Individual Therapy, Group Therapy and Co-Therapy Work with Infertile Couples

George Christie and Ann Morgan

In recent years some pioneering technological discoveries in areas like I.V.F. have enabled many patients to conceive babies despite the presence of such handicaps as damaged Fallopian tubes or chronic pelvic infection. To develop new ways of dealing with manifest organic pathology is one thing. However to allow an increasingly biological and technological focus to dominate our assessments and treatments surely restricts our vision, thereby shutting out awareness of broader issues involving the powerful generative and destructive forces that continue to influence functioning within all of us, as individuals, couples, families and societies.

Within any individual person mind and body function in an integrated way. Mind and body are one. It is only when we begin to explore and study the nature of this field that we tend to divide into somewhat polarized camps of medical-organic versus psychological areas of investigation.

Kentenich and Siedentopf (2002) state that both these groups have their own strengths and should be mutually respected. However they emphasize that certain personality characteristics play a part in making the choice of profession of a reproduction specialist. A high degree of specialization is a precondition for good reproductive medicine. But they point out that this may cause many reproductive specialists to consider counselling and psychosomatic care as an 'appendage' that should be performed by social workers, nurses, psychiatrists or psychologists rather than by themselves. The specialists should be in open communication with these other workers. In addition, however, in the words of Kentenich and Siedentopf, 'But psychological care of the couple should be part of their normal work; after all, they do not treat sperm or hormones, but human beings'.

Freud wrote that the purpose of psychoanalysis is not to provide answers but to open, or to reopen, the questions. The questions we wish to reopen here relate to the nature of the forces that can influence levels of fertility, and they emerge from our experience with many couples who have eventually conceived and successfully delivered babies after varying periods of infertility, and sometimes following protracted and unsuccessful technological forms of treatment.

A focussing upon investigation of 'stress' and ways of reducing it is not helpful to us in exploring the unknown psychological factors affecting fertility. We need to be able to sit down with the couple and quietly listen, giving the couple space and time in which to be able to reflect upon their feelings about having a baby. And they need time and space in which to associate in their own way to thoughts about their family relationships, currently, and in the past. In our experience this space is best provided by an experienced co-therapy couple.

In this paper we wish to emphasize the fundamental importance of holding and containment in this work, whether in individual, couple or group settings—a holding and containment of sufficient quality to facilitate the gradual emergence of genuine trust, and the emergence of a growing capacity to reflect upon and understand troublesome feelings at deeper levels. Modell quotes Winnicott (1963) in describing the therapeutic situation as follows : '… the analyst is *holding* the patient, and this often takes the form of conveying in words at the appropriate moment something that shows the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced'.

The container model of Bion is also relevant here (Sandler 1987). The capacity of the care-taking mother to be attentive to, and tolerant of, the needs, distress and anger of the infant, as well as to its love, and her capacity to convey, increasingly, a reassurance that she can 'contain' these feelings and, at an appropriate time, respond in a considered and relevant way, enables the infant to learn that its distress is not disastrous. By internalizing the 'containing' function of the mother the infant gains an internal source of strength and well-being. Similarly the capacity of the therapist or co-therapy couple to be attentive to and tolerant of the emerging fear and anger feelings, and containing of them, can facilitate an internalizing of this containment by the individual or couple.

In this paper Dr. Morgan and I will be providing increasing evidence that such holding and containment has been increasingly effective as we have gradually moved in the direction from individual psychotherapy to some group work with couples, and now to increasingly experienced co-therapy work with the couples.

Statistics

Overall Results
Number of cases **83**
Number of conceptions (17 with I.V.F.) **52**
39 first babies, **3** ongoing pregnancies, **2** sets of twins,
1 ectopic, **1** still-born, **6** miscarriages,
At least **12** women (probably many more) have had more babies.

Individual Psychotherapy with Dr. C. or Dr. M.

