Some socio-cultural and psychological aspects of infertility

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A link is suggested to exist between any unexplained or relatively unexplained lowering of fertility and an inner sensitivity, largely or wholly unconscious, to some situation that renders it an unsuitable time or place for the individual or couple to allow the arrival of a baby. The psycho-social and intra-psycho processes involved in such situations can be quite subtle, and the question of their neuro-endocrinological connections presents an intriguing area for future research. Some sociological, anthropological and psycho-analytical findings relevant for this theme are outlined here. Three illustrative vignettes are presented, the clinical material on which the findings are based is summarized briefly, and a discussion is held about what appears to be required in treatment.

Key words: infertility/psycho-social factors/psychotherapy

Introduction

Very few cases of infertility find their way to the psychoanalyst or analytical psychotherapist. In terms of quantitative scientific research, evidence for psychogenesis in infertility is limited and inconclusive. Many individuals and couples with serious psychological problems conceive and give birth to babies, and many couples seen as reasonably ‘normal’ do not.

However clinical experience has suggested to myself and others that the mind does have a part to play in bringing about many cases of unexplained, or relatively unexplained, infertility (Christie and Pawson, 1988, 1989). This view seems to be in harmony with a background of findings that socio-cultural forces can exert a striking influence on human birth rates over time, an influence that is still far from fully understood.

Perhaps we psychiatrists and psychologists have contributed to a widespread failure to accept the importance of psychological and psycho-social influences upon human fertility. There has been a tendency on our part to support an assumption that this will require proving the infertile are more psychiatrically ill or psychologically disturbed than their fertile counterparts. A number of well-controlled studies (e.g. Ford et al., 1953; Eisner, 1963; Seward et al., 1965; Mai et al., 1972; Platt et al., 1973; Brand et al., 1982) have explored this area without establishing such proof. Some studies appear to claim a link between emotional stress and infertility, but as Seibel and Taymor (1982) point out, they do not always distinguish between emotional stress resulting from infertility and stress that might cause it.

But do we really know what to look for in the area of psychogenesis? In evaluating an infertile couple it is surely not enough to find that a woman is failing to ovulate or a man is failing to produce sufficient healthy spermatozoa, even if we can demonstrate neurotransmitter or hormonal imbalances or the presence of various types of relevant antibody. It is also not enough to find that a woman’s cervical mucus is having a paralysing effect on her partner’s spermatozoa. Do such findings provide answers in any fundamental sense? Do we even know what the questions are here, or how they may relate to the essential nature of what is happening between a man and a woman?

The role of psychoanalysis in seeking answers is best served by its capacity to reopen the questions. The questions I wish to reopen here concern variations in the levels of fertility, and they emerge from my experience with several women in psychotherapy who have conceived, carried and successfully delivered babies after varying periods of infertility or subfertility, and sometimes following protracted and unsuccessful fertility investigations and treatment.

Ambivalence about the prospect of conception and childbirth is universal (Feder, 1980) and, in itself, of course, does not cause infertility. But if the hostile and fearful side of this ambivalence is disavowed, and its return to consciousness warded off by a defensive idealization of the state of being pregnant and a frenetic need to conceive, then fertility levels can fall, at least temporarily. In psychotherapy with such patients it is noteworthy how often conception can follow the woman’s increasing capacity to retrieve her negative feelings and achieve a more balanced awareness of having strong feelings both for and against allowing a baby to arrive.

Clinical experience also suggests that a link can exist between unexplained infertility and a deep sensitivity within the individual, at an unconscious level, to some situation rendering it an unsuitable time or place to allow the arrival of a baby. Such a situation may involve intra-psycho conflict or some inter-personal or psycho-social problem. The unconscious processes involved can be quite subtle, going deeper than anything represented in currently popular concepts of stress and its management. I am referring to a deep readiness to allow the arrival of a baby or a temporary or more lasting inhibition of that readiness.

Some individuals are more sensitive in this respect than others. Benedek (1952) has suggested that a woman who inhibits her procreative potential in this way is often psychologically stronger than one who conceives irrespective of the situation. I have certainly been impressed by the quality of parenting displayed by several such women when eventually they have been able to allow the arrival of a baby, suggesting
perhaps that the past inhibition may have included a deep intuitive awareness of what was best for the potential child at that point in her life.

Anyone working with cases of unexplained or relatively unexplained infertility must be able to provide a setting in which the individual or couple can explore, in an unhurried way, the hidden and sometimes moving conflicts that may lie behind such an unconscious holding back from successful conception. In my view such an unhurried exploration should be undertaken before the couple is fully launched into our established programmes of skilled technological intervention, even sometimes with women presenting relatively late in the reproductive years.

Perhaps we need to keep in mind the words of two German workers in the field (Petersen and Teichmann, 1984), that ‘a baby will come when it wants to come’, and try to deepen our understanding of what this means. They also quote an old French proverb: ‘Time respects nothing that has been done without it.’ We must take time to deepen our understanding of these problems before we take action.

