Uncommon Misery: Modern Psychoanalytic Perspectives On Infertility

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UNCOMMON MISERY: MODERN PSYCHOANALYTIC PERSPECTIVES ON INFERTILITY

Harriet Wolfe, chair of the panel, introduced the topic under discussion as “a complex emotional experience . . . the unexpected discovery of infertility and the choices and events that follow upon it, an emotional experience that may have a uniquely disturbing quality, a truly uncommon misery.” She noted the relative lack of psychoanalytic investigation of this topic, despite the IPA panels held in 1997 and 1999. “With the exception of work by Roberta Apfel and Rheta Keylor, Nancy Chodorow, Sharon Zalusky, and Allison Rosen, the literature since the late 1990s is sparse.” She noted that our knowledge about infertility has changed, and that we now view the concept of “psychogenic infertility” as simplistic and anachronistic, since new technology can enable conception.

Wolfe thought that our new perspective, and the new technology, require an ongoing adaptation and integration in our thinking about infertility. She also felt that we are now challenged to integrate child and adult perspectives on infertility, and to better understand the nature of the desire to conceive, as well as of the pain of infertility and miscarriage. Our decisions for, and reactions to, either outcome have psychological and developmental implications. Wolfe highlighted additional questions the panel would address concerning the psychoanalytic treatment of women with infertility, including questions about the “nature of the desire to conceive; the nature of the pain one endures when desired conception is thwarted; the ever present issue of loss, even when the outcome is a happy one, and the need for effective mourning; the complexity of decision making when assistance in family-building is necessary; the developmental issues faced by children of adults who have been infertile, including the implications of disclosure when offspring are adopted or


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result from ART (Assisted Reproduction Technology); and, finally, how we think about the goals of analysis and the nature of therapeutic action in relation to infertility.”

Jane Kite followed with a reading of her paper “Uncommon Misery: Can We Analyze Infertility?” In it she focused her attention on the nature of the desire to conceive a child, comparing it to a bedrock Freudian instinct. She began by citing a well-known jump rope rhyme in which the inevitability of fertility and child bearing seemed securely established in the minds of children who would become mature adults. Kite wondered with the audience what is to be done when those secure expectations are disappointed: “what happens in our consulting rooms when the time hasn’t come, and may never come, for our patients?” She asked how, as analysts, we understand the condition, and how we treat it in our women patients who are infertile.

Kite’s brief historical review of the psychoanalytic treatment of infertility offered many examples of failed psychogenic explanations, which often laid the blame for infertility on the women seeking analytic help. Often infertility was viewed as the outcome of psychological conflicts with the patient’s mother, a kind of talion punishment for having depreciated motherhood and favored professional success. Kite said that in such a formulation the “causes of infertility are routinely mixed up with its consequence,” adding that in many examples infertility was thought to be the result of psychological conflicts with one’s mother, rather than viewing it as often the cause of conflicts within oneself and with others. Kite cited Nancy Chodorow’s idea (2003) that for women who feel ambivalent about motherhood and pregnancy, time seems to stand still. Subsequent infertility often brings with it the fantasy that one is being punished for misdeeds. Kite was convinced that infertility in fact “precipitates a crisis in which the familiar sense of oneself collapses.” The “private speculation about infertility,” she said, “is ‘If there’s something this basic wrong with my female body, there must be something really wrong with me.’”

Kite followed with clinical material from a lengthy treatment of an analysand named Alice, who came for treatment at the age of thirty-six, realizing that she was late in finding a partner and in getting pregnant, but confident that both could be achieved. However, after two years of analytic treatment, she began to pursue artificial insemination on her own. Kite emphasized “the driven nature of the wish for a baby, and the singular quality of the psychological devastation when this wish is frustrated.” She
explained that although Alice was anxious over not having a partner, she feared that she would be devastated if she didn’t have a baby. It was the patient’s first experience of profound failure, and Kite recalled Alice saying that “this way I can’t be a real woman. I can be a real mother, if I want, but I can’t be a real woman. I’m just not right inside . . . really, what’s the use of being a woman if you can’t have a baby?” Kite considers this “the painful heart of infertility . . . the perception of having failed as a ‘real woman.’” Alice started IVF treatment the following year, initiating a lengthy process of hormonal stimulation, ultrasound, egg retrieval, and assisted hatching.

