

**Education Institution: Dublin Business School**

**Name: Eimear Walsh**

**Title: Giving up the Ghost: An Examination of Women's Needs in Coming to Terms With Infertility Following Unsuccessful In-Vitro Fertilisation Treatment.**

**Thesis submitted in partial fulfilment of the requirements of the BA Counselling and Psychotherapy.**

**Supervisor: Anne-Marie Reynolds**

**Date: 27<sup>th</sup> April 2012**

When inspiration has become hidden, when we feel ready to give up, this is the time  
when healing can be found in the tenderness of pain itself

-Pema Chödrön, *When Things Fall Apart*

	<b>Page Number</b>
<b>Table of Contents</b>	<b>3</b>
<b>Acknowledgements</b>	<b>5</b>
<b>Abstract</b>	<b>6</b>
<b>Chapter 1: Introduction</b>	<b>7</b>
<b>1.1 Introduction</b>	<b>7</b>
<b>1.2 Rationale</b>	<b>8</b>
<b>1.3 Aims and Objectives</b>	<b>9</b>
<b>1.4 Chapter Outline</b>	<b>9</b>
<b>Chapter 2: Literature Review</b>	<b>11</b>
<b>2.1 Introduction</b>	<b>11</b>
<b>2.2 Infertility: Traditional Psychotherapeutic Thinking</b>	<b>12</b>
<b>2.3 Infertility: A Contemporary View</b>	<b>16</b>
<b>2.4 Infertility and Grief</b>	<b>20</b>
<b>2.5 Conclusion</b>	<b>22</b>
<b>Chapter 3: Methodology</b>	<b>24</b>
<b>3.1 Introduction</b>	<b>24</b>
<b>3.2 Research Strategy and Design</b>	<b>24</b>
<b>3.3 Research Sample</b>	<b>25</b>
<b>3.4 Research Procedure</b>	<b>26</b>
<b>3.5 Data Analysis</b>	<b>27</b>
<b>3.6 Ethical Issues</b>	<b>28</b>

<b>Chapter 4</b>	<b>Results</b>	<b>29</b>
	<b>4.1 Participants</b>	<b>29</b>
	<b>4.2 Results</b>	<b>30</b>
<b>Chapter 5</b>	<b>Discussion</b>	<b>39</b>
	<b>5.1 Introduction</b>	<b>39</b>
	<b>5.2 Elaboration of findings</b>	<b>40</b>
	<b>5.3 Strengths and Limitations</b>	<b>46</b>
<b>Chapter 6</b>	<b>Conclusion and Recommendations</b>	<b>48</b>
<b>References</b>		<b>50</b>
<b>Appendices</b>		<b>54</b>
<b>Appendix 1</b>	<b>Participant Consent Form</b>	<b>54</b>
<b>Appendix 2</b>	<b>Interview Guide</b>	<b>56</b>

## **Acknowledgements**

Firstly, I would like to thank all those who participated in this study, whose wealth of experience and generosity with their time and knowledge made it all possible.

I would like to thank my supervisor Anne-Marie for her patience, honesty, common sense and guidance.

A special thanks to the wonderful people, peers and tutors alike who I have met along the way, who have inspired me, valued me and spurred me on when it all seemed so unattainable.

To my family, whose faith in me never faltered, even when my own seemed out of sight.

And finally to Pat, whose unwavering patience, support and caring attention was never far away.

## **Abstract**

This study aimed to explore the most salient issues experienced by women faced with definitive infertility and childlessness following unsuccessful in-vitro fertilisation (IVF) treatment as told by the psychotherapists who work with them. A qualitative research design was employed, semi-structured interviews were conducted and analysed in adherence to qualitative content analysis guidelines. The participants were accredited psychotherapists; five females and one male, with clinical experience in working with women who have undergone failed IVF treatment and remained childless thereafter. The findings indicate that definitive infertility and childlessness significantly impact on women's psychological and emotional well-being, their relationships with their partners and their wider social functioning. There was a general consensus among participants that women were often ill-prepared for both the intensity and demands of IVF treatment and that greater support is required post IVF failure in the process of facilitating women's acceptance of their infertility.

## **Introduction**

### **1.1 Introduction**

Infertility is defined as a lack of conception following one year of unprotected sexual intercourse (WHO, 1993). It is estimated that one in six couples of reproductive age experience fertility difficulties (Lord, 2005). Fertility rates have remained relatively constant for the past one hundred years (Mosher & Pratt, 1990), lower fecundity is widely accepted as being related to age and the growing trend for women in the Western world to delay childbearing until their late twenties, thirties and even forties has seen a significant rise in the demand for Assisted Reproductive Techniques (ARTs) such as IVF, intra-cytoplasmic sperm injection (ICSI) and in uterine insemination (IUI) (Nyboe et al., 2005). Success rates for those who avail of ARTs run at approximately one third (Walsh et al., 2011). For the purpose of this study IVF treatment will be the focus. The treatment involves four basic stages; firstly the ovaries are stimulated through the use of a hormone treatment and the eggs are matured, the second stage is to harvest or retrieve the matured eggs. The third stage involves the fertilisation of the eggs, successful fertilisation leading to the final stage, that of transferring the embryos back into the uterus. During the treatment the woman undergoes hyper stimulation of her ovaries; her reproductive system is then virtually shut down to a 'menopause', only to be blasted back into reproductive capability. Advances in medical technology have helped to identify many physiological factors such as endometriosis, ovarian failure and poor sperm production, contributing to or causing infertility. Psychological factors impeding the occurrence of normal sexual intercourse such as male impotence or vaginismus have also been identified as

have other psychopathologies owing to what psychoanalysts have traditionally referred to as psychogenic infertility. For one third of couples no cause for the infertility can be found (CAHR, 2005).

## **1.2 Rationale**

Infertility and its treatment have been found to cause significant impairment to women's mental health, quality of life and psychological well-being (Shapiro, 1982). In the Republic of Ireland ART is not State regulated despite a report issued in 2005 by The Commission of Assisted Human Reproduction (CAHR), strongly recommending for legislation to be enacted by the Oireachtas on the grounds that Medical Council guidelines were not sufficient to deal with the ethical and legal issues involved in ART. The report also highlighted the fact that ART is not available under the Public Health system in Ireland, that it is run privately and thus is vulnerable to the risks of commercialisation, wherein "commercial consideration gets priority over patient welfare" (p. xi). CAHR advocate that counselling should be an integral part of the service of the treatment provider, on the basis that "appropriately qualified counsellors" can assist in educating the prospective clients of the benefits and risks associated with ART and also to help alleviate emotional and psychological distress before, during and after treatment; especially in helping those who do not become pregnant, come to terms with the fact that ART cannot help them conceive (p. 18). Without the presence of a State sanctioned and quality assured framework and to combat the paucity of research conducted in the Republic of Ireland to date, it is the purpose of this study to explore women's needs in their coming to terms with definitive infertility and childlessness and to ascertain if their needs are met. Ideally the



participants of this study would be the women themselves however due to ethical restrictions imposed by Dublin Business School limiting access to service providers and not service users; the experiences are as reported by the therapists who work with them. It is to the researcher's knowledge that no research has previously been conducted in Ireland specifically focusing on this phenomenon from this viewpoint.

