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# An Infertility Primer for Family Therapists: II. Working with Couples Who Struggle with Infertility\*

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*The distress of infertility and its medical treatments are profound, and the effects reverberate in each partner, the couple dyad, and the couple's relationships with family, friends, and medical systems. Yet family therapists, like others in our society, are often uninformed or misinformed about the experience of infertility. While the legacies of infertility may be painful and enduring, they often remain unspoken, and hence may be overlooked in standard interviews. This article describes the experiences of couples struggling with infertility, most of whom have sought medical intervention, and it provides treatment interventions for guiding couples through this difficult and often uncharted terrain.*

*Case vignettes derived from 2 years of this clinical research study are included.*

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You were made out of our love and hope. We wanted to be parents. We wanted to create a life that we could love and nourish. We wanted to see a more perfect version of ourselves. We wanted to create us. We wanted to heal our childhood wounds and have the family we never had. Our hearts are heavy still. Our losses weigh heavily on us. We wonder why we have been denied the gift of life. And yet we live on together.<sup>1</sup>

**C**HILDREN provide existential meaning, identity, and status; they grant parents the traditional means of participating in the continuity of a family, a culture, and the human race. The majority of North American couples marry with the intention of having children (Matthews, 1991). Couples who practice contraception engage in a ritual that reinforces their supposition that they are fertile. Before

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<sup>1</sup> Written by a couple struggling with infertility; the text is part of a requiem ritual following a stillbirth.

marriage, mate selection criteria may include an assessment of a future spouse's parenting potential; after marriage, preparation for the anticipated children can be highly structured.

A couple made critical life decisions assuming they would have a child: the wife selected a career that would not conflict with childrearing; they uprooted themselves from their neighborhood and friends and moved to a child-centered community with good schools and parks; and they bought a home to fit a child's needs. Infertility deprived them of the child, the keystone that would give their lives structure and meaning.

Once diagnosed as "infertile," most people assume an infertile identity: they are beset by blame, guilt, self-accusations over past behaviors, and thoughts about incompetence and physical abnormality. The bearing of a child, an act of consummate "normality," becomes a means of liberation from the negative identities that cluster around infertility. Some older couples facing age-related infertility, who chose or were forced to delay child-bearing, may find identities apart from parenthood; they are able to accept childlessness with relative equanimity (Ireland, 1993). Most others, aware of their declining fertility, may become more riveted on having a child than their younger counterparts.

When one or both partners put aside other activities and interests and devote most of their energies to becoming pregnant, the strains of conducting such a unidimensional life take their toll. Sexual activity becomes a chore; sensual pleasure and spontaneity evaporate. While tensions may arise between partners regarding medical interventions and/or alternatives to biological children, they may also cleave more tightly to each other, feeling isolated from the "normal" world.

Since most couples are bound together by the implicit and/or explicit presumptions of parenthood, during the long or-

deals of unsuccessful treatments, couples may ask themselves: "If we cannot have a baby, should we be married?" The spouse diagnosed with infertility may worry that the other will leave in order to have a biological child with a new mate. The fertile spouse may indeed fantasize leaving—in part to have a child and in part to flee the anguish infertility creates within the relationship.

### Assumptions and Paradigms

An encounter with infertility necessitates an encounter with one's explicit and implicit assumptions about one's self, one's partner, and the future. One may find oneself at odds with a cluster of assumptions that had served as a foundation for one's life—assumptions about gender, marriage, parenthood, generativity, sexuality, health, competence, control, and success. Couples may also find themselves confused and at odds with each other when each partner's previously unarticulated assumptions surface; they may become increasingly alienated from and/or polarized toward each other.

A couple shared a strong desire for children, but both partners were in conflict over initiating expensive fertility procedures. The husband, coming from a Depression-scarred family, opposed costly infertility protocols, preferring the certainty of adoption; he felt that financial security was more important than having a biological child. The wife, while eager to experience pregnancy and childbirth, was especially convinced that the only means of receiving validation from both families of origin was through the birth of a biological child.