Number of cases **53**
Number of conceptions (4 with I.V.F.) **28**
24 first babies, **1** set of twins, **1** still-born, **1** ectopic,
1 miscarriage

Indiv. P/T + Group Psychotherapy (Co-Therapists Dr. C. and Dr. M.)
Number of Cases **12**
Number of conceptions (**4** with I.V.F.) **10**
6 first babies, **1** set of twins, **3** miscarriages

The Co-Therapists Engage with the Couple in Sessions
Number of cases **18**
Number seen in ongoing therapy (**3** couples withdrew) **16**
Number of conceptions (**10** with I.V.F.) **14**
9 first babies, **3** ongoing pregnancies, **2** miscarriages

12 couples, who had failed repeatedly on I. V.F. in the past, decided to havefurther I. V.F. s after Co-Therapy Couple sessions and/or Group Psychotherapy sessions with Dr. C. and Dr. M
Number of successful conceptions **11**
Cases successful with first subsequent I.V.F. **9**
Cases successful with second subsequent I.V.F. **1**
Cases successful with third subsequent I.V.F. **1** Failed case, ? will continue I.V.F. **1**
6 first babies, **2** sets of twins, **2** continuing pregnancies, **1** miscarriage

As the statistics show, many of our women have conceived with I.V.F. after attending group and/or couple sessions with Dr. Morgan and myself. An observer may understandably argue how can we claim these figures as indicating success for our psychotherapeutic approach.

However it is surely significant that of the twelve couples previously failing on I.V.F. programs who did choose to have a further I.V.F. after sessions with us, eleven conceived successfully. Nine of them conceived with their first attempts. Two other women failed with their first I.V.F.s, but conceived after their second and third attempts. And all the couples appear convinced that our work has been an effective influence upon their subsequent success.

The Psychogenic Aspects of Infertility

The tasks faced by any couple as prospective parents include:

> (1) an adequate separation-individuation from their own families of origin
> (2) an adequate commitment in their relationship with each other
> (3) a capacity to move from a dyadic to a triadic relationship, where the need for each other can be threatened by the arrival of a child. John Steiner (1985) points out the need for us to understand the Oedipal Myth in its entirety, i.e. the fear the couple, Laius and Jocasta, have of the power of their infant son, and their response to this fear, i.e. their infanticidal wish towards Oedipus.

We agree with those who see psychogenic infertility as primarily a motivational problem, largely

unconscious, and related to the universal and deep human ambivalence about producing children (Christie and Pawson, 1988, Christie, 1998). The potential readiness to create and nurture a child co-exists with its opposite, i.e. a deep potential readiness to avoid, abort or otherwise destroy the child. The stage of mature generativity requires the former to prevail optimally over the latter, but the balance between the two forces varies from time to time, in individuals and in communities.

Infertility does not result from conscious ambivalence about conceiving, e.g. a victim of rape may well conceive. Ambivalence is an inescapable part of the human condition. Ambivalent feelings about having children are universal, and are currently heightened for Western women by their increasing freedom to seek higher education and careers, and their increasing success in this. Rozsika Parker even suggests that ambivalence provides a woman with a sense of individual identity thus providing a spur to individuation for both mother and child.'

But infertility can develop, mediated along psycho-neuro-endocrinological pathways in at least two situations, e.g.

(1) where there is a repression of the hostile side of the ambivalence
(2) where there is a repression of unresolved grief after a past loss.

Both these situations can be defended against by the development of an over-idealisation of pregnancy and a frenetic need to conceive at any cost—'Give me children or I shall die!' This is a neurotic defensive position, qualitatively different from the mature, phase-specific and normally somewhat apprehensive readiness to take care of and nurture a baby. It is of interest that the Strauss opera *The Woman Without a Shadow* is about an ideal woman who, lacking awareness of the negative side of her feelings, is sterile.