Such an attitude, Petersen and Teichmann (1984) believe, will increase our awareness of a deeper level involved in the creation of a human being. It will enable us to make contact with aspects of conception or its inhibition that go deeper than our current fragmented knowledge of bodily processes, and deeper than our current notions of external stress. Petersen and Teichmann (1984) are attempting to describe a level that incorporates such phenomena as the feelings of certainty, perceptual aliveness and sudden sense of a three-person situation that can characterize the onset of conception for a couple who are ready to allow the arrival of a baby and to nurture it.

We know very little about this deeper level. We need a pooling of information, not only from our physicians and physiological researchers, but also from our infertility counselors, psychoanalysts, sociologists and anthropologists, and from workers like Ann Morgan, Campbell Paul and Frances Salo-Thompson in Melbourne, Australia, who are interested in the most subtle aspects of the interaction between mother, father and baby, both in anticipation (pre-birth, even pre-conception) and in the actual interactions postnatally (Paul and Salo-Thompson, 1997).

**Socio-cultural aspects of human fertility and infertility**

‘Every human society’, wrote Margaret Mead (1950), ‘is faced not with one population problem, but with two — how to beget and rear enough children, and how not to beget and rear too many’.

However, as Seibel and Taymor (1982) point out, we are only in the earliest stages of understanding the nature of the interaction between socio-cultural forces and the mind, and between the mind and the neurological, hormonal and immune systems of the body.

Human birth rates are clearly influenced by socio-cultural forces. May (1978) informs us that if an agriculturally based tribe enters a nomadic phase, where children would impede travel, the birth rate falls markedly because of a combination of physiological and culturally ingrained behavioural adaptations.

There is a delay in the onset of menarche in the girls, a delay in marrying, a decreased frequency of intercourse, an increase in the number of celibates, an increase in abortion and infanticide, and greatly lengthened periods of breast-feeding, with its associated contraceptive effect. If the nomads eventually settle down into being an agrarian society, and start to farm the land again, these processes are reversed and the birth rate rises steeply.

It was in 1798 that Thomas Malthus, the English curate with an economics degree, argued that any population, if unchecked, tends to grow faster than the available supply of food and other resources (Malthus, 1966). He went on to suggest that when this phenomenon exceeds a certain point, natural checks come into operation. Malthus described two kinds of check: those that increase mortality — war, poverty, pestilence and plague — and those that reduce fecundity — abortion, infanticide and sexual deviance.

Anthropologists are sometimes able to observe Malthusian factors in action. In the 1940s poor seasons had a devastating effect on the food supply of the Aborigines on Bentinck Island in the Gulf of Carpentaria in the north of Australia. Professor John Cawte (1975) described the striking increase in abortion, infanticide, kinship killing and suicide — in short, psychic genocide — that followed this famine. When two Aborigines, Shark and Rainbow, were arrested for murder and imprisoned, they tore out their testicles with their fingernails and handed them through the bars. They didn’t know why they did this, and later one of them died.

It is clear, then, that primitive psycho-social forces can operate deeply and powerfully in determining human fertility behaviours. But in the modern world Malthusian responses can be obscured by other factors. Major advances in food production and health care in Western societies, combined with steep birth rate rises in Third World countries, have resulted in a 6-fold increase in the world population in the last 150 years (from 1 billion to ~6 billion). During the same period the birth rate in advanced Western societies has shown a gradual continuing drop, except for a post-war baby boom so extended that several sociologists suggested voluntary childlessness was nearly extinct (Veevers, 1971).

However since the baby boom ended in the 1960s an extraordinary and unprecedented increase in childlessness has begun and continues to this day. Much of this increase is voluntary, and has evolved as a consequence of some major social changes. These include the increasing opportunity for humans to separate the pleasure of sexual activity from its reproductive function, and the increasing acceptance of a woman’s right to choose not to have children. This acceptance has been facilitated by the increasing availability of career opportunities for women, and the increasing success of women in these careers. Such changes have made it possible for many couples to make a sensitive and responsible decision not to have children.

But other factors appear to be operating as well, as suggested, for example, by the findings that family fertility levels in European cities and towns are consistently lower than in rural areas (Andorca, 1978). All social strata show greater fertility in rural villages than in towns; the type of residence, type of
neighbourhood and distance from the central city all seem to influence the level of fertility. The single detached dwellings, mostly with gardens, are those where the couples with highest fertility live, and apartment houses are the least conducive to large families.

The History of Childhood by de Mause (1974) emphasized the past ubiquity of infanticide, its persistence until relatively recently in parts of Europe, and its existence today, e.g. in some rural areas of China. Its disappearance may be more apparent than real, of course, e.g. the increasing incidence of serious child abuse. There are more ways of destroying an Oedipus than by exposing him upon a hillside.

A psychoanalyst, Luis Feder (1980), includes the infanticidal wish in his concept of ‘pre-conceptive ambivalence’, i.e. an ambivalence towards pregnancy present in all of us, with a particular emphasis on both members of a potential parental couple. He emphasizes a universal repression in relation to this ambivalence, seeing the universality of the infanticidal component as being matched by the universality of its denial. According to Feder (1980), such preconceptional ambivalence, contributing to the inner conflicts we all have as parents, continues to exert its influence during the ensuing development of the child. For example, he sees it as an important factor in the genesis of the Oedipus Complex. It certainly applied to the legendary Oedipus himself, whose parents tried to kill him in infancy.