### **1.3 Aims and Objectives**

Based on the views and experiences of therapists working with women who have undergone ART treatments such as IVF and ICSI and owing to a lack of previously conducted study on the topic in Ireland, this research aimed to explore the most salient issues, which arise for infertile women and to assess the emotional, psychological and social implications, if any, of failed IVF treatment and involuntary childlessness and also to establish the affected women's needs in their process of coming to terms with infertility.

The objectives, in consideration of the aims and the facts revealed, were to determine if the women's needs were met routinely and if not, to identify prospective improvements that could be made in the delivery of fertility treatment services in Ireland.

### **1.4 Chapter Outline**

In Chapter 2 a review of the relevant literature is presented and sub-categorised into, an introduction, a review of the traditional psychotherapeutic approach to infertility, followed by a review of more contemporary approaches and finally a review of the recommended treatment modalities.

Chapter 3 presents the methodological approach, specifically, the strategy and

design, the sample used, the procedure and data analyses. Chapter 3 closes with a discussion of the ethical issues involved in conducting this study. In chapter 4 an outlay of the results is presented, discussion of which is found in chapter 5. The conclusions and recommendations of the research are presented in chapter 6.

## **Chapter 2 Literature Review**

### **2.1 Introduction**

The following key search terms were used to locate peer-reviewed journal articles and relevant literature using EBSCOhost to access the online databases of Psych Info, Psych Articles, Pep Web and Pep Archive, the key search terms were: infertility, fertility IVF, involuntary childlessness and coping.

The increasing practice of postponing childbirth in Western culture has seen a rise in the demand for ARTs such as IVF, ICSI and IUI (WHO, 2003).

Between the years 1997 and 2005 the rate of European women availing of ARTs increased by forty per cent (Nyboe et al., 2005). Recent figures as reported by The Commission of the European Communities (2008) found that in 2005 the average age of women on their first pregnancy was between twenty-eight and thirty years. Women are said to be at their most fertile from their late teens to early twenties and it is a widely acknowledged fact that lower fecundity is associated with age in both men and women; it is of no surprise then to learn that the European Society of Human Reproduction and Embryology (2009) reported that in 2005 the majority of women who availed of IVF in Ireland were over 30 years of age, twenty five per cent being between thirty and thirty-four years and over forty-five per cent between the ages of thirty-five and forty. Schmidt (2010) reports of other lifestyle risk factors to infertility such as the increasing prevalence of obesity, diabetes and unprotected sex resulting in the transmission of infections such as chlamydia, which carry with them a host of health risks, also smoking in women of childbearing age has been shown not only to negatively affect the smoker's

fertility but also that of their unborn child should they smoke through pregnancy. Of those couples that undergo IVF treatment in Ireland approximately, one third will be successful (Walsh et al., 2011). A diagnosis of infertility regardless of its aetiology has been described a major life crisis affecting how women feel about themselves, their relationships and the world around them (Hart, 2002). Owing to the often prolonged and indeterminate time span of infertility and the uncertainty of treatment success, infertility is associated with substantial stress which can be chronic and thus can have major repercussions for women's health (Schneider & Forthofer, 2005). Attributing to the stressful nature of infertility and treatments such as IVF, therapeutic intervention has been found to be helpful at any time in the process (Bergart, 2000). In the following piece a review of the traditional psychodynamic view of infertility, its aetiology and its treatment will be reviewed, traced back to the teachings of Freud right up to the present day developments of neuropsychanalysis.

## **2.2 Infertility: Traditional Psychotherapeutic Thinking**

Up to the 1960s almost half of those diagnosed as infertile were diagnosed with psychogenic or psychosomatic infertility, which ascribed the infertility to psychological causes, such as unresolved unconscious conflicts regarding motherhood, femininity and masculinity (Apfel, 2002). Menninger (1943) described the psychogenic aspect of infertility as “a psychic illness sailing under a gynaecological flag (p. 7)”. With the advancement of medical technology psychogenic diagnoses have reduced to approximately five per cent of cases (Apfel, 2002). Psychogenic diagnoses find their roots in traditional psychoanalytic thinking (Allison, 1997). Freud with his ground

breaking theory of psychosexual development proposed his famous developmental milestone, the Oedipus Complex, wherein a young boy unconsciously fears castration by his father owing to his desire for his mother, to survive and overcome his anxiety the boy must take a position outside of his mother and father. Freud (1917, 1930) theorised that girls paralleled their male counterparts' process with what he called 'penis envy'. The girl enters her Oedipus or Electra Complex as having already been castrated. Successful navigation through her process sees the girl change the object of her desire from mother to father and her wish for a penis becomes a wish for a child of her own (Wellson, 1988). Fixation then for the female during this multifarious stage of development may lay the foundation for the development of neuroses in later life, particularly those pertaining to sexuality and motherhood. As French psychoanalyst Sylvie Faure-Prugier (2003) surmises, "failing development of an early triangulation, the excessive closeness with the mother occupies the representational space which is not free and available for space" (p. 55). Psychoanalysis has received much criticism for its lack of scientific validity and reliability; Paola Mariotti (2012) replies to this claim on the basis that psychoanalysis is more concerned with reports that provide insight into an individual's state of mind than reports, which hold statistical significance. Increasing pressure and demand for empiricism, efficiency and value for money in psychotherapeutic practice raises questions as to the relevance of the traditional psychoanalytic stance as taken by Mariotti. In her paper *The Baby Makers*, British psychoanalyst and social psychologist, Joan Raphael-Leff (1992) discusses the conscious and unconscious psychological reactions to infertility based on the data extrapolated from her

analyses of nineteen infertile or subfertile female patients and with reference to one particular analysand, Eve who over a five year, bi-weekly analysis underwent two and prepared for a third, unsuccessful IVF treatment. The experience of the final failed treatment, Eve likened to a hysterectomy. Based on her experience Raphael-Leff discusses the myriad of psychological and emotional reactions, disturbances and defences to infertility and its treatment, ranging from depression, anxiety and guilt to hypochondria, paranoia and magical thinking, and identifies ten specific emotional difficulties commonly affecting those who undertake infertility treatment, such as, a loss of existential meaning in the natural order for procreation, lack of bodily control and lack of faith and dissatisfaction with the body, obsessional thinking and relationship difficulties. In her experience of working with infertile women, the analyst also describes the phenomenon of the Oedipal longing for and “heightened emotional attachment to” the fertility consultant, the “baby maker” (p. 208). Dinora Pines, another British analyst substantiates this finding in her article *Emotional Aspects of Infertility and its Remedies* (1990), wherein she describes two cases the first of Ms A who seduced and had sexual intercourse with the very gynaecologist who had previously inseminated her with donor sperm, an event which Pines analysed as a re-enactment of Ms A’s Oedipal desire for her father and triumph over her mother and the second case of Ms B, whose fertility treatment resulted in pregnancy, held in fantasy her obstetrician as the father of her child. Both authors through the publishing of their clients’ material describe the poignant and arduous journey that women navigate, who for various reasons cannot conceive a child of their own and on their own with their partners. The rich material derived from clinical

experience serves not only to illuminate the experiences of the women but also the effective therapeutic interventions that can be made in assisting women to overcome the grief and personal difficulty associated with accepting definitive infertility and relinquishing the dream for a longed-for child.

Apfel and Keylor (2002) in their meta-analysis of the literature regarding psychogenic infertility call for a complete abandonment of the use of the term, when they state, “there is no simple psychodynamic causality” (p.85).