Some research suggests that there is as much psycho-pathology to be found among those who produce children as among those who don't. In fact some infertile individuals or couples exhibiting 'a deep somatic awareness' that conditions are not right for producing a child, may be potentially better parents at some future time than many who conceive without difficulty.

A good, sound relationship can perhaps be regarded as a generatively ambivalent one, as compared with a destructively ambivalent one, or a defensively idealized one. A generatively ambivalent relating is one where the periodic emergence of genuinely expressed derivatives of hate in certain situations provides no lasting threat to the mutual love and respect, and where the conflict is eventually resolved with access to a shared sense of humour.

Dinora Pines (1990) underlines the dual and conflicting maturational tasks faced by any woman entering the child-bearing years, i.e. of being able to identify with her mother's womanly capacities, while at the same time continuing to separate and individuate from her emotionally, so as to take over full responsibility for her sexuality and her own body. These findings are clearly in accord with Erikson's formulations, which require the progressive establishment of a sound sense of identity, followed by an adult capacity for intimacy, before a phase-specific generativity can emerge.

According to Dinora Pines, a woman with unexplained infertility had often failed to achieve these dual maturational tasks. This may mean that she and her partner have not been able to help each other complete their moves in the direction of taking responsibility for themselves away from

their families of origin.

Such a woman often possesses deep ambivalent feelings towards both her own mother and a fantasied infant. She may be unable to own, consciously, her underlying hostility, either towards the mother, or the fantasied infant. A genuine love for her mother may be buried beneath an intensified compliance with what she believes are her mother's wishes (e.g. feeling she has to ring her mother every day), a compliance that represents a defence against awareness of the hostile side of her feelings. On the other hand she may move in the other direction of distancing her self from the mother in a degree of paranoid relating, again without conscious awareness of her love and needful feelings towards the mother.

A woman will need time to uncover the repressed hatred that, for example, lies behind her defensively compliant ringing of her mother every day. Her ambivalence must not be interpreted prematurely. It is interesting that as a woman begins to make contact with her underlying negative feelings, she often begins to make contact with her genuine positive feelings also, with an increasing capacity to relate genuinely with her mother, and with a positive response from the mother. And such an unhurried exploration needs to occur before any couple is launched into a protracted, stressful and costly treatment program, or at least occur in parallel with such a program.

The co-therapist couple must be able to provide (Christie and Morgan, 2003):

> (1) An adequate holding or containment of the infertile couple. We believe this to be of fundamental importance, whether in individual or couple or group treatment settings.
> (2) The provision of time and quiet listening, allowing understanding to emerge in its own way and its own time
> (3) The above background allowing the emergence of words to describe the conflicts and fears in ways that provide relief rather than dread of what might feel unspeakable.

Individual Psychotherapy with Unexplained Infertility Cases

We will start with three examples of our individual work with clients providing early results in our exploration into the psychological side of unexplained infertility.

Case Study 1 (Dr. Christie)

(Repression of the hostile side of the ambivalence)
At the time of her referral the 37 year-old Ms. A had been living with her partner for 10 years, and trying to conceive for 3 years. At one stage gynaecological investigation had revealed a degree of cervical mucus acidity, with poor sperm penetration, for which alkaline douches were prescribed.

Ms. A had been distressed by her failure to conceive, and was convinced she had an organic problem. She initially resisted her gynaecologist's suggestion that she come and see me. However she eventually made an appointment, appearing very guarded in the initial sessions. Ms. A revealed she was wary of psychiatrists, and felt resistant to the idea of psychotherapeutic probing. As I continued to listen in an unhurried way, her resistance began to lessen. We settled into

weekly sessions, and there were gradual indications of developing positive feelings.

