile women. One limitation is that participants were recruited from a single infertility clinic at Bent Al-Hoda Hospital in Bojnourd. Given the province's ethnic diversity, cultural differences may influence health behaviors, beliefs, and perceptions about infertility, which may limit generalizability to other regions.

## 5 Conclusion

The findings demonstrate that the Continuous Care Model significantly improved resilience in infertile women. Future studies could enhance reliability by implementing longitudinal designs with multi-month follow-ups and training sessions. Expanding research to include both fertile and infertile men and comparing their outcomes with those of women is also recommended.

For clinical practice, it is advised that health and treatment authorities develop and implement educational and supportive programs based on the Continuous Care Model in infertility treatment centers. These interventions should be ongoing, delivered by trained multidisciplinary teams, and integrate psychological and social support alongside standard medical care to promote mental health and resilience in infertile women.

## Declarations

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**Artificial Intelligence Disclosure**
No artificial intelligence tools, including AI-based text generation or image creation software, were utilized in the preparation, analysis, or composition of this manuscript. All aspects of the work were performed independently by the authors.

**Authors' Contributions**
A. A. & N. S & M.B & T.F Conceptualization, methodology, investigation, data collection, writing the original draft
M.H.B Conceptualization, methodology, investigation, writing the original draft, writing, review & editing, supervision, project administration
M. A. & A.N Conceptualization, investigation, data collection
H. S. Conceptualization, writing the original draft, data analysis, writing, review & editing. All authors approved submission of the final version.

**Availability of Data and Materials**
The data collected and analyzed during this study are not publicly available due to privacy protection and ethical considerations but are available from the corresponding author upon reasonable request.

**Conflict of Interest**
The authors declare no conflict of interest.

**Consent for Publication**
Not applicable.

**Ethical Considerations**
This quasi-experimental study was approved by the Ethics Committee of North Khorasan University of Medical Sciences with the clinical trial registration code IRCT: 20230126057235N1 and ethics approval code IR.NKUMS.REC.1401.088.

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