So the lessons of history, the findings of anthropologists and sociologists, and the clinical experience of psychoanalysts all support a view that there is a balance in all of us between the human wish to allow the arrival of a baby and to nurture it, and the human wish to prevent it coming, to abort it or to destroy it in other ways, a balance that can shift towards one side or the other. In these shifts our individual psychic functioning is responsive, as always, to large and small group forces, as well as to the forces within us. We humans show a varying degree of susceptibility to such group forces, yet we know relatively little about their essential nature.

The mind and infertility

Unexplained or relatively unexplained infertility should always be explored first as a conjugal or couple phenomenon. At times deeper psychotherapeutic explorations may be indicated with one partner, but this should be augmented every now and then by further sessions with both partners together. We need to keep in mind the psycho-physiological processes arising in two people, and allow for the continuing effect of each individual on the other in a particular psycho-social setting. It is interesting to note that instances are recorded where fertility has started to decline in one partner as it begins to return as a result of treatment in the other.

Psychogenic infertility in the woman

The motivational problem in motherhood for any woman does not lie simply in having ambivalent feelings about producing children, for the existence of such feelings, as we have seen, is universal, and is heightened for Western women by their increasing freedom to seek higher education and careers. Even pathological degrees of inner conflict over conception do not necessarily lead to infertility. For example, some women seem to develop a compulsive hyperfertility, even in the face of successive puerperal depressions. Helene Deutsch (1925) has commented as follows: ‘... how often sterility and excessive fertility stem from identical sources and merely represent two faces of a psychic Janus.’ We can be blind to this, and may even transform one into the other through hormonal and technological interventions.

In exploring this area it can be helpful to consider what characterizes those women in whom a readiness to deliver and mother a child has begun to prevail over all other feelings. Erik Erikson (1963) was considering women who had reached this stage when he coined the term ‘generativity’ to express the human need to take care of a child and be responsible for its upbringing.

Generativity implies a primary interest in establishing and guiding the next generation, and Erikson (1963) believed that this emerges predictably in each of us when and if we reach a certain stage of psycho-social maturity. This means having not only the capacity to take responsibility for our own lives through achieving a sound sense of self, but also the emerging ability to lose ourselves in a meeting of bodies and minds, in other words a capacity for a deep intimacy with another adult. According to Erikson (1963), these achievements in a woman lead to a gradual expansion of her interest and instinctive investment to include a child, which has been generated and accepted as a responsibility. The same considerations apply to the male partner. So we need to have two people, each with a defined sense of personal and sexual identity, joined in a fond and cooperative (meaning a generatively ambivalent) relationship, both ready, as a couple, to care for the child and accept a long period of responsibility for its upbringing.

A good deal is involved in reaching such levels of maturity. Dinora Pines (1990), a psychoanalyst specializing in the treatment of women, has underlined the dual and conflicting maturational tasks faced by any woman entering the child-bearing years. These involve being able to identify with her own mother’s womanly capacities, while at the same time continuing to separate and individuate from her mother emotionally, so as to take over full responsibility for her own sexuality and her own body. In this, of course, she will be helped by the support of an understanding partner, who has achieved a similar separation individuation. These findings are clearly in accord with Erikson’s (1963) 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.

As part of our growing capacity to take over our own lives we need to acquire an optimal awareness of our own ambivalence, together with a readiness to take responsibility for this. The sense of freedom that accompanies a real move towards separation individuation, and the growing capacity (with some humour perhaps) to acknowledge our own ambivalent feelings, are both important prerequisites for our readiness to allow the arrival of a baby.

But of course there are other reasons why human beings
may wish to conceive, e.g. a need to bolster self-esteem, repair cracks in a marriage or meet a parent’s need to become a grandparent. Referring to women, Dinora Pines (1982) states that these other reasons may well be accompanied covertly by an increased resistance to the challenge of parenthood. Such an unconscious resistance can lead a woman to ‘forget’ certain steps in her consciously sought infertility clinic treatment programme in the same way that the woman consciously seeking to avoid pregnancy can ‘forget’ to take the Pill after nursing a neighbour’s baby. In addition, a woman can be stimulated into ovulation, only to find her husband impotent during the fertile period. He can be helped to overcome this, and she can then lose her desire. Such is the strength of our consciously disowned motives.

In 1959 Grete Bibring reported on the findings of a 1951 screening team set up in the Pre-Natal Clinic of the Beth Israel Hospital in Boston, MA, USA. The team’s task was to interview newly admitted pregnant women and refer emotionally disturbed individuals for psychotherapy at an early stage. A great number of early cases were referred, presenting with disturbing symptoms involving depressive reactions, primitive anxieties and paranoid mechanisms, frequently associated with the woman’s relationship to her own mother.

However the past and subsequent histories of these women were usually very different from those of non-pregnant individuals referred to therapists with such disturbances. The pregnant women’s past histories rarely revealed major symptoms or pathological behaviours prior to the pregnancy. Even more striking was the relative ease with which good results could be obtained with a largely supportive therapy. The subsequent adaptation of these patients to pregnancy, delivery and parenthood was often better than had been anticipated.