A lively, emotional and articulate woman, Ms. A told me of extreme frustration felt in relation to her partner, seen by her as a silent, introverted man. She also told me of difficulties she experienced in relation to her family of origin. The eldest of four children Ms. A had found it difficult, as an adolescent, to separate from her possessive, anxious parents. She had always had a troubled relationship with her mother. She knew her mother was unhappy about the de facto relationship, and Ms. A felt very uncomfortable about this. She kept a distance from her mother, and in her presence found it difficult to differ openly with her. Ms. A began to recount some childhood memories of maternal criticism about her care of the younger siblings that led her to feel she lacked the capacity to look after children responsibly. As our therapeutic contact developed, Ms. A's frenetic need for answers seemed to recede, and she was increasingly able to own a wish not to have a child, together with a feeling of sadness about this. In other words she was now able to stay with awareness of both sides of her ambivalence re having a child, a new and positive development.

After enjoying a short holiday, Ms. A returned to the weekly sessions with me, and almost immediately conceived. The unexpected development aroused intense mixed feelings in her. She became preoccupied with the question of whether or not she would seek an abortion, initially seeming to favour doing so. Morning sickness was continual, developing into severe nausea for most of each day. She could not bring herself to tell anybody what had happened, and was terrified her parents would find out she was pregnant, feeling sure her mother would disapprove strongly. Incidentally, her partner, in his quiet way, seemed delighted with the news.

As we continued to reflect upon the issues there was a steady decline in her wish to abort, and a gradual lessening in her nausea. She showed a quietly enthusiastic response to successive ultra-sound picture showing a growing foetus.

Around 5–6 months she was able to find the courage to face her mother and give her the news. The mother reacted calmly and began to do things for Ms. A. Things now began to change markedly for her. The nausea disappeared completely. She began to discuss future plans more maturely in our weekly sessions, and seemed less dependent upon my support.

The birth of a delightful little baby girl was greeted with great pleasure by Ms. A and her partner. The baby sucked well, breast milk flowed freely, and the baby was soon sleeping long hours at night. The sound father-mother–infant relating was striking to observe, in the light of her early inclination to seek an abortion. The couple married, and a year or more later a second daughter arrived.

We believe this case illustrates several important features in the psychotherapeutic management of the infertile patient:

> (1) Premature interpretation of this woman's pre-conceptive ambivalence could well have been a persecutory experience for her. It was of paramount importance here to allow a satisfactory containment and therapeutic engagement to develop, with awareness of her own ambivalence able to emerge in its own way, and in its own time.
> (2) Ms. A was able to become increasingly aware of a wish not to have a child, and at the same time experience a sadness about this, because of her parallel wish to have a child. It is interesting to speculate whether the creative implication of this emerging awareness of

contraries could have served to facilitate Ms. A.'s biological conception.
(3) Aided by the therapeutic containment, Ms. A could face her mother during the pregnancy, achieve a further degree of real separation-individuation from her, and further facilitate the emergence of her own maternal functioning.

Case Study 2 (Dr. Christie)

(Repression of unresolved early infantile grief, rage, terror)
Some years ago Mrs. B, aged 39, was referred to the writer with a long-standing unexplained infertility, which had persisted despite several unsuccessful cycles of artificial insemination with her husband's semen. She had a University degree, a good job and a sound marriage. One of several children, she had always had a rather tempestuous relationship with her mother, but they had always been able to resolve their conflicts productively, aided by the mutual respect they had for each other. Mrs. B had been able to separate and individuate satisfactorily from her family of origin, and take over responsibility for her own life, supported by the sound relationship with her husband. So how could a psychological factor be operating in her fertility problem?

In a following session the interesting fact emerged that whereas Mrs. B had wept at length following her father's death many years ago, she had failed to shed a tear when her mother had died a year or so previously. A short time after her mother's death, feeling unwell, Mrs. B had gone to see her female GP who found she was suffering from high blood pressure. The sensitive and supportive GP said that before initiating any organic investigation she would like Mrs. B to sit down and think about whether anything significant had happened in her life recently.

