The Management of Grief in Work with Infertile Couples

In the broadening field of reproductive medicine there is an increasing need for careful reflection about how growing areas of medical and psychological knowledge can be better integrated. Mozley (1) suggested in 1976 that abnormalities in structure, physiology, or chemistry may be demonstrated eventually in all cases of infertility, a significant number "refined and processed by various parts of the limbic system." Seibel and Taymor (2) reported in 1982 that we were only beginning to grasp the complexity of "the enormous interplay between the psychologic and the physiologic." They went on to detail many neuroendocrinological avenues through which emotional influences can disturb the sensitive and subtle regulation of reproduction.

The management of grief is a relevant area for our consideration in infertility treatment. How can we reconcile the processes of grief and procreativity? Creating life can be very difficult during a period of mourning, especially when the mourning is inhibited in some way.

In her coverage of the psychological processes of childbearing, Raphael-Leff (3) describes how overt attitudes and unconscious pressures in caretakers can impinge upon patients under their care. An integral part of traditional medical training has always been its objectivity. This is essential, of course, but some vulnerable staff members can draw upon it defensively in developing a self-protective distancing from those under their care. Unresolved emotional reactions in doctors and midwives to a perinatal death or stillbirth may lead them to avoid the mother during or after delivery, concentrate only upon her physical care, discharge her prematurely ("See you next year"), make attempts to cheer her up, or encourage her to see her loss as some sort of "blessing in disguise."

Raphael-Leff points out how genuinely involved professionals can help the mother and father to keep their status of parenthood alive, establish memories of their dead baby, and so facilitate the mourning process, by encouraging them to see and hold the baby, name the baby, and proceed to take part in burial of the baby. Any failure to

mourn successfully, on the other hand, can serve to inhibit subsequent fertility.

Some of these ideas can be illustrated by the following case studies from my practice. Case 1 has been described previously by Christie and Pawson (4).

Case 1. In an initial interview with her gynecologist Mrs. A complained of secondary infertility. Her only pregnancy had resulted in a stillbirth 2 years previously. She had not seen or held the baby, nor had photographs been taken. She had declined to make her own funeral arrangements, and the hospital had disposed of the baby.

Mrs. A became increasingly tearful as the gynecologist proceeded to explore this aspect of her history. Before she came again, he proceeded to ring the hospital concerned and establish where the baby was buried. A few routine infertility investigations were undertaken, but the gynecologist then gave her the burial site number and informed her that, in his opinion, the most important thing would be for her to visit the baby's grave. Any further investigation would be delayed until this was done. But on returning a few weeks later, Mrs. A confessed she had not been able to find the courage to make the visit. The gynecologist then suggested that her husband might accompany her there the following weekend, this being their wedding anniversary.

When she returned 6 weeks later, the situation had clearly changed. She was confident and relaxed, and reported that they had visited the grave several times. She proceeded to conceive 4 months later, no other treatment having become necessary.

Case 2. If left unrecognized, the inhibition of the mourning process, with its effect upon fertility, can turn out to be a subtle, deep-seated phenomenon.

Mrs. B, aged 39, was referred to the writer with long-standing unexplained infertility, which had persisted despite several unsuccessful cycles of artificial insemination with her husband's semen. She had a university degree, a good job, and what appeared to be a sound marriage. Both she and her husband, aged 50, were aware of mixed feelings about whether or not they wanted children.

The youngest of three children, Mrs. B had been her father's favorite, and she had wept at length

when he died in her 15th year. Tears came to her eyes as she recounted this story. Her mother had also been devastated by his death, and Mrs. B had to be very supportive of her. She added that she had always had a rather tempestuous relationship with the mother, mitigated by a mutual respect for each other.

Tension developed in their relationship when she 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 this, but the difficulties between the newly married couple and the mother were eventually resolved through persistent discussion among the three of them, leading to an apparently good quality of relating subsequently.

So Mrs. B had been able to separate and individuate satisfactorily from her mother, 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 awareness of ambivalent feelings about the prospect of parenthood. How, then, could a psychological factor be operating in Mrs. B's fertility problem?