### Hope and Despair

Women's monthly cycles and infertility treatment protocols generate emotional oscillations: hope with each ovulation and new procedure, despair with the onset of each menstrual cycle, negative laboratory results, or miscarriage; stillbirths follow-

ing labor and delivery are particularly painful. Unfortunately, these distressed couples have little time or opportunity to grieve as they are pressured by the "ticking clock" to launch into still more treatments.

Contemporary North American society offers no mourning rituals for couples grappling with repeated miscarriages—the "forgotten grief" (Kirkley-Best & Kellner, 1982). While some hospitals may compound the grief by placing a woman who has miscarried on a maternity ward, other hospitals have changed their policies, and some offer bereavement counseling for couples who have miscarried (McDaniel, Hepworth, & Doherty, 1992).

#### Distress and Secrecy

The psychological distress resulting from infertility and its treatments may impair each partner's capacity to comfort and support the other (Meyers, Diamond, Kezur, et al., 1995). A woman may, for example, have difficulty comforting her infertile mate if she feels he has deprived her of motherhood. Overwhelmed by his sense of failure, the man may feel undeserving of his partner's consolation. Another impasse may arise when a husband, in attempting to console his wife, tells her: "Look on the bright side, we can always adopt." Feeling alone in her grief, she rejects his consolation; each perceives the other's response as an implicit criticism.

Partners may avoid conversations so as to protect each other from pain, especially if the male is infertile. When spouses, usually women, confide in family or friends, their sense of guilt and isolation are deepened when they are cautioned against revealing their distress to their mates. Secrecy, which often increases isolation and resentment, can thereby compromise the process of evaluating critical medical options. Couples may make hasty, ill-advised choices, defer timely decisions, or delegate

one member to make decisions that will have consequences in the future.

The wife of a man with infection-induced infertility had, years earlier, been inseminated with donor sperm. Intending to spare her husband distress, she had not fully discussed the decision with him. Thinking she had only gone to "window shop," he was stunned by her action. However, his guilt for carrying the infertility factor prevented him from raising any objections. By the time they sought marital counseling, the husband's resentment had turned into fury: he wanted to leave both his wife and the child with whom he had never bonded. He had never stopped seeing the child as another man's son.

#### Ruptures in the Social Network

A couple's family and friends expect them to have children in a timely fashion; delays in this process are questioned. Couples may tell others of their infertile status only to regret this when they are greeted with unsolicited advice and unfounded myths such as "just relax" or "adopt and you'll get pregnant." Furthermore, couples perceive such advice as intrusive, embarrassing, and blaming; it both trivializes their problem and insinuates defect by implying that they are incapable of managing their emotions appropriately.

Understandably, many couples choose not to share their infertile status. Others may discuss their condition but will not identify the carrier of the infertility factor, especially when it is the husband.

A couple from a culture that stressed *machismo*, colluded to hide the man's sterility from the family by attributing the infertility to the wife. They reasoned that both would lose status in the eyes of the family: he would be less of a man, and she would be viewed as less of a woman by virtue of her connection to an infertile partner. Ironically, after this fabricated account had circulated, the wife's

father took the husband aside and granted his son-in-law permission to end the marriage in order to find a woman who could give him children.

As the couple distances from family and friends, often avoiding child-centered occasions, members of their support systems may be uncertain about how to respond to the couple: friends and family may circumvent discussions of infertility or avoid the couple. Escalations develop as the couple withdraws, and others who are out of the information loop are unaware of the couple's plight.

Couples engaged in infertility protocols must also contend with societal censure; often reminded of overpopulation and the abundance of parentless children, they feel accused of selfishness and "political incorrectness." Unlike fertile couples, they must defend their desire for biological children. In response to the ignorance and misconceptions of the larger society, a national self-help organization, RESOLVE, Inc.,<sup>2</sup> was founded. It functions as an information exchange and provides membership in a community of persons with whom to share their experiences.

While couples' connections to their standard networks may shrink, their connections to and dependency on the medical system increase in frequency and intensity. They are obliged to discuss their intimate sexual behavior and submit to a variety of physically intrusive, time-consuming, and personally embarrassing procedures. Couples may conceal their distress, fearing that if they are not "good" patients their physicians will withhold treatment.