Furthermore they advise that women are better serviced in their therapy when treatment is focused on the pain and difficulties experienced as a result of their condition rather than theories as to the psychological elements, which might have caused it. The authors also criticise the practice by analysts to generalise their findings made from individual case material regarding infertility, to the greater female population of reproductive age. They base their claim on the view that the themes postulated as causative in the aetiology of psychogenic infertility, such as unconscious conflicts towards motherhood and femininity, envy of and identification with masculinity and insecure and disorganised attachment patterns, to name but a few, are also present in the analyses of women who can and do conceive naturally. Zalusky (2000) advises “we must be careful not to confuse correlational data with causality” (p. 1543).

Nonetheless medical studies have highlighted that emotions do indeed affect the endocrine and autonomic nervous systems, which govern the reproductive system (Karahasanaglu et al., 1972; Mozley, 1976). The emergence in the last decade or so of a new wave of psychoanalysis, that of neuropsychanalysis has contributed to a revived analytic interest into the relationship between the psyche and the soma and has produced hard scientific fact of the fluid,

complex and inter-relational dynamic of the two in specific areas such as attachment behaviours (Matthis, 2005). Given that approximately one third of couples are diagnosed with ‘unexplained infertility’ perhaps future neuropsychanalytic research focusing on infertility will provide new information and understanding of the complex relationship between the emotional and the physical elements preventing a woman from conceiving. While Apfel and Keylor’s (2002) and Zalusky’s (2000) recommendations remain valid, to ignore the valuable and rich material emergent from clinical practice is to exclude that most precious form of phenomenological data that of the experience of infertile women as felt by infertile women. The following sub chapter will present a review of contemporary literature focusing on women’s experience of infertility, their emotional reactions to failed IVF treatment and identifiable vulnerability factors which can be used to predict those reactions.

### **2.3 Infertility: A Contemporary View**

Of those couples that undergo IVF treatment in Ireland approximately, one third will be successful (Walsh et al., 2011). A diagnosis of infertility regardless of its aetiology has been described in terms of a major existential crisis affecting functioning on various levels from the intrapsychic and interpersonal to the psychosexual and occupational (Raphael-Leff, 1986). Studies on the emotional responses of couples to failed IVF have shown that while the majority of couples recover from the loss and manage to adjust well, a minority develop severe emotional problems (Reading et al., 1989). Research has shown a link between several vulnerability factors and the emotional response to failed fertility treatment, in their quantitative study,



Verhaak et al. (2004) examined the role of a comprehensive set of vulnerability factors in the prediction of emotional responses of Dutch women to a failed IVF or ICSI treatment cycle; they identified as the vulnerability factors, personality characteristics and with it levels of neuroticism, stating that higher levels of neuroticism and psychopathology predict higher levels of negative emotional responses; the second vulnerability criterion was infertility related cognitions on the basis that the evaluation of the perceived stressor, infertility, led to the adoption of cognitions of helplessness and or acceptance. They cite Terry and Hynes' (1998) study when they state, "acceptance as a result of a re-evaluation of the stressor, was predictive of a more positive course of the emotional response after a failed IVF or ICSI treatment cycle" (p. 182). Coping styles were also used to predict the emotional response to a failed IVF and or ICSI treatment cycle; an avoidant coping style is predictive of a negative emotional response while an active coping style is related to a more positive emotional response. The fourth vulnerability factor explored was that of social support and in particular the marital and sexual relationship as being the most important social support in the context of women entering into an IVF or ICSI treatment cycle. The researchers report that marital dissatisfaction contributed to the women's anxiety, while poor social support contributed to the level of depression; neuroticism was found to be the most salient predictor of the emotional response to a failed IVF or ICSI treatment cycle. The researchers on the basis of their findings recommended that fertility-related cognitions and social support should receive focused attention in the counselling of women undergoing IVF or ICSI treatment. One of the limitations of the study was that it concentrated on emotional responses to a

single failed treatment cycle, where most women will opt for another cycle, further research into the emotional response to further failed treatments and certainly the final treatment is recommended so that for those women for whom ART will not work, an evidence based care plan is available.

These recommendations are in line with the qualitative study conducted by Volgsten, et al., (2010) wherein they explored the experiences of men and women in Sweden following three unsuccessful IVF treatments and found that women experienced infertility in terms of grief, their grieving processes susceptible to the effects of prolonged and repetitive loss and menstrual reminders of conception failure, often becomes a complicated one with symptoms consistent with a major depression, such as excessive guilt, emptiness, suicidal ideation and feelings of worthlessness. The researchers chose to interview after three unsuccessful cycles as in Sweden, infertile couples are offered three treatment cycle attempts under the Public Health system. Their participants' reports substantiated the findings of Verhaak et al. that vulnerability factors such as neuroticism, infertility related cognitions, coping ability and quality of social support can predict excessive emotional distress following failed IVF treatment. The researchers' overall finding was that unresolved grief was the main experience of their participants who remained childless three years after unsuccessful IVF or ICSI treatment. The use of semi-structured interviews served to further illuminate the experiences of the participants beyond the researchers' guiding topics in terms of sexual difficulties experienced and reported by both men and women. The participants also reported a perceived lack of professional support in terms of counselling and how they felt ill prepared for both the physical and emotional

challenges involved in undertaking fertility treatment. The researchers report that the most common reason for the participants' discontinuation of IVF or ICSI was the emotional strain and not medical advice. It is on this basis that the researchers make the recommendation for counselling staff to offer a more supportive and educational role, to recognise the symptoms of a complicated grieving process and to offer evidence-based interventions for its treatment so as to ameliorate the emotional reaction to failed fertility treatment. Of the limitations of this study, the researchers identify as one, the transferability of their findings to other populations, in that all of their participants were Swedish, therefore comparisons with other nationalities would depend on cultural similarities and differences. Another limitation referred to by the researchers was their neglect to include women's sexual difficulties as a guiding topic in the interviews, a topic which women spontaneously interjected into the interview. The psychotherapeutic space can provide a holding environment in this instance especially given that many women feel unable to avail of other social supports since they are compounded by the shame that is so often associated with infertility (Hart, 2002). The shift from 'normal' sexual intimacy to purposive pro-creative sex has been reported to have an increasingly deleterious effect on the relationship of the infertile couple the longer they are trying to conceive (Gervaize, 1993). The author describes how the optimism and vitality of the initial period of procreative lovemaking transforms into anxious and cycle focused intercourse, which can result in a decrease in sexual satisfaction. This element is yet another invasive aspect of ART, which Dinora Pines (1990) describes as a *ménage à trois*, the third party present being the consultant physician. Gervaize (1993)

recommends for early interventions to be made to educate and advise prospective patients as to the possible emotional and sexual consequences of infertility treatment and advises that counselling can serve to provide this function. That grief is a common experience of the infertile women following failed IVF has been well documented (Verhaak et al., 2005) & (Volgsten et al.), that the grieving process can easily become a complicated one is also an issue, and while both these studies go far to present the issue, a dearth of research still exists concerning the long term implications of failed IVF and involuntary childlessness. In the next piece a further elaboration of infertility related grief and grieving processes will be presented.