In reflecting about all this, Grete Bibring (1959) was able to recognize that a maturational ‘crisis’ of pregnancy was being demonstrated by the women. She concluded that the acute disequilibrium found in this crisis provides another testing ground for psychological health, to be compared with the earlier maturational crisis of adolescence and the later one of the menopause. She saw the mastery of this crisis as crowned by the achievement of motherhood, and proceeded to add this footnote: ‘These conceptions which we arrived at were often very different from those of non-pregnant individuals referred to therapists with such disturbances. The pregnant women’s past histories rarely revealed major symptoms or pathological behaviours prior to the pregnancy. Even more striking was the relative ease with which good results could be obtained with a largely supportive therapy. The subsequent adaptation of these patients to pregnancy, delivery and parenthood was often better than had been anticipated.

In his extraordinary work, The Marriage of Heaven and Hell, the English poet, William Blake (1977), indicated that when our destructive feelings are unrecognized, then our creative urges are blocked. But as Donald Winnicott (1982b) has shown, when the destructive side of our ambivalent feelings is recognized, as well as the loving side, then our creative potential can be released, as in the genesis of playful humour. So if a woman isn’t ready to face the maturational crisis of pregnancy, and the uncovering of deeply ambivalent feelings, her creative urges may become blocked, at least temporarily.

An analogy for any such defensive lowering of fertility might be found in the way an adolescent can adopt a recognizably defensive position (e.g. a temporary asceticism) until the individual ego strengthens enough to be capable of managing the hormonally intensified libidinal and destructive impulses.

If it is possible for infertility to represent such a defensive position, why do only some women respond in this way? What evidence for such a psychogenesis is available from reports of women treated in analytical forms of psychotherapy? Only a limited number of papers have been published dealing with these questions. Both Therese Benedek (1952) and Dinora Pines (1990) have described how the behaviour, fantasies and dreams of women in analysis can reveal themes that correspond with different phases of the menstrual cycle. Benedek (1952) showed how, during the luteal phase, a regressive intensification of needful and receptive tendencies towards their own mothers can, in some women, revive anxiety, depression and powerful conflicts associated with the very early child–mother relationship. Benedek (1952) saw this as evoking a core of danger for these women, and suggested that a process of psychic repression can then inhibit either phase of the menstrual cycle, with resulting infertility. She added, however, that this may well be a transitory, curable condition. As mentioned previously, Benedek (1952) has suggested that a woman inhibiting her procreative function in this way is often psychologically stronger than one who conceives irrespective of the situation.
A number of early American papers are also relevant here, e.g. Rubinstein (1951), Ford et al. (1953), Rothman et al. (1962) and McLeod (1964). All these workers reported on the frequent finding in infertile women of repressed hostile feelings towards their own mothers, warded off by a defensive over-protectiveness, e.g. an obligation to maintain daily telephone contact with them. This repressed hostility was also leading these women to fear, subconsciously, that if they became mothers they would hate their own children and be hated by them in return. In analytical treatment, as these women became aware of how much underlying hostility they felt towards their mothers, they started to make contact with the genuinely loving side of their ambivalent feelings, and started to relate authentically with the mothers, rather than over-protectively, usually with a positive response from the mothers. Almost all these women conceived during or shortly after a period of analytical treatment that had enabled them to achieve further increments of separation individuation from their mothers.

It is also worth noting that a woman with ‘unexplained infertility’ may become so free of anxiety through the psychic repression involved that she can assert, apparently unambivalently, her conscious wish to become pregnant. Moreover a difficulty in repressing more intense ambivalent feelings may then lead to an increasingly defensive over-idealization of pregnancy, and a frenetic need to conceive at any price — ‘Give me children or I shall die!’, as Rachel cried out to Jacob (Genesis, Chapter XXX).

Different degrees of Rachel’s attitude can often be found among those seeking help from modern technology. But such an attitude derives from a defensive position based on repression and denial, something qualitatively different from the more mature, somewhat apprehensive, readiness to allow the arrival of a baby and to nurture it, and to be responsible for it, conveyed by Erikson’s (1963) concept of ‘generativity’.

**Psychogenic infertility in the man**

The male partner can contribute to a barren union either by failing to manufacture healthy spermatozoa or by failing to deliver them to the right place at the right time. The psychopathology of different forms of psychogenic impotence has been outlined by Rothman and Kaplan (1972).

The story is different when we turn to dealing with reduced or absent spermatogenesis. There is an extensive field of well-documented research into organic pathological processes, but for some reason the possibility of a psychosomatic process seems largely to elude the interest of research teams, psychiatrists or even psychoanalysts, despite the fact that an organic basis can be established in only a minority of cases. Benedek et al. (1953) have commented: ‘Psychoanalytic studies of men, however, hardly touch on the problem of infertility, as if it were tacitly assumed that man’s fertility, belonging to the realm of organic physiology, lies outside the territory of psychological investigation.’ Why is this so? Perhaps it is a surviving expression of an earlier reluctance to look closely at male infertility at all. Until relatively recently the female partner was often subjected to some sort of diagnostic surgical procedure before the male partner was investigated at all.