### Out of "Sync"

Since each partner may have a distinct set of psychological and interrelational

crises, and since each crisis requires its own length of time to resolve, partners are frequently "out of sync" with each other. While one partner may be prepared to proceed with a medical intervention, the other may not. The pressure of advancing time exacerbates this dysynchrony by increasing the tension between the partners; mutual support is diminished and decision making becomes more difficult.

### Donors and Surrogates

Individuals differ in their attitudes toward the source of genetic material. Some feel that unless their children are conceived with their own gametes there can be no continuity with the past and future. Aside from profound psychological, ethical, social, and legal questions, persons who use donor gametes must grapple with whether they should conceal or reveal the child's parentage to their families and others, and whether gametes should be from known or anonymous donors. While couples were once advised to keep donated gametes a secret (Waltzer, 1982), there is a growing movement to make this information open (Shapiro, 1988). In the future, secrecy may not be an option for parents of children conceived as the result of sperm or egg donations.

Couples considering the use of family member's gametes face unique dilemmas: the lines between generativity and sexuality can blur; role confusions and conflict can develop.

A sister who donated her egg assumed a parental position in the offspring's life. The relationship between the husband and sister-in-law took on aspects of joint-parenthood; sexual overtones surfaced as well. Understandably, this created shifts in the relationship between the wife, her husband, and her sister. Conflicts were played out in disputes about raising the child. If left unresolved, the child would surely become caught up in the adult struggles.

<sup>2</sup> RESOLVE, Inc., Somerville, Mass. 02144; (617) 623-0744.

## CLINICAL INTERVENTIONS

### Background

The Infertility Project was organized at the Ackerman Institute for Family Therapy in 1991. Its goal was to learn more about couples experiencing infertility, and, in so doing, to develop a treatment protocol to fit this population's unique needs. While the Institute's clinic attracts a diverse racial and socioeconomic population, those couples who presented with infertility difficulties were predominantly white, middle-class, and heterosexual.

The Institute's one-way mirrored interview rooms provided a laboratory in which our team of research clinicians was able to conduct and observe sessions, and to develop its ideas. Concepts from our evolving protocol were incorporated into the Institute's supervisory training programs and our private practice consultations. Data from these other settings were then folded back into our ongoing research project.

We approached couples experiencing infertility with generic, theoretical assumptions, and techniques that shape our work with all couples. The research component allowed us to fine-tune some of these elements and to create others for this particular population. Briefly, our generic work entails: (1) exploring the couple's problems and the way each partner experiences them; (2) tracking the interactional patterns of the couple (including communication patterns); (3) mapping the couple's relationships with family and other networks (including the medical systems); (4) unearthing the paradigms, beliefs, and legacies that color each partner's experiences of all of the above; and (5) offering couples opportunities to reshape problematic assumptions and interactions.

### Telling Their Story

During the early stages of the project, we invited couples experiencing infertility to meet with us and to describe their experi-

ences. Since we assumed an exploratory stance, one that was more concerned with learning about the couples' experiences than with "doing therapy," the couples were viewed as specialized consultants. In time, as couples were referred to the project for treatment, our stance continued to reflect an attitude of cooperative consultation. We began work with each couple by asking them to "tell us your story."

We soon discovered how marginalized couples felt when, at initial meetings, they told us how pleased they were that the project had been organized. Ignored by the larger society, they felt that the Institute lent legitimacy to their experience of infertility as a significant life crisis.<sup>3</sup> We noticed some degree of wariness, and soon discovered it was borne of their experiences with friends, family, and medical personnel. Anticipating misunderstanding and encroachment upon their privacy, they had learned to suppress negative affect and criticism, especially toward "helpers" upon whom they relied.

Sensitive to these feelings, we adopted an attitude of attentive and respectful interest. Priority was given to the couples' preferences regarding topics and scheduling of meetings. Comfort levels were carefully monitored: clinicians probed gently and were alert to any verbal and analogic feedback that expressed "stay away" or "that question is too painful." When probing hit sensitive spots, care was taken to allow couples to recover.