Kite evocatively described the parallel, and alternating, states of hopefulness and hopelessness, both in the transference and in the counter-transference, as she and Alice encountered success and then failure with IVF.

Kite then presented a psychoanalytic perspective on infertility by recalling the Freudian mind-body dialectic of early drive theory. Noting Freud’s idea that psychological illness can be due to either bodily or psychic trauma, she said the discovery of infertility can occasion both. Kite portrayed her theory as possibly “risking an essentialist point of view. . . . I think that in order to fathom the psychological experience of infertility, we have to step away from conceptions of gender identity that emphasize its fluidity back into the biology of one’s purely sexual identity. . . .”

The earlier wish to conceive is a sexual wish, on the order of an instinct, to test one’s female body by making a baby inside it. . . .” Kite believes that when this sexual wish to be reproductive is frustrated, as in the “uncommon misery” of infertility, the result is a prototype of “blank” mourning, the mourning for a wished-for experience, rather than over the loss of an object, often ending with painful bitterness and resentment. Kite illustrated similar phenomena by citing a patient in an article she wrote with Adrienne Applegarth (Kite and Applegarth 1992). Although this woman eventually succeeded at conceiving without IVF, she endured comparably painful conflicts over fertility and conception: “sometimes even a biological mother who is vulnerable to particular conflicts around aggression and envy can feel that she has ‘stolen’ her own child from the fates.”

Kite underscored the psychological costs to the analyst in treating infertile women, where the treatment itself can feel blighted and uncreative, leading to a defensive retreat from thinking deeply about the meaning of the experience, to a search for rescue in the action-oriented medical procedures of fertility treatments. Kite ended on a cautionary
note: “Our essential job as analysts is to keep our patients’ emotional reality in view, in tandem with the biological, testing and exploring fantasies, and respecting the limitations of reality. Most important, perhaps, we hold the hope of continuing emotional growth, particularly in the light of harsh disappointments.”

Next Judith Yanof, a child analyst, looked at the topic of infertility from the child’s perspective. Despite infertility, many parents do eventually conceive, often with the help of others. Yanof was particularly interested in the question, What does the child make of being the product of ART? Because this is a very new field of study, there are few answers to this question. The first child produced by egg donation was born in 1984, and although donor insemination of sperm has been used since the 1940s, it has often been shrouded in secrecy, much as adoption once was.

Yanof reminded the audience that although current research is limited, it finds no differences in psychological well-being between children born through in vitro fertilization, egg donation, or sperm donation and children conceived naturally.

However, many of the issues that interest psychoanalysts are not addressed in this research. Yanof, for instance, wanted to explore “how children deal with their ‘difference,’ how they think about and understand their conception, and whether there are common fantasies, misunderstandings, strengths, or vulnerabilities that grow out of the ART experience for them or for their parents.” The clinical literature on these topics has been minimal.

Yanof next noted the painful experiences of infertile parents, including challenges to their identity and self-esteem as men and women. She stated that even adults who successfully become parents through alternate means, whether ART or adoption, often have not had time to reflect on or fully grieve the disappointment of being unable to conceive their own, genetically related children.

One of the issues that parents face is when or even whether to disclose information about ART to their child. Yanof said that current research shows that the majority of heterosexual couples who use donor egg or donor sperm do not tell their children, although most medical professionals advise disclosure. Yanof cited a 2003 report of the Ethics Committee of the American Society for Reproductive Medicine that encouraged parents to disclose information to their children about gamete donation. She mentioned that the advice to disclose is based on our experience with adoption. The established practice for adoptive parents today
is to tell their children about adoption at an early age, even before children are fully able to integrate it, and then to revisit the topic as the child matures cognitively. It is well documented, she said, that secrecy about adoption has had negative consequences for both the children and their adoptive families.