Mrs. B did so, spoke of her mother's death, and began to experience a whirl of chaotic feelings for which she had no words. She felt that she was going mad. She burst into tears, and continued to weep at length for the first time since her mother's death. She didn't know what she was weeping about. However her raised blood pressure then began to recede, and returned to normal. It is known that a stirring psychosis can transform into a psychosomatic illness and present that way. In the containment provided by her empathic female GP the inner psychotic experiencing here became evident, and the psychosomatic illness disappeared. However Mrs. B didn't become psychotic. She was able to reflect about and speak of having the terrifying chaotic experiencing for which she had no words.

In the next session Mrs. B said that there was something she hadn't told me because she has never felt it was important. Apparently a week or so after her birth Mrs. B's mother had proceeded to develop a severe illness which required admission to hospital for a couple of months. The baby was taken from the mother, placed with friends for a short time, and then transferred to a maternal aunt who apparently looked after her well. She was eventually reunited with the mother, and the apparently reasonable relationship grew into being, with its admittedly 'tempestuous' element.

Thus a separation had occurred at a time in early infancy when psyche and soma are not clearly separated out from each other. Joyce McDougall (1989) describes how many of her psychosomatic patients have an incomplete sense of bodily differentiation from the mother in the area of their psychosomatic pathology, together with, as yet, no developed words with which to express their emotional pain.

In subsequent sessions it was possible to take up with Mrs. B the possibility that the sudden

separation occasioned by her mother's death had revived, in the depth of her inner being, something of an original powerful response to the first separation in early infancy, a response for which there would have been no words, nor images nor playfully creative avenues of expression, only an experienced turmoil of primitive rage and terror. Was it possible that this second loss of her mother had revived these chaotic, primitive feelings from deep inside her, and now expressed through her body in the form of a raised blood pressure? When she had been able to weep at length in the empathic, holding and containing presence of her woman doctor, had she been able to find an avenue for expressing something of her reaction to the original loss, as well as the more recent one, allowing her blood pressure to return to normal?

Mrs. B said she could follow what I was saying intellectually but continued to find it hard to think about them in our subsequent sessions. Although she would love to have an older child, she gradually began to emphasize reasons why she didn't want to have a baby at this stage of her life. And she experienced increasing feelings of sadness about this, because of a persisting wish to have one.

Now increasingly able to hold such ambivalent feelings clearly in consciousness, Mrs. B proceeded to conceive for the first time in her life. Nausea in the first trimester was very severe, but this eventually cleared, and she started to enjoy ultra-sound pictures of the foetus. Apprehensive about the prospect of labour, she nevertheless resisted any suggestion of Caesarian section. She eventually had a normal labour, was deeply gratified to achieve her recently increasing wish to have a lovely baby boy in her arms, and her breast milk flowed freely. She felt no need to continue seeing me.

On weaning the baby nine months later, Mrs. B suddenly became so depressed that she rang me to seek some literature on post-partum depression. Before I could return her call, she started to think about the possible effect upon herself of the separation from the baby brought about by weaning. This is a good example of a patient internalizing the containing function of the therapist. She began to weep at length and soon felt well again.

So a deep inner turmoil of primitive chaotic feelings, held at an early pre-verbal level, had not only blocked this woman's procreativity, but also pre-disposed her to future life-threatening illness. However when she was able to internalize the holding and containing provided by her sensitive female GP and myself, and proceed to find some avenue of expression for these deep chaotic feelings within herself, she was able to achieve relief from the recently developed hypertension, and gain access, at last, to her capacity to conceive a baby.

Case Study 3 (Dr. Christie)

(Repression of unresolved grief after a past loss)
Mrs. C was referred to me by a psychiatrist who had been treating her father over many years for a bipolar disorder. Apparently the father had received several courses of ECT over the years, had been suicidal at one point and had recently experienced a manic episode.

Mrs. C presented as a slim woman, with a bright and cheerful manner, who had been trying to conceive for four years. She had had irregular periods, at times going for some months without a period. Laparoscopy had revealed a degree of endometriosis, and she also had a polycystic ovarian syndrome. Turning to herbal therapy she had felt much better in herself, and her cycles

had reduced from 44 to 30 days.