#### **2.4 Infertility and Grief**

The initial realisation of infertility sees those affected encounter what has been described as the phenomenon of “Paradise Lost”, wherein the couple enter the complicated grieving process attached to infertility and begin to mourn the ‘death’, initially of their own health and finally of their idealised child (Burns, 2005). Infertility can be thought of what Worden (2009) terms “a socially negated loss”, a loss not sanctioned by society as no physical loss or death has taken place (p. 195). This type of unseen loss can complicate a woman’s grieving process and is often associated with self-blame, in that some women feel their infertility is a punishment for past sexual transgressions, promiscuity and other behaviours (Raphael-Leff, 1991). Bereavement is a fundamental aspect of infertility, as couples are faced with the ‘death’ of the longed-for child who is “psychologically present but physically absent” (Burns, 2005, p. 9). Menning (1980) applied Kubler-Ross’s five stages of death and dying model (shock, denial, anger, bargaining, and acceptance) to the experience of

infertility, contending that each stage must be negotiated in order to effectively work through the losses associated with infertility and in so doing enabling them to move on with their lives. Furthermore he applied Erikson's psychosocial developmental life stage model to infertility. According to Erikson's theory those in early adulthood who are proceeding successfully from the "intimacy versus isolation stage", having formed an intimate relationship and having found their partner, enter the "generativity versus stagnation stage of life", wherein it is expected they will start a family. Infertile couples then are faced with a psychosocial life crisis, which they must negotiate and resolve before they can successfully proceed developmentally. Linda Applegarth (2000) proposes five stages to the infertility grieving process. Firstly, the therapist should encourage the client to accept the loss of the child, real or imagined; secondly as proposed by Leon (1996) the client should be helped to experience and express the pain of the loss and the feelings, and emotions attached to it; thirdly the child and the loss of that child should be commemorated. In the penultimate stage the therapist will help the client to let go of the child, Applegarth (2000) states "the bereaved ultimately must withdraw their emotional investment in the loss in order to go forward with life" (p. 95). In the final stage of grief counselling, the therapist can help the client to 'move-on'. At this stage the client is required to relinquish their dream insofar as to allow them to proceed with their lives. Dinora Pines (1990) describes shame and guilt as inevitable aspects of infertility, which compounded by the "powerful blow to the individual's narcissism" make the painful acceptance of childlessness difficult to say the least and one which may not be actually realised until menopause (p. 115).

## 2.5 **Conclusion**

The experience of infertility, of not being able to conceive and give birth to a longed for child has profound and far-reaching implications on a woman's emotional, physical and psychological well-being (Burns & Covington, 2000). Numerous studies (Boivin & Takefman, 1995), (Hynes et al., 1992) have recommended and emphasised the importance of psychotherapeutic intervention to alleviate women's distress before, during and after IVF or ICSI treatment cycles. Furthermore empirical evidence exists showing that vulnerability to severe emotional distress following failed fertility treatment can be predicted prior to treatment and as such it is possible to the most part to identify the women who are most at risk and implement a care plan accordingly (Verhaak et al., 2005). Infertility although involving a complex constellation of contributing factors is a specific problem and one, which will be experienced by one in six women. It is agreed by most that psychotherapy will not cure infertility, but what it can offer is an environment catered to facilitate, support and alleviate the distress of an individual in crisis. The recommendations made by the CAHR report (2005) have not yet been enacted by the Irish government and as such no statutory framework has been designed for the treatment of infertility through ART (Walsh et al, 2011). The ambiguity resultant of an absence of a specific State sanctioned treatment plan, calls for further research to be conducted into catering for the needs of infertile women in Ireland. Ireland is one of the only countries in Europe where fertility treatment centres are not specifically legislated for, and as the CAHR report (2005) advised, patients, infertile women are vulnerable to the risks of commercialisation. It is the purpose of this study to explore women's

needs and experiences from an Irish standpoint and to investigate if, in the view of psychotherapists with experience in the area, those needs are satisfied.

## **Chapter 3 Methodology**

### **3.1 Introduction**

This study was conducted with a view to exploring women's experience of infertility, failed IVF and subsequent childlessness, as told by the psychotherapists who work with them. Infertility is a poignant and sensitive issue and great care is required when undertaking an investigation into the delicate themes, which emerge from it. Ideally the affected women themselves would be the target participants as they would hold the truest account of their experience, however in light of ethical restrictions limiting access to service providers and not service users, interviewing the therapists who work with the women was felt to hold significant value for research purposes. Had it been possible to interview the women, the researcher would have done so and analysed the data using interpretative phenomenological analysis (IPA). IPA is a recently developed form of qualitative research analysis, which aims to explore and understand the personal experience of an individual in relation to a particular phenomenon (Smith et al., 2009). As it was, the researcher used qualitative content analysis to analyse the data collected from the therapists' interviews.

### **3.2 Research Strategy and Design**

Owing to the exploratory nature of this study a qualitative research design was chosen. Qualitative research seeks to understand and attain meaning from the perspective of the local population it involves (Bryman, 1992). Participants were interviewed using qualitative semi-structured interviews; the interviews were analysed using qualitative content analysis. The researcher conducted



semi-structured interviews with the therapists as opposed to using quantitative questionnaires on the basis that the former more flexible method is likely to elicit more in-depth responses from the participants and provide additional, spontaneous and beneficial information unanticipated by the researcher and which may provide scope for future research (Walliman, 2006). Mason (2002) describes four qualities that effective semi-structured interviews should encompass; there should be an interactional exchange of dialogue, the interviews should be informal “conversations with a purpose” (Burgess, 1984, p. 108), the interviews should be fluid and flexible with guiding topics which lend to a generation of unexpected themes and based on the view that knowledge is situated and contextual, the interview should bring focus to the contexts relevant to the research. While the interviews in this study were designed bearing Mason’s (2002) advice in mind, timing was an issue, with interview length spanning between twenty minutes and one hour and twenty minutes. The interviews in this study were guided by four main topics and subsequent open-ended questions were posed and prompts made so as to encourage participant elaboration and contribution. Please see Appendix 2 and 3 respectively for the list of guiding topic questions and prompts used in this study.

### **3.3 Research Sample: Participants**

The research sample for this study was six accredited psychotherapists with clinical experience in working with women who had undergone failed IVF treatment and remained childless thereafter. The participants were located using a variety of resources, such as fertility clinic websites, relationship counselling centre websites and the IACP open registry. Purposive sampling

was used to identify the participants in line with Walliman's (2006) description of purposive sampling as "a sampling method based on what the researcher selects what he/she thinks is a typical sample based on specialist knowledge on selection criteria" (p. 79). A snowball sampling approach was also used and was found effective in gaining contact with additional participants. Snowball sampling is where "the researcher makes initial contact with a small group of people who are relevant to the research topic and then uses these to establish contact with others" (Bryman, 2008, p. 184). The inclusion criteria for participant recruitment were: therapist accreditation and clinical experience in working with women who had undergone unsuccessful IVF treatment and remained childless thereafter. Exclusion criteria then were therapists who were not accredited with a governing body and or therapists who had no clinical experience working with infertile women or for those who did, whose clients' IVF treatment was successful.

### **3.4 Research Procedure**

The researcher contacted prospective participants by telephone and email, the researcher then identified herself and gave the rationale for conducting the study so that informed consent could be obtained. Participants' anonymity was assured and permission to record the conversations was granted in all cases. A sample of the consent form can be found in Appendix 1.