The interesting fact then emerged that a year or so previously, when her mother had died, Mrs. B had been unable to cry. A short time later she was found to be suffering from raised blood pressure, diagnosed as essential hypertension. Before initiating any medical investigation, her sensitive and supportive woman doctor had asked, "Has anything significant happened in your life recently?" Mrs. B began to speak of the loss of her mother, burst into tears, and wept at length for the first time. Her raised blood pressure began to subside, without any treatment being required.

Mrs. B went on to inform me that whereas her mother had been in her 20s when two elder siblings had been born, Mrs. B had been conceived "accidentally" when her mother was 43. After Mrs. B's birth, the mother proceeded to develop a severe puerperal depression which required hospitalization. The baby was taken from the mother and placed with an aunt for a few months. She was eventually reunited with the mother, and an apparently reasonable relationship grew into being, with its admittedly "tempestuous" element.

Thus a separation had occurred at a time in early infancy when psyche and soma are not clearly separated from each other and when disturbing feelings tend to be split off into bodily expression (5). In a recent book McDougall (6) 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.

In subsequent sessions it became possible to take up with Mrs. B the possibility that the sudden separation occasioned by her mother's death had revived in the depth of her inner being something of an originally powerful response to the separation in early infancy, a response for which there would have been no words, or images or playful avenues of expression, only a turmoil of primitively ambivalent feelings, expressed largely through her body in the form of a raised blood pressure. When she had been able to weep at length about the loss of mother, in the empathic, holding presence of her woman 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. B was intrigued by these possibilities, but also found it hard to think about them. As we worked with all this in subsequent sessions, Mrs. B gradually became increasingly aware of the reasons why she did not want to have a baby at her stage of life, as well as feeling an increasing sadness about this, because of her persisting wish to have one.

Now able to hold increased awareness of her ambivalent feelings clearly in consciousness, Mrs. B proceeded to conceive for the first time in her life, at the age of 40. 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 labor, she nevertheless resisted any suggestion of cesarean section. She eventually had a normal labor, was deeply gratified to find a lovely baby boy in her arms, and her breast milk flowed freely.

The interesting speculation we can make here is that a deep inner turmoil of unconscious ambivalent feelings, held at an early preverbal level, not only had served to provide an unconscious block to this woman's procreativity, but also had predisposed her to future life-threatening illness. The opening up of an avenue of expression for derivatives of these deep feelings rendered it possible for Mrs. B to gain increased conscious access to her range of ambivalent feelings about having a baby, with the resulting conception that can so often follow this in some patients with previously unexplained infertility (7).

Just as individuals or couples who suffer a still-birth, or other form of bereavement, need to be able to mourn their loss before starting a further pregnancy, so should a couple be able to mourn the loss of their fertility, and their idealized fantasy child, before embarking upon any alternative path to parenthood. A final diagnosis of infertility is always traumatic for the couple, no matter how much inner conflict has been aroused by the prospect of parenthood. For many it is a final devastating blow after a long and stressful period of investigation and treatment.

The role of physician and other staff members, as in the cases outlined above, is to help the couple through their period of grief. The couple feel isolated and angry, with loss of the sense of sexual and generative identity. Grief is felt not only over the loss of fertility, but also over the implicit loss of an idealized child. Nijs and Rouffa (8) report a sequence of four stages, reminiscent of those which follow bereavement, i.e., a short period of confusion, followed by puzzlement, rebellion, and doubting for 2 or 3 weeks, sexual dysfunction for a few months, and a depression which may last for 6 months.

Each couple has to work through and resolve such emotional reactions to the diagnosis of infertility before they can be regarded as prepared and ready to take up any alternative path to parenthood. Wiehe (9) has demonstrated how this resolution is rendered more difficult by an initial inclination of the couple to deny or repress these feelings. One indicator of such denial is the emergence of a frenetic wish to rush off prematurely into one of the

alternative paths, e.g., artificial insemination, in vitro fertilization, or intercountry adoption.

If medical staff members can retain an empathy for the couple, and help them work through their grief and other feelings, the consequences can include a renewal of hope, an optimal adjustment to reality, and the emergence of new and sound initiatives. Such a desirable outcome will require adequate containment and a sufficient passage of time, and can be strengthened by the help of other people, including professional counselors, relatives, and friends.

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