There is, however, one striking and macabre report of psychogenic inhibition of spermatogenesis in the literature. de Watteville (1957) refers to a German book by Stieve who examined the testicles of men convicted and executed shortly after committing rape. Even in cases where the rape had allegedly led to pregnancy, the autopsy material without exception showed complete inhibition of spermatogenesis and complete absence of spermatoza. Similarly, if a woman is summarily sentenced to death, her uterus begins to bleed within hours, no matter where she is in her menstrual cycle. The rapidity of these processes, evoked by fear of death, suggested a neurogenic, rather than hormonal, mechanism. The starkness of these pictures seems to provide an allegory for the primary forces of life and death. There can be no doubt about the power of the human psyche here.

Of considerable interest also is evidence that the stresses associated with prolonged infertility clinic investigations can provoke impotence in some males (Berger, 1980) or even a drop in semen quality (Rothman and Kaplan, 1972). There is also the finding that 10% of infertile males show an improvement in their semen analysis results after cessation of all infertility clinic treatment for a prolonged period (Weisman, quoted by Seibel and Taymor, 1982).

**Adjustment to an established diagnosis of infertility**

Important aspects of the reactions of individuals and couples to the diagnosis of infertility have been described carefully by Joan Raphael-Leff (1991). The discovery of a somatic disorder in infertility investigation is always traumatic for the individual or couple. There is often an initial inclination to repress or deny emotional reactions, with, for example, the emergence of a frenetic wish to rush into adoption, artificial insemination, in-vitro fertilization, surrogacy, etc. At this point it is necessary for someone to stay with the couple and to help them explore and work through their feelings. Only then may it be possible for the couple to find the most appropriate choice emerging naturally from the options open to them, options that might include psychotherapy for one or both partners.

The emotional and relationship consequences for the infertile couple before, during and after in-vitro fertilization treatments, and the necessity for relevant psychological services, have been carefully explored recently by Slade et al. (1997).

**Clinical material**

I would now like to outline briefly three cases of infertility where time and space have been provided for an unhurried exploration of the situation. These will serve to illustrate some aspects of the different levels of difficulty that can arise for patients in this area.

**Case A**

The first case is of a woman who asked her general practitioner to recommend a psychotherapist to help her explore her feelings, a promising prognostic sign in my experience. A 37 year old woman, Mrs A., had been married for 10 years and trying to conceive for 3 years. Infertility investigations had
revealed no abnormality, although there had been a slight question about her husband’s sperm motility. Mrs A. had always wanted children, e.g. she chose a name for a future daughter while still a teenager. On marrying, she and her husband became preoccupied with developing their careers and establishing themselves financially. Her own career success had been spectacular. Over a period, however, as their friends started having babies, she began to feel that it was time for her to have a baby too, and she found her subsequent failure to conceive frustrating and perplexing. She was used to a scientific world where one could go after answers with alacrity. She enjoyed the feeling of being in control in this world, and wondered whether this could be interfering with her reproductive capacity.

Mrs A. had been placed on an in-vitro fertilization programme previously, and had conceived for the first time, only to have a spontaneous miscarriage at 8 weeks. She had felt devastated by this experience, remaining ‘always on the verge of tears’, for she had been brought up always to show ‘a stiff upper lip’. Eventually she found herself deciding that there was something within her that she didn’t understand, and that she needed to explore it with a psychotherapist.

The eldest of four children, Mrs A. felt that a deterioration in the marriage of her parents over 15 years or so had exerted a powerful effect on herself and her siblings, although this seemed to have lessened since the parental divorce 4 years previously. She had felt inhibited and unable to speak freely with her parents. Clearly over-protective in her attitude towards her mother, Mrs A. had allowed herself to become the mother’s confidante. She was now accustomed to allowing her mother to criticize the father continually. This was at the price of suppressing her own feelings as a daughter, for she had rather idealized her father in childhood.

I arranged to see Mrs A. regularly to allow her to explore the situation further. I expressed the view that a fertility problem such as hers was sometimes associated with some hidden emotional conflict, with often a very human story behind it. After some reflection about the emerging story, Mrs A. told me that she had decided, with her husband’s support, to ask her mother to come and stay for a period, and said she intended, for the first time in her life, to talk with the mother and give expression to her own genuine feelings.

Mrs A. began her fourth session by saying ‘I’m pregnant, I’m 5 days overdue!’ When I suggested that perhaps this might need confirmation, she smiled rather tolerantly and said ‘No, I know I’m pregnant, and this time there will be no miscarriage.’

Mrs A. went ahead with the plan for the mother’s visit, and proceeded to talk with her mother at length about her own previously concealed feelings concerning the unhappy parental marriage, and about her intention now to resume and maintain the valued contact with the father. There were some disagreements between daughter and mother, but the latter grew to accept the new developments in their relationship. It was clear that Mrs A. had handled the situation with firmness and tact. When she eventually gave birth to a cherished baby daughter, Mrs A. gave her the name she had chosen in her teenage years. And a year or so later, a baby son arrived.

Mrs A. had presented as a highly motivated woman, able to challenge her tendency to over-control feelings, able to face the fact of her own ambivalent feelings towards the father and to find a constructive avenue of expression for them, and able to achieve thereby a further increment of individuation from the mother. In all this she was assisted by her husband’s support and understanding.