Semi-structured interviews were used so as to allow the participants to offer their own thoughts, feelings and experiences regarding infertility counselling and to offer recommendations if any to further enhance and improve the delivery of care to women in Ireland faced with involuntary childlessness.

Initially it was hoped to conduct face-to-face interviews with all participants however due to time and travel constraints pre-scheduled telephone interviews were conducted in three cases. Walliman (2006) describes the advantages of telephone interviewing in qualitative research, as the use of telephones circumnavigates the difficulty of arranging meetings, especially with people who due to busy schedules are time limited. Of course a fundamental disadvantage of conducting telephone over face-to-face interviews is that in the former the interviewer does not have the beneficial use of non-verbal communicative cues, such as nods, smiles and frowns (Walliman, 2005), and perhaps owing to this the telephone interviews in this study were shorter than the face-to-face interviews.

### **3.5 Data Analyses**

Qualitative content analysis was used to interpret the data collected and transcribed from the interviews in line with the operational definition of qualitative content analysis as proposed by Hsieh & Shannon (2005) who describe it as “a research method for the subjective interpretation of the content of text data through the systemic classification process of coding and identifying themes or patterns” (p. 1,278). The authors provide a step-by-step guide for conducting content analysis which was used for this study. The data transcribed from the interviews was read word for word and codes were derived and exact words identified that captured the key thoughts and concepts relating to the aims of this study. The researcher then analysed these codes, made labels for them and categorised them, based on similarities and differences in content. It was hoped that the knowledge generated from the content analysis of the participants’ interviews regarding their professional

experience in working with infertile women who have undergone unsuccessful IVF treatment would serve to capture the experiences of many women and thus it was felt that this would counteract not interviewing the women themselves, which could be described as a limitation to this study.

### **3.6 Ethical Issues**

Obtaining informed consent from participants is integral to ethical best practice in any research project. The participants of this study were informed of the researcher's aims, objectives and rationale for conducting the research, their anonymity was guaranteed and the researcher emphasised their right to withdraw their participation at any time. The researcher compiled a consent form including the full name of the researcher, the educational institute, contact details and the title of the study, for a sample of this consent form, please see appendix 1. In the cases of the face-to-face interviews written consent was obtained, verbal consent was given from the telephone interviewees. Pseudonyms were used for the participants when coding the transcribed interviews and in presenting the results. Actual identities and demographic information were filed separately. The recorded interviews were filed separately again, to be destroyed one year after research submission.

## **Chapter 4 Results**

### **4.1 Participants**

The participants were five female and one male IACP accredited psychotherapists all of whom had received relationship counselling training in addition to their primary counselling qualification. Two participants, Karen and Michelle, counsellors working in a Dublin city fertility clinic had received specialist fertility counselling training in the UK with the British Infertility Counselling Association (BICA) and at the time the study was conducted were members of the Irish Fertility Counselling Association (IFCA). Anne, was based in Sligo, where she worked as an individual and couples' counsellor. Mary came from a nursing background and while not a member of the IFCA had significant experience in working with women, couples and fertility issues. The fifth female participant, Paula previously worked as a nurse and midwife in a Dublin maternity hospital and in her capacity as a psychotherapist receives referrals from a maternity hospital, of women suffering with post-natal depression, miscarriage and infertility. The only male participant, Chris, works in private practice as an individual and couples counsellor, and has clinical experience with fertility issues relevant to this research topic. Two participants, Mary and Paula spontaneously reported experience with infertility and unsuccessful IVF treatment in their personal lives. Table 1 reflects the participants' clinical experience, while Table 2 reflects the key concepts and themes that arose from the interviews, the major themes are presented in the top row and the sub-themes are presented below them.

**Table 1: Participants**

<b>Name</b>	<b>Years of Clinical Practice</b>	<b>Place of Work</b>
Karen	13	Fertility Clinic
Michelle	11	Fertility Clinic
Anne	15	Private Practice
Mary	9	Private Practice
Paula	7	Private Practice
Chris	10	Private Practice

**Table 2: Research Findings**

<b>Grief and Loss</b>	<b>Implications of Failed IVF &amp; Childlessness</b>	<b>Further Support Recommended</b>
Preparation	Emotional	Earlier Intervention
Acceptance	Psychological	Better Education
	Interpersonal: Relationship With Partner	After- Care & support
	Social Isolation	Regulation

## 4.2 Findings

### Grief and Loss

All participants interviewed, identified grief and loss as the most prominent experience of infertile women. All stages of Kubler-Ross's Death and Dying Model (shock, denial, anger, bargaining and acceptance) were consistently referred to by all participants. Shock and denial were terms used to describe women's reactions to their initial diagnosis of infertility, their realisation that they must avail of IVF for a chance to conceive and the failure of the treatment. The term 'grieving process' was used to describe women's

experience in coming to terms with the reality that they will most likely never give birth to child of their own. Grief regarding infertility was referred to as similar to the grieving process associated with bereavement.

***Karen:** the main issues that arise are, well obviously the grief related to not becoming pregnant.... In terms of after a failed cycle, grief, anger, sadness and desperation are common for the patients.*

***Mary:** The grief and loss is so profound that the body literally aches.*

***Anne:** As you can imagine the pain that infertility causes runs deep and in my experience never really leaves. The intensity of it lessens with time, just as with the grief that follows the bereavement of a loved one. What is grieved for in infertility is the death of a dream, the dream of a longed-for child, the dream of being a mother. I am always amazed at the body's capacity to numb and protect itself, but the incomprehension and stunnedness eventually subsides and then the rage and anger, pain and heart wrenching grief start wreaking their havoc.*

***Chris:** When the shock, numbness and disbelief wears off, intense sadness, anger and devastation take its place. That devastation and sense of injustice and envy of others can ravage the couple's capacity to cope with otherwise normal daily life*

### **Preparation**

A lack of preparation for the physical and emotional demands that IVF treatment entails was referred to by the participants as impeding women's ability to cope with a negative treatment outcome. Denial and hope on the side of the women undergoing treatment plus a lack of preparation and education

on behalf of the service providers was described as having a negative coping outcome for women.

***Paula:** The biggest thing is that people don't come for counselling early enough, they're not referred by their G.P. or obstetrician...the counselling they receive in the clinic-well they only give them information and as such they don't look at their feelings around it.*

***Karen:** The women in particular become more physically and emotionally drained with each cycle... In my experience with being part of the treatment team and as part of my role in the clinic to help prepare the couple, I find invariably that their hope at the beginning almost serves as barrier against hearing the facts, perhaps that is part of its function.*

***Mary:** The waiting game after the embryos are transferred back, that's if the treatment even gets that far, is particularly intense, with the hormone stimulation, the body becomes pregnant, with effects that are magnified compared to a natural pregnancy and if the bleeding comes, well that's where the real devastation is and personally and professionally I feel that women are not prepared for it.*

### **Acceptance**

Allowing their clients time and space and facilitating their clients' grieving processes and bringing about acceptance were identified by all participants as central to the needs of women in their coming to terms with infertility and involuntary childlessness. Distinction was made between those women who were more prepared and who had a more realistic expectation of the treatment than those who were not, the former parties faring better in terms of their emotional reaction than the latter.