I had a joint session with Mrs. C and her husband, another session with Mrs. C and then an extraordinary session followed. Apparently a friend of hers had talked of a suicide (by hanging) of another person. Mrs. C had turned away and was looking out the window. Her friend drew attention to this, and asked what could this be saying. Tears started to come, as Mrs. C was reminded of her father speaking of a suicidal wish. Mrs. C felt that her grief was welling up from deep down within her, and eventually she wept at length, with a sense of great relief. There was also the question of whether this included a revival of feelings associated with her having witnessed the death on a beach of her maternal grandfather, from a heart attack, when she was 5 years old. She felt that this could be so because she remembered having enjoyed his playfulness. She was also reminded of the death of a cousin from a brain tumour. She wept in the session about this also, and this seemed to have a further freeing effect.

When I next saw Mrs. C she reported there had been a remarkable improvement since the above experiences. She had always kept a photograph of her cousin on a table beside her bed, together with a photograph of herself. However since the last session she had put it away, and felt that she was emerging from something. She felt freer than she had experienced for years. 'And now I know that I can have babies'. Her mood was bright, but she was sleeping soundly so I didn't think there was a manic element.

Mrs. C didn't feel that she needed to continue seeing me. She contacted me some months later to report that she was pregnant.

Group Therapy with Infertile Couples, led by the Co-Therapy Couple

A woman gynaecologist in Melbourne, Dr. Chris Bayly, became increasingly interested in possible psychogenic aspects of infertility when Dr. Dinora Pines, from the UK, met with a group of gynaecologists in Melbourne. Dr. Bayly later took up with her colleagues on a Melbourne IVF programme the idea of referring selected couples to Dr. Morgan and myself for inclusion in a time-limited psychotherapeutic group as an experimental measure (Christie and Morgan, 2000).

Ten couples were seen by us in evaluation interviews. Several wives, and some of the couples, were seen in psychotherapeutic sessions, as this can be a beneficial preparation for inclusion in a group. With six of these ten couples, seven conceptions took place during this initial period of investigation and individual or couple treatment, resulting in five babies and two spontaneous miscarriages.

We then proceeded to form a group with two of the four couples and two other couples, a time-limited group, agreeing to meet fortnightly.

After a few sessions one wife informed us that further medical investigation had revealed complete blockage of her Fallopian tubes. She acknowledged the help she had received from

earlier individual and couple sessions, enabling her to achieve further separation-individuation from her own mother and gain a better understanding of the difficulties arising from being the good, compliant eldest child in her family. However she and her husband decided to discontinue the group sessions and proceed to try I.V.F.. She went ahead with this, conceived with the first I.V.F. and transfer, and proceeded to deliver a baby boy. We then settled down with the other three couples.

One woman had been told that she formed antibodies to her husband's sperm. I.V.F. had been attempted unsuccessfully with seven egg collection cycles. Sometimes no eggs were found, three times fertilization failed, and any embryos forming appeared immature. A noticeable feature in the early life of the group was the relief experienced by this woman in finding that it was acceptable in the presence of other group members to own and express the negative aspect of her ambivalent feelings about having a child at forty-one, and about how this would interrupt her developing career. Feeling a lot freer as a result she decided to have one more I.V.F. during the life of the group, and immediately conceived twins.

One of the other two women was able to express intense feelings of envy about this. A manic defence style of relating had earlier characterized her behaviour in the group, but this now began to lessen as she talked with difficulty about her envy, and was then able to confess to the group that she had terminated the one pregnancy that had occurred many years earlier in the marriage. Tearful moments followed, and one session ended up with the three women hugging each other.