Case B

At the time of her referral, Ms B., a 37 year old, successful businesswoman, had been living with her partner for 10 years and trying to conceive for 3 years. At one stage a gynaecological investigation had revealed a degree of cervical mucus acidity, with poor sperm penetration, for which alkaline douches had been prescribed.

Ms B. had been distressed by her failure to conceive, and was initially convinced that she had an organic problem. She had used an intrauterine device for some years, and suspected this had caused uterine damage. Seeking help for her infertility, she wanted absolute answers and quick and definitive treatment.

When her gynaecologist suggested she come to see me, Ms B. resisted the idea at first. She eventually made an appointment, appearing very guarded in the initial sessions. A lively, emotional and articulate woman, she told me of the extreme frustration felt in relation to her partner, whom she saw as a silent, introverted man.

She also told me of difficulties she had in relation to her immigrant family of origin. The eldest of four children, Ms B. had found it difficult as an adolescent to separate from her possessive, anxious parents. She had always had a troubled relationship with her mother, and even now was still finding it difficult to differ openly with her. She knew her mother was unhappy, on religious grounds, about the de facto relationship, and Ms B. felt very uncomfortable about this.

In revealing her reluctance to see me Ms B. went on to say that she had suffered from an eating disorder in late adolescence, was wary of psychiatrists and felt resistant to the idea of psychotherapeutic probing. As we continued to meet in an unhurried atmosphere, her resistance began to lessen. We settled into weekly sessions, and soon there were signs of a developing positive transference within the relationship. However Ms B. told me she was feeling increasingly that she would never be able to have a baby. She wanted her gynaecologist to make appropriate tests that would confirm this, so she could devote her time fully to a successful business career.

Ms B. began to recount some traumatic experiences as a child. At one stage she had been required to look after her younger siblings, including a toddler. One day the little child slipped and fell, injuring his leg. She recalled her panic attempts to ring a hospital. The mother flew into a rage on her return, and for months continued to criticize the daughter’s ‘neglect’ of the sibling. The child apparently recovered satisfactorily, but this and similar experiences combined to make the patient feel she lacked a capacity to look after a child responsibly.

As our therapeutic contact developed further, her frenetic need for answers seemed to recede, and she was increasingly able to own a conscious 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 (a new and positive development).

After enjoying a short holiday, Ms B. returned to her 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 that 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 in our weekly sessions, 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 ultrasound photographs showing a growing fetus. Around 5–6 months she was eventually able to find the courage to face her mother and give her the news. The mother reacted calmly to this, and gradually began to do things for her daughter.

Things now began to change markedly for Ms B. Her nausea disappeared completely. She began to discuss future plans more maturely in our weekly sessions, and seemed to be less dependent on my support.

The birth of a delightful little baby girl was greeted with great pleasure by both the patient and her partner. The baby sucked well, breast milk flowed freely and the baby was soon sleeping long hours at night. The sound mother–infant relationship and father–mother–infant relationship was striking to observe in the light of Ms B.'s initial inclination to seek an abortion.

Subsequently her partner was transferred to a responsible work position in Ms B.'s beloved country of origin. He and Ms B. proceeded to marry, and she, although a little apprehensive, looked forward to the new life overseas. On a brief trip back to Melbourne she was able to inform me she was again pregnant, and since then a second baby daughter has arrived.

I believe that this case illustrates several important features in the psychotherapeutic management of the infertile patient.

(i) Premature interpretation of this woman's preconceptive ambivalence could well have been a persecutory experience for her. It was of paramount importance here to establish a successful therapeutic engagement, with provision of a genuine containment, so that awareness of her own ambivalence could emerge in its own way and in its own time.

(ii) Ms B. 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 the persisting wish to have a child. It is interesting to speculate on the creative implication of her emerging awareness of these contrary, and how this may have helped to release her capacity to allow the arrival of a baby and to nurture it.

(iii) Aided by the psychotherapeutic containment, Ms B. could face her mother during the pregnancy, achieve a further degree of separation-individuation from her and further facilitate the emergence of her own maternal functioning.

I would now like to present a short vignette of a couple where no psychological factor seemed evident at first, until an intriguing story suddenly emerged.

Case C

Mrs C., aged 39 years, was referred to me following several unsuccessful cycles of artificial insemination with the use of her husband's semen. She has a university degree, a good job and what appears to be a sound marriage. Both she and her husband, aged 50 years, were aware of mixed feelings about whether or not they wanted children.

The youngest of three children, Mrs C. had been her father's favourite and she had left at length when he died in her 15th year. Tears came to her eyes again as she recounted this story to me. Her mother was also devastated by his death, and Mrs C. had to be very supportive of her. She added that she had always had a rather tempestuous relationship with the mother, mitigated by the mutual respect they had for each other.

Tension developed in the relationship with her mother when Mrs C. went to university and started going out with young men. She eventually moved in to live with her future husband and, after a year, they married. Mother initially opposed all of this, but the difficulties between the newly married couple and the mother were eventually resolved through persistent discussion between the three of them, leading to an apparently good quality of relating since then.