***Mary:** The preparatory work differs from the after care and I suppose in my experience grief is central to the whole thing and the gentle working through of that grief for me is the key to getting the woman back on her feet, to heal and to accept the cruel hand she has been dealt with and hopefully to find happiness and hope elsewhere, whether that involves adoption or not.*

***Chris:** The process of giving up the dream for something that is so longed for is a very painful journey, and requires time and patience, sometimes just sitting with the client, and waiting for that shift to come when the depression lifts, that's all part of the work. Allowing the client the space and time to name and explore, their anger and sadness and also their envy of others who do conceive.*

### **Emotional and Psychological Implications of Failed IVF & Childlessness**

The emotions shame, sadness, anger and rage were identified by the participants as being common to women's experience of failed IVF and childlessness and as negatively impacting self-esteem. A negative impact on self-esteem plus the woman's ability to cope with the range of emotions she experiences when faced with failed IVF and definitive infertility were described as increasing the potentiality for the development of anxiety and depression. The side-effects of the drug treatment compounded by feelings of isolation and exclusion were also identified as having a negative impact on the mental health of the women as a consequence of infertility, failed IVF treatment and involuntary childlessness. One participant, Paula, knew of two cases where women took their own lives in response to failed IVF.

***Anne:** The emotional aspects then, women will experience a range of emotions and feelings from anger to sadness, rage and shock, vengeance, the*

*psychological implications of how they deal with and work through these feeling really has a real forbearance as to their mental health in the long-term.*

**Chris:** *They are going through the dream of becoming pregnant and the long term psychological problems will remain until they accept the fact that infertility is the diagnosis and grieve and move on to look at their life and their other options and what other prospects they have.*

Self blame was also described as common to the infertile woman's experience as if she was being punished for previous transgressions.

**Paula:** *Maybe it's a punishment for that abortion....Another lady, her mother told her, that as she slept around she would never get pregnant, that was a huge message to get and the guilt was enormous then....Women tend to blame themselves big time.*

Blame and guilt were also referred to by Mary: *The diagnosis of infertility is a shock in itself and can really evoke intense feelings of shame, a feeling a being flawed, of not being a real woman or not being a real man. Intense feelings of self blame for not being able to give their partners or their parents a child or grandchild*

### **Implications of failed IVF For Interpersonal Relations**

Failed IVF treatment, infertility and childlessness were reported as causing increased strain on the relationship of the couple, the experience in some cases leading to break-up and in other cases bringing the couple closer together.

**Michelle:** *Infertility is a real test on the strength of the relationship and often by the time we get to see them that strain is already considerable. There are many implications for that type of strain or difficulty. I mean, there is the*

*obvious that for conception to take place, sexual intercourse needs to happen, the stress of not conceiving can serve as a major blow to the sexual relationship of the particular couple. Part of that blow is a sense of shame and that shame is usually felt by both parties. The greater the pressure to get pregnant the less attractive sex becomes.*

***Karen:*** *For some couples the strain is too much and very often infertility can lead to break up. Relationships that may not have been in a strong position beforehand break down under the pressure.*

***Anne:*** *The effects on the sexual relationship are immense, the joy of sexual intimacy can easily become a joyless mechanical operation and this really is a great loss. On the other hand infertility can bring some couples closer together, especially when that pain is shared and when the couple works through it together and that is really quite beautiful and deeply moving to see, I really do feel privileged to witness that precious and very special type of intimacy in my work.*

***Paula:*** *I would always ask for the partner to come to counselling as well. Very often one won't tell the other how they're feeling because it can cause upset and worry. Particularly the male partner, he is just as upset and angry, but doesn't say anything in case he upsets her.*

### **Social Implications of failed IVF & childlessness**

All participants referred to the social implications of infertility, failed IVF and involuntary childlessness for women in terms of isolation and reluctance to seek social support.

***Chris:*** *They set themselves aside from society and also are set aside by society. It's the norm for a couple in their twenties and thirties to have*

*children, they, the infertile couple are always on the outside looking in, always on the hopeful, always wishing it was them. It is heart wrenching to hear the couple describe this standing on the sidelines of their own dream.*

**Michelle:** *Social functioning is of course affected by infertility. Well, the majority of the population don't experience infertility, so it follows that most of the couple's social circle don't either. Shame and envy will often stop women from seeking support from their usual sources.*

### **Further Support Recommended**

Among the participants' recommendations for the improvement of the delivery of fertility treatment in Ireland was for early intervention from a psychotherapeutic point of view, with therapists taking an active role in the preparation regarding the implications of the treatment but also in the initial stages about how their bodies work. Two participants felt that couples were referred to fertility clinics too hastily by G.P.s that better sex education regarding natural fertility-boosting methods should be given to clients first. Better after-care with a purpose designed support network in place was also identified as a major requirement for the improvement in the delivery of fertility services in Ireland. Person-centred, Humanistic, Cognitive Behavioural Therapy, Mindfulness, Integrative and Psychodynamic were all identified as being beneficial in the therapy of infertile women, depending on the time-frame of the therapy and the women themselves.

### **Early Intervention**

**Karen:** *I would recommend for couples as soon as possible to attain counselling, I would recommend that the G.P., usually the first port of call for*

*the couple trying to conceive would in their referral of the couple to a consultant also advise counselling support.*

**Michelle:** *I find CBT is an effective way to help track, name and identify thought patterns, to sort out what is helpful from what is not and also to help establish self-supportive belief patterns. Helping clients to practice mindfulness techniques helps foster acceptance and compassion for self and other, while gentle relaxation and grounding techniques can help the client to self soothe and keep them in touch with their body.*

### **After-Care**

**Paula:** *The main one- put a support network in place.....Infertility is a huge issue, more than many counsellors think and we as therapists should be shouting it from the rooftops, you know, I think we need to be doing an awful lot more than this.*

**Mary:** *When the couple that do not get pregnant stop treatment, they can find themselves in an isolated limbo and without support can become very isolated, they are bruised and raw and it is at this time that they really need a special and sensitive care.*

Improved availability of affordable psychotherapeutic services, State regulation of fertility treatment and a closer linkage between fertility treatment centres and adoption services, were all proposed for an improved delivery of fertility care in Ireland.

**Chris:** *Well, I think fertility treatment should be regulated and that psychosexual, psychosocial etc. education should make up a more strategic part of treatment prior to the treatment and especially post failure rather than closing the door and saying thank you very much. There needs to be automatic*

*treatment with doctors, psychiatrists and psychotherapists, for what the person must come to terms with as a life changing and life altering reality.*

**5.1 Introduction**

This study was designed to explore the phenomena of infertility, failed IVF treatment and involuntary childlessness as experienced by women in Ireland; to investigate what issues arise for those women affected on an emotional, psychological, interpersonal and social level; what needs arise for women in their process of coming to terms with their inability to conceive and how those needs are worked with in their psychotherapy. The research was undertaken in response to the lack of studies on the subject previously conducted in Ireland. Many studies and much research has been conducted in the Western world and it was the purpose of this research study to ascertain the transferability and applicability of those findings to the Irish context, bearing in mind of cultural and legislative differences and similarities. Given that Ireland is one of the few countries in Europe that does not have State regulation of ART as does the UK, America, Australia and most European countries, where IVF treatment is available and is funded or subsidised through the relevant countries' public health systems it was hoped to investigate how findings from these countries fit with the Irish experience. The research set about to explore these phenomena through the qualitative content and thematic analysis of semi-structured interviews with the therapists who work with the affected women. In purposely targeting therapists experienced in the area of infertility it was hoped that rich data of many affected women would emerge also it was hoped that the use of semi-structured interviews would enhance this process and allow the participants to elaborate where they felt so inclined.