### Refocusing the Problem

Throughout the course of meetings, clinicians neither implied that sessions should continue nor that they be held at fixed intervals. We did not suggest that

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<sup>3</sup> Pauline Boss visited the project and suggested that the team, serving as witnesses to the experience of infertility, was providing the couple with a sense of community.

either partner or the couple's relationship needed to be "fixed" or "treated." Using Michael White's concept of "externalizing the problem" (1988), we expressed the conviction that it was the infertility and its repercussions that were problematic. Our intention was to separate the identities of the infertile individuals and the couple from the medical condition—shifting from "We are infertile" to "We are struggling with infertility."

### Speaking the Unspeakable

The unresolvable conflicts generated by infertility may lead to increased polarization and/or protective silence. Communication difficulties need to be addressed since these extremes neither satisfy the profound emotional needs of people struggling with infertility, nor allow the couple to handle the difficult exigencies of their lives. While it seems obvious that polarized couples have difficulty meeting individual needs, less expectedly, we encountered as much difficulty with couples who presented as unified and loving. They were, in fact, avoiding essential conversations.

Occasionally, especially in the early meetings, partners would show some reticence about speaking. Their responses were tentative and, as they spoke, they visually monitored the other's reactions. We wondered whether this was an artifact of their severe distress and/or an intense desire for cohesion: whether conversations about infertility were so threatening to an individual's identity and a couple's privacy that spouses felt obliged to obtain each partner's consent before volunteering information. Deciding to explore these questions further, we proposed meeting separately with each spouse. And, to mitigate against the separation of partners common in medical protocols, we assured them that the couple meetings would continue as well.

The individual meetings revealed how the acute pain and anxiety of infertility spawns protection: partners feel con-

strained to silence their most intense feelings lest they harm their mate and, consequently, the marital relationships. The separate meetings with each spouse led to the surfacing of private thoughts that had been walled-off from the partner and, at times, the self.

Whereas most clinicians use separate meetings as an optional procedure when working with couples, the project routinely offered these meetings. Since infertility invokes complex and deep-seated beliefs, which in turn produce intense feelings of shame and defectiveness, airing secrets and fears with a nonjudgmental clinician is liberating. Not surprisingly, we often discovered that secrets were typically generated by problematic premises. Once these premises were explored, partners felt able to discuss them with each other. We termed this process "speaking the unspeakable."

### The Meaning of Infertility

After telling their story, couples were asked to describe the impact of infertility: how it affected their perceptions of themselves, their partners, their relationship, the past, and the future. Through exploration of these descriptions, in separate or conjoint sessions, clinicians were able to highlight each partner's unique premises related to sexuality, gender roles, generativity, parenthood, competence, mastery, and destiny.

Explicit questions encouraged couples to describe their assumptions: "What does infertility mean to you?" "How has infertility shaped the way you see life, yourself?" "How is it connected to your view of yourself as a woman/man?" "What were your ideas about being a mother/father?" "What were the expectations you and your family had about having children?" "How has your partner's infertility affected how you view him/her?"

Another layer of questioning was focused on how family and societal messages, usually gender-specific, influenced couples'

thinking and feelings: "Who else in your family would see it this way?" "Have your ideas about infertility (men/women/mothering/fathering) been influenced by ideas in our culture?" From this perspective, individuals were encouraged to then consider alternative ways of perceiving themselves, their partners, and the experience of infertility: "Are there other ways of seeing infertility that you would prefer to have?"

At times, the clinician or the team would speculate about different ways of viewing a situation, especially when an individual seemed locked in the logic of a problematic premise. For example, "Would you view yourself differently if you saw infertility as random bad luck—instead of believing that it is confirmation that you are unmanly?" "How would an alternative view affect the way you function in your marriage and in the world?" The team might wonder about the effects a persistent belief might have on the individual, his or her mate, and the couple relationship.

One woman redefined herself as "post-fertile." This distinction permitted her to see herself as a woman who had been able to bear children, but one who had made other life choices, one of which resulted in "post-fertility." She said, "From this perspective I found that I was able to move beyond the despair of infertility. I am not overcome by endless regret, nor do I think that life or fate has tricked me."