So Mrs C. has been able to separate and individuate satisfactorily from her mother and take over responsibility for her life, supported by the sound relationship with her husband. In addition, both husband and wife had been able to hold on to an awareness of ambivalent feelings about the prospect of parenthood. How then could a psychological factor be operating in Mrs C.'s fertility problem?

The interesting fact then emerged that a few years ago, when the mother died, aged 80 years, Mrs C. had been unable to cry. A short time later she was found to be suffering from raised blood pressure, diagnosed as essential hypertension. During a consultation, 3 months after the mother's death, Mrs C. was asked by her sensitive woman general practitioner: 'Has anything significant happened in your life recently?' Mrs C. began to speak of the loss of her mother, burst into tears, and began to weep at length for the first time. She didn't understand what she was experiencing, but her raised blood pressure began to subside.

It also emerged that whereas Mrs C.'s mother had been only in her 20s when the two elder siblings had been born, Mrs C. had been conceived by her 'accidentally' at the age of 43 years. After the birth of Mrs C., the mother developed painful, swollen breasts and proceeded to suffer a severe puerperal depression which required hospitalization. The baby was taken from the mother, placed with friends for a short time and then placed with an aunt for a few months. She was eventually reunited with the mother. An apparently reasonable relationship between mother and daughter developed, with its admittedly 'tempestuous' element.

In a series of sessions it became possible to take up with Mrs C. the possibility that the sudden separation occasioned by her mother's death had revived in the depth of her inner
being something of an originally powerful response to the separation in early infancy. As Bion (1961) points out, in the initial proto-mental processes of infantile life, psyche and soma are not clearly separated out from each other. In a recent book, Joyce McDougall (1978) 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 in which to express their emotional pain.

I proceeded to raise with Mrs C. the possibility that as a newborn infant, abruptly separated from her mother, she may well have experienced a powerful response for which there would have been no words or images or playful avenues of expression, only a psychosomatic one, as represented later by her raised blood pressure. When she had been able to weep at length about the loss of her mother, in the empathic, holding presence of her female doctor, she had, perhaps, been expressing something of the original loss as well as the more recent one, and her raised blood pressure had returned to normal. Mrs C. was intrigued by these possibilities, but found it hard to think about them.

In our subsequent sessions Mrs C.’s feelings of reluctance about having a baby at her stage of life began to intensify, along with the feeling of sadness about this. However, now aged 40 years, she proceeded to conceive for the first time in her life. Nausea in the first trimester was very troublesome for her, but this eventually cleared and she started to enjoy ultrasound pictures of the fetus. Apprehensive about the prospect of labour, she nevertheless resisted any suggestion of a Caesarean section. She eventually had a normal labour, was deeply gratified to find a lovely baby boy in her arms, and her breast milk flowed freely.

On weaning the baby 9 months later Mrs C. suddenly felt so depressed that she sought out some literature on post-partum depression. She then rang me, but before I could return her call she apparently started to weep and soon felt quite well again. This sequence suggests that the increment of mother–infant separation implicit in the weaning process had once again revived a trace of the original separation experience deep within Mrs C.’s psyche.

The clinical figures
Over a period of several years 30 patients with unexplained, or relatively unexplained, infertility have been referred to myself, or, more recently, to myself and my group co-therapist, Ann Morgan (see Table I). In each case the female partner has been interviewed and, where possible, the couple.

In all, 20 of the female partners involved had never been pregnant previously. Of the other 10, four women had given birth to at least one child many years earlier, and two had voluntarily terminated earlier pregnancies; four women had conceived and miscarried (two of these repeatedly); two of the 10 had a history of one ectopic pregnancy.

Of the 30 cases referred, only initial exploratory sessions were conducted with eight. One couple came from New Zealand for evaluation, and the woman was subsequently referred to an Auckland psychotherapist. In 22 cases the female partner or the couple have attended individual and/or group psychotherapy.

Of the 30 cases seen, 17 of the female partners have proceeded, sooner or later, to conceive. In five cases conception followed the initial evaluation sessions. In 12 cases conception occurred after the onset of individual and/or couple group psychotherapy.

In all, 15 babies have been born to these 17 women: one was a second pregnancy after the initial one during psychotherapy miscarried and one pregnancy is continuing. The 15 babies born so far include a pair of twins, while two pregnancies miscarried spontaneously. Of the 17 women, six have gone on to deliver at least one additional baby at a later date.

Of the 17 women who conceived, 12 presented with unexplained infertility, two with a gynaecological diagnosis of ‘hostile cervical mucus’, one with a report of immature ova and two with a story of repeated spontaneous miscarriages. Three had had unsuccessful in-vitro fertilization cycles, and two had received monthly intra-uterine injections of their husband’s semen over an extended period.

A total of 13 women failed to conceive. In five cases treatment is continuing. The remaining eight women have stopped attending therapy sessions.

One woman with severe endometriosis discovered that both her Fallopian tubes were blocked. She and her husband left our group therapy and proceeded with in-vitro fertilization. Two of three transferred ova began to develop. One miscarried, but the remaining pregnancy is continuing. (This pregnancy was not included in the success figures above.)