Two of the husbands were able to admit that although they had been supportive of their wives'wishes to conceive, they really didn't want children. As they began to express these negative feelings, they proceeded to some exploration of relationships within their background families, and gradually began to feel a little different about having children. The genuine expression of difficult feelings was leading to increasing freedom and spontaneity in relating within the group, and a strong attachment was clearly developing between the three couples. The group came to an end by mutual agreement, following the departure of the first woman and her husband late in her pregnancy. She eventually went into labour, and delivered a boy and a girl.

The other two couples agreed they would like to join a new group planned for early the next year. But late in the year one of the women rang to say that she and her husband had decided she would have one more I.V.F. attempt, and she too had conceived twins. Then early the next year we received a phone call from the other woman to say she and her husband had changed their minds about I.V.F., and that she, too, had conceived with the first attempt.

So here four couples had been able to achieve immediate success with their first I.V.F. attempts taken after inclusion in our group (two of the couples having failed earlier I.V.F. procedures). They have all been adamant in feeling that their individual and group experiences have played a significant, and even crucial role in bringing about the successful conceptions, after many years of struggle and frustration.

The couples sought permission to continue contact with each other outside the group, and we agreed to this. The greater part of a year later they contacted us with a request that they bring their babies in with them to sit in a circle with us for one more meeting and we agreed to this too.

Two of these couples have had several further children naturally since then.

We began a new time-limited group with four couples the following year. Three of the wives conceived naturally during the continuing life of the group. One baby was born, but the other two pregnancies miscarried. The fourth wife decided against parenthood, and resumed taking the pill. We have been interested to realize that our work with the two infertile couple groups has differed in certain ways from what we have experienced over years in working with our analytic psychotherapy groups. We were both struck with the sense of overall containment, cohesion and trust that seemed to develop quickly, particularly in the first group. This led us to have relatively little to say as co–therapists. We preferred to carry out a containing or holding function, and just listen carefully, providing time for some understanding to become evident (time needed for the baby to be ready to be born).

The infertile couples appeared to identify quickly with each other, and welcome the opportunity to express the troublesome feelings of envy, frustration and a sense of isolation, feelings difficult to ventilate freely in their family, social or even fertility clinic settings. A gradually increasing awareness of their ambivalence became possible. Many of the couples had used splitting e.g. the woman becoming preoccupied with the wish to become pregnant, and the man holding back. The groups were very important for the men, allowing them to have a real voice, which actually strengthened the couple rather than dividing it. The fear of moving to a triadic relationship is another area of importance. These are all areas that can be quite complex in their nature and background, but can gradually achieve some exploration and expression in the group setting.

We are left with the belief that the holding, containment and quiet listening provided by us as an experienced co–therapy couple have been of crucial importance in our work with these couples.

Is it also possible that the co-therapy containment provided for infertile couples (and mother-infant couples) facilitates a regression and playful interaction in ways that open access to a deeper level of experiencing, with its generative possibilities? There is still so much work to be done in these areas, so much for us still to learn, so much room for future research.

The Co-Therapy Couple Engage with the Infertile Couple

Case Study 4 (Dr. Christie and Dr. Morgan)

Mrs. D, aged 37, was seen in an initial consultation by Dr Christie on 17/04/03. She had a single sister one year older, and a married brother with two children two years younger. Mrs. D married at 33 but separated and divorced after a year. She married Mr. D in 2001. She had always felt she would have trouble having children, but had gone ahead with several I.V.F. cycles over the previous year, with only one brief conception.

Mrs. D had little memory of her early childhood. Her father, rarely home, had apparently left the family when she was 8. Her mother has told Mrs. D that she had been the closest child to her father and had idealized him, but Mrs. D has no conscious memory of this. Within a year of father's departure the mother married again, and Mrs. D developed a continuing feeling of hatred for her step-father. The family continued moving to different parts of Australia, so that Mrs. D wasn't able to develop lasting relationships with any other school children.