The "trying on" of alternative views was particularly helpful in individual sessions with partners who were so paralyzed by problematic premises that they were unable to talk with their partners. When preferable options were entertained, partners could then return to their spouses—in or out of sessions—and describe their new ideas, thereby loosening the emotional logjams.

When individuals were reluctant to talk with their mates, clinicians focused on the

future consequences of talking or not talking with partners, talking only with a therapist, or remaining silent; repercussions of each were weighed. The vantage point of a future perspective (Penn, 1985) is doubly effective: constraining secrets can be made more conspicuous when they are projected ahead, and the uncharted future may open up new possibilities. The desire to attain their preferred future often led partners to initiate previously feared areas of conversations.

### Using Metaphors

Metaphors offer a domain free of the one-size-fits-all, negative descriptions that are prevalent in the culture at large. The distress of infertility may draw couples to use this language of dysfunction and deficiency since it offers a means (albeit negative) of conceptualizing their anguish. When clinicians challenge these descriptions, couples may feel criticized. Metaphors, on the other hand, provide avenues for discussions that avoid the struggle altogether. In attending to metaphorical description, clinicians can also avoid tendencies to lump individuals into a larger class of "infertile couples." Whereas it is important to be mindful of the pervasive themes that are evoked by infertility, finding each person's unique emotional response to the experience is equally important.

Metaphors used by couples to describe their experiences with infertility often reveal their most negative opinions about themselves, especially because infertility elicits feelings of abnormality, deficit, defect, affliction, and punishment. Images of catastrophe, annihilation, alienation, and failure evoke feelings of anxiety, fear, shame, helplessness, and hopelessness. Clinicians can encourage couples to transform imprisoning metaphors into ones that show a way out or around their difficulties, as well as ones that enhance their views of themselves. The following illustrates how

the clinical team assisted in the revision of a problematic metaphor:

A husband who had always seen himself as different from other people had a recurrent image of himself as a solitary wolf on the tundra. His metaphor intensified when, diagnosed as sterile, the couple elected donor insemination. He then pictured his wife and future child as a female wolf and her cub; he, the lone wolf, wandered in the wilderness isolated and forsaken.

After a discussion about the limiting aspects of this metaphor, the team wondered whether it could be transformed. At a later session, he described his revised metaphor: he saw himself as a German Shepherd protecting a ewe and lamb. And, at the same time, he reported having a more positive view of himself and his future role in his family.

### Designing Rituals

As our culture offers no bereavement rituals for couples struggling with infertility, they may live in states of chronic, unresolved loss (Weinshel, 1990). After addressing the significance of rituals with each couple, we ask whether it would be worthwhile to create their own. One couple, for example, invented a ritual to help them cope with the monthly grief that begins with each menstruation: she telephones her husband with the news, leaves work, goes home, and gets into bed. He leaves his work early, picks up videotapes and chocolates, and then joins her in bed. While they are grieved and cannot always find words to console the other; they can, nonetheless, share a comforting experience together. They call it the "Bed and Chocolate Ritual."

Even when couples devise rituals that allow them to mourn, and even when spouses, family, and friends are empathic and supportive, it is unrealistic to expect couples to "get over" their pain; the legacy may last years (Dickstein, 1990; Menning, 1988; Sandelowski, 1993). Since couples must learn to live with the aftermath, and

the mourning is rarely "finished," the team neither implies that the pain engendered by infertility will disappear, nor implies that couples are deficient because they cannot make the pain disappear.

### To Meet or Not to Meet

Since the pacing of sessions is left to couples, and since infertility and its treatments often create unpredictable circumstances, great flexibility is needed when scheduling meetings. In the midst of infertility treatment, for example, a couple may be awaiting test results regarding a possible pregnancy, or they may be uncertain about the viability of the fetus. At such emotionally charged times, when hopes and fears peak, couples may wish to suspend sessions; they may be reluctant to "tempt fate" by discussing the pregnancy and/or disturb the fragile defenses they are using to deal with the waiting. For couples who prefer to meet during the waiting periods, their participation tends to be more tentative; they seem wary of "rocking the boat."