## **5.2 Elaboration of Findings**

The participants of this study were the therapists of women who had experienced definitive infertility, failed IVF and involuntary childlessness. The participants reported how grief plays a prominent role in the process of coming to terms with an inability to conceive a child. The grief and loss associated with the painful realisation that comes with infertility was referred to as profound and comparable to the bereavement of a loved one. The terms grief and loss were used in reference with the initial diagnosis of sub or infertility, the reaction to a failed treatment cycle and in finding resolution or coming terms with the reality that giving birth to a child is unlikely. The finding corroborates previous research, which likens the grieving process of infertile women to bereavement, it was reported that what infertile women mourn is the loss of a desired child and the dream of being a mother. The pain of infertility was described as deep and one, which in the opinion of some of the participants, never truly leaves. This sentiment echoes the experience of Raphael-Leff's patient Eve, who likened her final failed IVF treatment to a hysterectomy and Dinora Pines' (1990) claim that acceptance is never fully realised until the advent of menopause. What was also striking was the blame that women placed on themselves regarding their infertility, as if they were being punished for previous sexual and behavioural transgressions. One participant made reference to a client's mother admonishing her daughter's promiscuity with a warning that she would never get pregnant because of it and the huge impact that this had for the client. That grief and loss form a salient part of the experience of infertility is based on the findings of this study and the plethora of previously published findings (Burns, 2005), (Leon, 1996)



unquestionable. Previous research has recommended for therapists to be alert to the signs of a complicated grieving process (Volgsten et al., 2010) and various stage models have been shown to be effective in helping the infertile woman to accept, grieve and move on (Menning, 1980), (Applegarth, 2000); the participants in this study made frequent references to grief, loss, shock, anger, rage, denial, envy, acceptance, working through, letting go and moving on, which would suggest that these are common stages in the process of infertility and finding meaning in life thereafter, future research into finding if there is a specific and definitive infertility model is warranted as this could assist counsellors and clients alike.

The physical and emotional demands of IVF treatment were referred to by the participants of this study and in their experience they found that women were ill-prepared for both the physical demands of IVF and the reality that no conception occurring is the most likely result of treatment. The participants, who worked in a fertility clinic, said that in their experience the odds of the treatment are explicitly given to the women undergoing treatment and, women can be blinded by their hope and expectation that they will be successful. The level of preparedness and acceptance of likely chances was reported as being related to the emotional state of the women for whom treatment is unsuccessful and likely never to work. This is in line with previous findings referring to vulnerability factors such as coping styles and neuroticism, which can be used to predict emotional distress after failed IVF (Verhaak et. al., 2005). That neuroticism is a prominent predictor of elevated emotional distress, is consonant with one participant's view that all prospective IVF candidates should be initially assessed by a psychiatrist. The findings of this

study support the recommendation of the CAHR report (2005) with regard to the need for appropriately trained counsellors to help prepare and educate women about fertility treatment and to help women to come to terms with failed treatment and childlessness.

Regarding the emotional and psychological implications of infertility and failed IVF, this study found that women experienced shame regarding their infertility, that they often blamed themselves and felt that they were flawed as women by their inability to get pregnant and deliver a child, these findings are in line with previous literature (Allison, 1997), (Apfel et al., 2002), however what was not anticipated in this research was the report that some women experience inadequacy not only in their inability to conceive a child, but they also feel that they have let their families and friends down by not ‘giving’ them a grandchild, niece or nephew. In viewing the infertile woman as part of a complex family and social structure, perhaps counselling from a family systems perspective might prove helpful in alleviating some of that pressure that women feel to produce children and the role their families play in adding to that pressure, future research investigating this is required. The participants in this study also reported of the negative effects of infertility on self-esteem and psychological well being and women’s vulnerability to the development of depression, long-term mental health difficulties and even suicide. The importance of grieving and accepting the fact of infertility was emphasised by the participants and this is consistent with the findings of previous studies (Volgsten et al., 2010), (Mariotti, 2012).

Social isolation and exclusion were reported as being part of the infertility experience for women who do not have children, as was a reluctance to seek

out support. It was reported that often on account of the shame and envy experienced by women who cannot have children, women isolate themselves from society and from those whom they would generally turn to for support. In terms of exclusion, one participant referred to how it is the norm for women in their twenties and thirties to have children and that not being able to fulfil this function serves as a barrier to normal social interaction and a barrier to normal life. The envy infertile women feel towards the childbearing women in their social circle was one factor, which was referred to by the participants as effecting socialisation and also as feeding into an obsessive focus on baby-making and motherhood, serving not just as a socially excluding factor but also as having a deleterious impact on relationships, with sisters, female relatives and friends, whom might otherwise have been a source of support. Verhaak et al. (2005) found that less perceived social support increased the chances of developing depression after failed IVF and recommended for enhancement of social support perception in ameliorating the adjustment to definitive infertility. The findings of this study corroborate Verhaak et al.'s (2005) research but also suggest a need for further research to be conducted with regard to developing a specific treatment guide for dealing with infertility.

The CAHR report advised that for those women who undergo failed IVF and for whom the chances of becoming pregnant are unlikely, specialist support from appropriately trained counsellors is required and they recommended for this to form a strategic part of the ART treatment framework. The findings of this study suggest that this recommendation is not the norm in the delivery of fertility treatment in Ireland; the participants referred to a sense of

abandonment experienced by women when they give up treatment, describing the oscillation from intense scrutiny and support in the fertility clinic to isolation, alienation and loneliness when no longer attached to the clinic. A loss of faith in the self, the other and the treatment team was described as contributing to the feeling of abandonment and helplessness and was recognised as a time when special support is required, this finding is in line with the CAHR report's recommendations and also previous studies especially that of Volgsten et al. (2010) whose participants reported, three years after failed IVF a feeling of frustration about being left on their own when treatment failed.

Women's relationships with their partners were described as being the most valuable source of social support for both involved. Couples therapy and individual therapy was identified as a useful adage to treatment in helping couples to communicate and explore their thoughts and feelings about infertility. That infertility may result in relationship difficulties and ultimate breakdown in that relationship was also referred to by the participants of this study, in that for some relationships the strain of infertility was too much to withstand. Loss of enjoyment in sex, blame and shame were all reported as contributing to relationship difficulties in consonant with other research findings (Gervaise, 1993), (Hart, 2002). On the other hand, dealing with and coping with definitive infertility was also found for some women as having brought the relationship with their partners closer together. Lord (2005) found that women who managed to maintain a varied and fulfilling lifestyle, engaged in active problem-focused coping style and sought social support, fared best when it came to coping with infertility, it was beyond the scope of this study

to investigate these phenomena; further doing so might lead to more definite conclusions regarding support for women and their partners in dealing with their painful predicament. Facilitating women's grieving processes and encouraging the process of acceptance was found in this study to be central to the needs of women in their process of coming to terms with their unfulfilled desire to become a mother. No single treatment modality was proposed by all participants as being the most effective, different approaches were used by different therapists, although there was a general consensus that the type of therapy engaged with depended not only on the therapeutic orientation of the therapist but also at what stage the woman was in terms of her infertility process, also for some participants, infertility was the motivation for seeking counselling while for others the infertility was realised during the course of the woman's therapeutic process. Previous literature complies with this consensus in that cognitive behavioural, psychodynamic, solution focused and crisis intervention have all been shown to be effective in the treatment of infertility specifically, in the short term and the long term, depending on the needs of the women involved (Applegarth, 2000). What has been identified as essential in the treatment of infertile women is a knowledge of the physiological, psychological and emotional implications that ART treatments and definitive infertility have for women (Burns, 2000) (CAHR, 2005). The fact that neither ART treatment nor psychotherapy are regulated by the Irish State emerged as significant during the course of this study and formed as one of the recommendations made by the participants for the improvement of fertility treatment services in the Republic of Ireland. These findings lend to a unique and somewhat ambiguous standing of the experience of infertility in