In the ART research, however, nondisclosure has not been found to bring the same negative consequences, at least not so far, raising the question of why there should be this difference between adoption and ART. Nevertheless, as ART becomes increasingly more prevalent, one might expect there to be more openness among ART families. Certainly in nontraditional families there is more openness about ART conception, because the issue of difference in family constellation is something that must be addressed from the beginning.

Yanof then posed a series of compelling questions that clarified many of the developmental, interpersonal, and intrapsychic issues that parents must face in deciding when or whether to tell their child that he or she was conceived through ART. In the voice of the parent she posed the following questions: “If I tell my child at a young age about his donor conception, it may introduce notions of connections to others that are hard for a small child to fathom. How will I explain to a young child the concept of shared genes, blood relationships, or the mechanics of gamete transfer? Will I interfere with my child’s secure feeling about our relationship by introducing the important role another has played in his creation? Will this information make him feel different from other children? Will he tell this story to outsiders without understanding that it may be private? But if I wait until my child is eight or nine, that is, until middle childhood, when he will have more realistic concepts about biological ties and making babies, will this news come as a shock to his already well established identity? Will my earlier lack of openness be seen as a betrayal? Moreover, will my child assume that his donor conception is something shameful and that’s why I hadn’t broached the subject? If I never intend to tell my child about donor conception, is that really in my child’s best interest? Doesn’t my child have the right to know as much as possible about his medical and biological history? Is it fair that others in my family will know his story without his knowing it? Will he find out from others and not from me? Will he find out in a moment of anger? How will that secret affect my relationship with my child over a lifetime? In an age of readily available DNA testing and an ever increasing sophistication among the general population about ART, is it likely that this
secret will never be discovered?” Yanof did not attempt to answer the questions specifically.

Judith Chused followed with a discussion of Yanof’s and Kite’s papers. She found that both had stimulated thoughts about “some core principles of psychoanalytic treatment.” One of these principles was the importance for the psychoanalyst to consider and address the psychological pain that differences can provoke in analysands and in oneself. “Having a child by ART . . . is not the same as having a child without ART, just as adopting a child is not the same as bearing one. . . . They are not the same for the child, and they are not the same for the parent or parents.” Chused emphasized that many new things are possible with new medical technologies. “But what is not possible, particularly if one is to treat a patient psychoanalytically, is to pretend that external reality is something it is not.”

Chused emphasized that a particularly salient issue in the psychoanalysis of children is the role of parents. She considers their role especially important in the treatment of children of ART because of a twofold problem: the parents’ unresolved mourning over the need for conception through ART, and the interference that this unresolved mourning can pose for a secure attachment between the parents and their child. Chused cautioned that “even if the parents are well educated in ‘how’ to tell a child of adoption or ART, and even if they do it in a developmentally appropriate manner, their own concerns, ambivalence, and distress will leak through in the delivery of information, contributing to the distress felt by the child.” When parents are reluctant to discuss ART or adoption with their children, particularly when there are no external indications that something is different about the family’s conception, the discussion may nevertheless become unavoidable since children are naturally curious about conception. They will detect discomfort in their parents’ attempts to discuss it, and this will contribute to their own discomfort with conception, and with their different experience. Chused noted also that the opposite situation, of “parents who, counterphobically, seem to talk of little else,” can be equally overwhelming for children.