The second marriage broke up when Mrs. D was 18. Mrs. D was able to leave home, move to another city, and proceed to gain a university degree and a teaching qualification. This was not yet a mature separation-individuation from her mother and family of origin, more a brave distancing of herself from mother, with some persisting paranoid feelings towards her.

In the second session Mrs. D talked about how her mother, now in her third marriage, had constantly said things over the years that put Mrs. D down, attributing this to humorous teasing if she complained. Apparently she cried all the way home after this session. Another I.V.F. cycle during these sessions was unsuccessful.

Mrs. D then started to bring some vivid dreams to explore in subsequent sessions.

On 3/06/03 Mrs. D and her husband were seen together by Dr. Morgan and myself in the first of what became regular fortnightly sessions. Initially Mr. D had been reluctant to come. It emerged that his parents had split up when he was 13, and this was Mr. D's second marriage also. However as the sessions developed he turned out to be an empathic husband in his response to Mrs. D, and increasingly interested in mutual exploration of their feelings.

In ensuing sessions with Dr. Morgan and myself both Mr. and Mrs. D continued to work through feelings experienced towards their respective family members, Mrs. D shedding more tears in relation to her mother. Mrs. D went on to speak of her early panic at the thought of having children. Now she very much wanted to have a baby, but had considerable anxiety about this as well, fearing she would be a mother like her own mother. Mr. D was reassuring in his response, referring to her warmness.

Dr. Morgan and I were pleased with the way Mr. and Mrs. D were increasingly able to express genuinely ambivalent feelings towards each other, with increasing access to a shared sense of humour. In mid-July Mrs. D had yet another I.V.F., and immediately conceived. The couple were pleased and relating well, with much family support, including that of Mrs. D's mother.

The last joint session occurred on 23/08/04 when Dr. Morgan and I sat with Mrs. D, Mr. D and their five-mont-old baby son. The infant looked well and laughed a lot in the session. Both Mr. and Mrs. D were sure we had helped them to conceive, and said they would like to be able to remain in contact with us.

We heard later that Mr. and Mrs. D had encouraged other couples at the I.V.F. Centre to meet together in informal group contact, including other couples we had seen. We feel that our co-therapy couple work with couples such as Mr. and Mrs. D has provided the most illuminating and satisfying experiences for us in a field where there is still so much for all of us to learn. The wish of these couples to bring their babies in to meet with us indicates their conviction that our work with them has been has been an essential part of the successful outcome, even where I.V.F. has been involved.

Conclusions

As stated earlier, just as the mind and body function in an integrated or holistic way, we believe

the therapeutic approach to infertility should be similar. Our organic-medical and psychotherapeutic staffs need to be able to open up avenues of regular communication, facilitating growth of mutual respect and an increasingly coordinated treatment approach.

Surely a strong case for this is made by the following facts. Of the twelve cases with a history of failed I.V.F. treatments who chose to have further I.V.F. after sessions with us, eleven conceived successfully. Nine of them conceived with their first attempts. Two other women failed with their first I.V.F.s, but conceived after their second and third attempts, and all the couples appear convinced that our work has been an effective influence upon their subsequent success.

On the psychological side there are reports of individuals being helped by the exploration of stress factors, the use of hypnotherapy and cognitive therapy approaches, etc. However we believe, from our experience as a co-therapy couple, that it is best initially to allow time for our couples to explore, in an unhurried way, aspects of the human story that may well lie behind a relatively unexplained infertility. It may be that specific psychotherapeutic approaches can become indicated later with some cases.

We also believe that such an unhurried exploration as ours must occur in parallel with any biologically-based intervention programmes, and preferably begin before-hand. And we have increasing statistical evidence that such an exploration on our part has been increasingly effective in our moves from our individual psychotherapeutic approaches with one or both partners, to the inclusion of some group work with the couples, and eventually to our increasingly experienced co-therapy work with the couples.

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Dr George Christie
24 Beaconsfield Road
East Hawthorn 3123