Ireland as compared with other Western cultures and reinforces the CAHR's recommendation for legislation of ART on the grounds that Medical Council Guidelines are not sufficient to cope with the ethical and legal implications that procedures like IVF raise. This lack of governance also leaves the infertile woman less protected than what she might be with a quality assured framework in place. Nonetheless in countries where ART services are State regulated, studies have found that women still report a lack of support in the aftermath of failed IVF and the process of accepting involuntary childlessness (Volgsten, 2010). The improved availability of affordable psychotherapeutic services was also recommended as was early psychotherapeutic and psychoeducational intervention in preparing the women and their partners for the physical and emotional demands of IVF treatment, the recovery from failed IVF and the process of acceptance and re-investing in other aspects of life. This finding is consonant with previous research (Lord, 2005) (Verhaak, et al., 2005) which advises that investment in preparatory therapy that is working with identified vulnerability factors such as perceived social support, coping strategies and reality testing with women ameliorates their emotional reaction to unsuccessful IVF.

### **5.3 Strengths and Limitations**

A fundamental limitation of this study was that the participants interviewed were the psychotherapists of infertile women who had undergone failed IVF treatment and not the women themselves. The research was conducted in this fashion due to college imposed ethical restrictions which limited participation to service providers and not users, therefore the experiences of women are not as told by the women themselves but by the therapists with whom they work

and therefore the generated data and results is vulnerable to participant bias. Also, the shortness in length of some of the interviews may have limited the recovery of important information. Nonetheless, rich, relevant and useful data was derived from the interviews and the therapists' wealth of experience was of huge benefit in the exploration of women's needs in coming to terms with definitive infertility. Another limitation of this study was that the findings are restricted to those women who do seek therapeutic support. The experience of women who do not seek support remains shrouded in mystery; it is unknown if these women do not need support or if they are for whatever reasons unable to seek it out.

It might be that the most vulnerable and in need of treatment are overlooked, especially since fertility treatment services in Ireland are not operated in accordance with a State sanctioned treatment plan, and as the CAHR report (2005) highlighted, privately run clinics are vulnerable to the risks of commercialisation; and in trusting that patient care is the priority of the clinic during treatment, there does appear to be a chasm in the aftercare, when the patient is no longer the clinic's client and research findings (Volgsten et al., 2010), (Verhaak et al, 2005) have shown a perceived lack of support in the long-term adjustment to definitive infertility.

## **Chapter 6 Conclusion and Recommendations**

The aim of this study was to explore the most salient issues which emerge for women regarding infertility, failed IVF and involuntary childlessness, from the perspective of the psychotherapists who work with them. In conducting semi-structured interviews, it was hoped that the participants' would have the space to elaborate on their experiences and to provide significant information not anticipated by the researcher. The study found in line with previous research that definitive infertility and childlessness have far reaching implications for the woman involved. A need for improved education, earlier psychotherapeutic intervention and tailored specialist support after IVF were all identified as lacking in the delivery of fertility services in Ireland. Further research is warranted into the experience of all women who undergo failed fertility treatment regardless of whether they seek subsequent counselling or not and furthermore and that which went beyond the scope of this study was the experience of women who for financial reasons are excluded from availing of ART services in Ireland. What also emerged from the data was the question of whether better and more informed education about natural fertility methods would reduce the necessity for some couples to have to undergo the trauma of IVF. An unanticipated finding in this study was participants' personal experience with failed IVF treatment and fertility difficulties, how this might impact on their work with infertile women for better or for worse was not pursued, but it is an area which merits future exploration. This study did not explore therapist attitudes or personal views of infertility and this may have proved enlightening with regard to the transference and countertransference dynamics at work in the therapy, also



given that ART is an ethical minefield, therapists' moral standing on the subject might prove significant. The findings of this study have shown how for some women infertility can lead to severe emotional distress and psychological disturbance which for some ends with suicide. A lack of support in the aftermath of failed IVF treatment and in the long-term process of adjusting to definitive infertility was identified by the participants of this study as an area which needs focussed attention by trained and specialist therapists and in line with the recommendations made by the CAHR report some seven years ago, a State approved treatment framework needs to be put in place which places patient needs over profit.

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## **Appendices**

### **Appendix 1**

#### **Participant Consent Form**

My name is Eimear Walsh and as part of my fulfilment of the BA(hons) Counselling and Psychotherapy programme in Dublin Business School, I am undertaking a research study exploring the themes around infertility, failed IVF and coming to terms with involuntary childlessness for women, from the perspectives of the psychotherapists who work with them.

#### **Purpose of the Study**

The research aims to explore the most salient issues, which arise for infertile women and to assess the emotional, psychological and social implications, if any, of failed IVF treatment and involuntary childlessness and also to establish the affected women's needs in their process of coming to terms with infertility.

The objectives of this study, in consideration of the aims are to determine if the women's needs were met routinely and if not, to identify prospective improvements that could be made in the delivery of fertility treatment services in Ireland.

Participation in this study is voluntary and participants may withdraw from partaking at any time.

In line with best ethical practice participant's identity will be protected and anonymity upheld.

The recorded interviews will be destroyed following data collection and analysis.

Please sign below to demonstrate that you understand and agree to the terms of interview.

Signature

Please do not hesitate in contacting me further should you have any further enquiries

Tel: 086 0305418

Email: [eimear80@gmail.com](mailto:eimear80@gmail.com)

## **Appendix 2**

### **Interview Guide**

#### **Guiding Topics**

1. General outline of clinical experience relevant to research
2. The prominent issues as identified by the participants which they find arise in their work with infertile women.
3. The emotional, psychological and social implications of failed IVF treatment and involuntary childlessness.
4. The needs, as identified by the participants, of infertile women in their coming to terms with their inability to conceive.
5. Recommendations for the improvement of fertility treatment services from a counselling and psychotherapeutic viewpoint.

#### **Interview Questions**

1. Can you give me an outline of your experience in working with infertile women who have undergone failed IVF treatment?  
(Prompts: Accrediting Body, relevant additional training)
2. What in your experience are the most salient issues, which emerge in your work with these women?  
(Prompts: Grieving process, IVF treatment failure)
3. How do you think infertility and failed IVF impact on women's emotional, psychological, interpersonal and social functioning?  
(Prompts: Relationship with spouse, mental health, support)
4. What have you found are women's needs in coming to terms with infertility?  
(Prompts: How needs are met)



5. Are there any recommendations you would make in improving the delivery of fertility services to women in Ireland?
6. Before we finish up is there anything else that you would like to say?