The clinician can normalize these feelings and schedule meetings accordingly. Longer intersessions may be planned, and/or couples may be invited to reschedule their next meeting when the time seems right to them. The clinician's maintaining brief phone contacts counterbalances the couple's abiding sense of isolation.

Some couples disagree with each other about scheduling. Since partners who cannot agree on timing are often having similar disagreements about managing the relationship and the infertility, the disagreement serves as a springboard to explore the conflict that may, in turn, reflect the lack of synchrony discussed above.

### Intersessions and "Endings"

While the encounter with infertility can last years, couples faced with the reality of



"time running out" may continue a program of uninterrupted and conscientiously timed sexual intercourse, and/or a series of medical protocols; they keep respites or treatment "holidays" to a minimum. Although not always able to "put the illness in its place" (Gonzalez, Steinglass, & Reiss, 1989), couples may nevertheless learn to manage the ordeals more effectively through coordinated teamwork.

One can think of infertility as having a trajectory shaped by a series of psychological and medical resolutions that end in a variety of configurations: having a biological child without assisted reproductive technology (ART); producing a child by using ART and one, both, or neither partners' gametes; adoption; having no children (with or without choice); or the relationship may be dissolved, thereby establishing different circumstances vis-à-vis having children. At the same time, there is no end point, no denouement, for the legacies of infertility. When then, does the couple therapy end?

One useful criterion to use in considering this question, and toward which the therapy can be geared, is the ability of couples to manage the events of their lives even though there are still times of great anguish, pain, and conflict. The clinician and couple can explore whether functioning is such that each can feel understood, supported, and able to lessen the emotional assaults engendered by the continuing saga of infertility.

At a last meeting, one couple compared infertility to the ocean: the diagnosis hit like a "tidal wave." Although the waves keep coming, "We now know how to handle them: we hang onto each other, we go with them and let them carry us a little, and then we pick ourselves up and get back to where we were."

Couples who have worked together in order to cope with infertility report that their bonds are stronger; they have greater faith in the relationship; they are able to

listen empathically and be clearer in their communications. When couples make this shift, we ask them whether they would like to extend the intersession intervals; they are also given the option to telephone for an earlier appointment. Telephone contacts initiated by the clinician are sometimes indicated. A formal ending is a helpful ritual to mark the couple's ordeal, discuss the changes that have taken place, and discuss the future. We believe it is important to end meetings with the idea that they can always be reconvened should the infertility overwhelm the couple in the future.

### The Legacy of Infertility

As our clinical team became more aware of the impact of infertility, we noted that many couples who had experienced infertility problems in their pasts were left with problematic legacies. Even after having biological children, these couples were still vulnerable to feelings of defect, shame, guilt, and blame. While they presented with a variety of problems and complaints, their encounters with infertility, and the secrecy it engenders, had played a role in contributing to their current difficulties.

Unless clinicians ask about infertility, couples may not volunteer the information. The reluctance to mention the infertility may be an avoidance of painful feelings, and/or it may belie unresolved personal or couple issues associated with the infertility. At first, couples often do not regard the encounter with infertility as relevant to their current problem. While inquiring about infertility seems obvious when a clinician learns, for example, that a couple has adopted a child, it is a useful practice to ask all couples about miscarriages or difficulties conceiving. If there were a history of infertility, it is useful to walk the couple back in time, discuss any problematic legacies of infertility, design rituals for mourning when appropriate,

and thereby put greater closure on the experience.

### Family Therapists and Infertility

Family therapists have a unique perspective that is particularly useful for couples struggling with infertility. Their focus on the larger system and the relationships within it, and their longitudinal examination of family patterns and beliefs, are well suited to analyzing and untangling many of the dilemmas raised by infertility. And the rewards for the clinician who works with these couples are great. In the process of learning more about couples' encounters with infertility, we have had the opportunity to uncover and reexamine an assortment of myths, as well as some of our own fundamental assumptions. The meaning of gender, sexuality, couple relationships, parenthood, and generativity has changed for each of us; and these changes have affected our work with all families.

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