One woman began an extra-marital affair during psychotherapy and stopped attending the sessions, one couple decided to seek adoption and one couple moved overseas (husband’s job transfer). Another woman had a past history of peritonitis, one damaged tube and only one ovary. One couple with sexual problems, mild endometriosis and a low sperm count sought referral to a sex therapist. One woman was already in psychotherapy externally, and presumably continues with this. One woman completed individual therapy without conceiving.

Conclusions
The figures that have been recorded here are not matched with figures from any control group. Ann Morgan and I accept that
in the course of time some of our female patients may have conceived and delivered a baby without our assistance. However our overall experience suggests strongly to us that the following factors can influence an outcome favourably in cases of unexplained or relatively unexplained infertility.

(i) A developing need in the individual or couple to explore their feelings and the human story that may lie behind their situation.

(ii) The presence of an individual therapist or co-therapy couple able to provide space and time for an analytically informed listening to the emerging material.

(iii) A mutually respectful relationship and communication between the gynaecologist, his or her team and the psychotherapist or co-therapy couple.

Discussion

There are many areas of high-quality research into the somatic pathology and immunology of human fertility disorders. However we still have much to learn about the neonatal and postnatal development of the human brain and the gradual evolution of the human immune system. We are still only in the earliest stages of uncovering basic human biopsychosocial truths relevant to the overall understanding of human reproductive functioning and the variable levels of fertility in our communities. If we are to understand these matters more fully, a continuing collation of insights from a wide spectrum of research areas will be necessary. Any preoccupation with new technologies developing out of our research that focuses on the manufacturing of babies without providing adequate time for exploring the psycho-social aspects of the situation should cause us some concern.

As we face our cases of unexplained or relatively unexplained infertility, we need to discover what prepares an individual or couple to be able to allow the arrival of a baby and be ready to nurture it, and what may interfere with such readiness. As we have seen, infertility does not result from ambivalence per se, as this is well-nigh universal. However clinical findings do suggest that a lowering of fertility can develop in a woman, mediated perhaps along psycho-neuro-endocrinological pathways, when there is failure to recognize a heightened ambivalence towards pregnancy, developing in the context of an incomplete separation individuation from the mother (cases A and B). Clinical experience also suggests that this is even more likely where there is unresolved grief and/or guilt over a past loss (case C). A heightened ambivalence may be defended against by the development of an over-idealization of pregnancy and a frenetic need to conceive at any price. But this is a defensive position, and is qualitatively different from the mature, phase-specific, somewhat apprehensive readiness to take care of and nurture a baby.

Unexplained infertility represents an exciting field for future exploration if we can stay with ‘not knowing’ and allow time for listening adequately to what our patients can teach us. As Joyce McDougall (1978) suggests, in relation to psychosomatic disorder generally, ‘... further insight into the processes at work may alter our way of listening to our patients.’ Clinical experience suggests that although some individuals may benefit from a psychoanalytical exploration, for the majority of our cases this is not indicated. Nor is the appropriate approach usually one of providing ‘strategies to deal with stress’.

What most individuals or couples with unexplained or relatively unexplained infertility seem to need is for somebody who will really listen to them, i.e. somebody able to provide time and space for a gradual exploration of feelings, providing an opportunity for the further growth of inner understanding that we all need from time to time in life. Just as an awareness of contrary feelings can facilitate the creative impulse in us all, so, apparently, can an increased awareness of a whole range of feelings about the prospect of conception help individuals and couples gain more access to their own creative potential as future parents. In addition, we have to be careful with our diagnostic categorizing. Essential as this is for the initial assessment, and for statistical purposes, it can get in the way of an interested exploration of the human story involved if it is a prevailing concern in the mind of the physician.

In all such work we are really groping for a more fundamental knowledge of the mysteries of love and hate, of birth and death. According to the ancient Greek myth, Persephone and her mother, Demeter, are initially inseparable. When Persephone is taken off to the underworld by Hades, and imprisoned, Demeter rages and grieves for her, and a great barrenness descends upon the land. Persephone proceeds to eat the seeds of the pomegranate, which ensures that even though she is free to go up above, she must always return to the underworld. She can be with her mother again, but on the condition that they always spend a third of the year separated. Only now can fertility return to the land. Stassinopoulos and Beny (1983) suggest that Demeter’s defensive clinging to the upper world, to the surface aspect of things, is associated with barrenness. When Demeter can finally accept a deeper reality, the earth blooms again in new life of its own.

Perhaps we pay a price if we ignore the creativity of these myths. To suggest this is not to devalue the quality of well-controlled research studies, but represents a plea that we bring our intuitive and objective approaches into some sort of relationship with each other, so that we can continue to assess all our findings from the broadest possible perspective.

Perhaps it is also a plea that we retain respect for what we can learn from our poets, and from those who are dignified bearers of the old folk beliefs. For it is not that these beliefs are always tested and found wanting. As Vann Spruiell (1988) points out, it is so easy for them to disintegrate and become lost in the face of expanding technologies and methods of mass communication. Profound splitting forces are operating here, and they can alienate us from our heritage and from parts of ourselves, depleting what we can otherwise offer to our patients.

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