Chused then focused her remarks on the driven nature of parental preoccupation with fertility, asking whether it illustrates, as Kite asserted, a biological drive to have a child. “But what does it mean,” she wondered, “for it to be a biological drive for those women who are unable to conceive, either because of delaying the process beyond their period of fertility or because of a specific biological disturbance? Is the feeling of
shame, the sense of inadequacy, the despair, any greater than for any other perceived lack?” Chused recalled Kite’s belief that it is a sexual wish “on the order of an instinct, to test one’s female body by making a baby inside of it.” However, Chused’s perspective on this wish for a baby, common in both girls and boys, was to see it rather as a “wish to be the mother. I would call it more of a gender wish, an identity wish, than a sexual wish.” Citing examples from her own practice where fertility was a problem, compared with cases where it was not, she was convinced that the contribution of infertility to her child patients’ developmental troubles seemed due to the mother’s own distress over her inability to conceive and to feel competent as a woman. However, she conceded that infertility can be one factor, among others, that can “contribute to a woman’s inability to feel comfortable within herself . . . ” as a creative and competent parent.

Chused felt strongly that it is the quality of relationship between parent and child that most often accounts for a child’s preoccupation with feeling different, and that this factor overshadows any difference of family structure, or the fact of being conceived by ART. She felt that when desires for a normal family cannot be met, both children and adults “will search for someone, something, to blame, rather than accept the hopelessness, the helplessness of knowing that nothing can be done, nothing can make things ‘normal.’” Chused regards the process of mourning as playing a central role in the development of a mature sense of reality that allows one to accept the fact that no matter how much we may desire something, and no matter how hard we may work to realize it, we may still not get what we most desire. In our current social milieu, where many different medical procedures seem able to correct virtually any known malady, accepting the limits to what we can have, and mourning the loss of what we cannot have, can be a challenging task. Chused found this ubiquitous human tendency to avoid the pain of facing what cannot be achieved as poignantly personified in Kite’s treatment of Alice. “I think Jane, with her belief in the instinctive nature of her patient’s desire for a child, may have been less attentive to the neurotic fantasy that was a rider on this desire, and so her sense of failure when the patient failed to conceive a viable child, was, like the patient’s, profound.” Chused added that each of us, like Kite, is susceptible to wanting to help our patients realize desires that are commonly attainable, and that we experience as realistic. However, she warned that our skills at treating neurotic functioning cannot change external reality, and accepting our own limitations can help our patients accept theirs. “But this does not mean that we
are helpless to help them . . . though it may not be in the way they wished.” As Alice was unable to conceive using ART, so was Kite unable to help her conceive, and both had to face the extreme disappointment of their desires. Nevertheless, Chused believed that Kite “was able to help her patient work through the ‘riders’ on her disappointment, the self-blame, the guilt, the anger, and the feeling she wasn’t a ‘real woman.’”

Wolfe then asked the panelists to speculate on the possible course of transition from childhood to adolescence in ART children who know they have received a donor gamete. Kite noted that adolescence is a time when one’s body becomes capable of conception. Consequently, when the reality of infertility is discovered, all of “the fantasies, and sense of oneself, are lost, since the body doesn’t work the way it was supposed to work.” Addressing her remarks to Chused, Kite said their disagreement seemed to be over the question of whether female infertility constitutes a challenge to gender identity or to sexual identity: “I don’t think that the wish to have a baby is a gendered wish to be a girl or to be a mother. There is a separate wish to have a baby, a very distinct wish having to do with an identification with the mother.”

Chused said that it was perhaps her perspective as a child analyst that explained her difference of opinion with Kite. Wolfe posed a question to the panel about male couples adopting female children: “Is that different from female single parents or lesbian couples adopting children who then have questions about fathers? When a girl has no mother present in her life, how does she represent her mother psychically? How does her representation of ‘mother’ evolve and influence her wishes to have a baby and her experience of childbearing in adulthood?” Chused cited one instance of a girl’s being raised by two fathers, “Daddy-mommy and Daddy-daddy,” which seemed a comfortable arrangement for all concerned.

Chused stressed again the universality of the wish for a baby: it is present in boys as well as in girls. She cited a case report she had published (Chused 1999) in which a boy spends many hours, week after week, gathering acorns, with the purpose of growing an oak. Chused felt that this play illustrates a “really intense wish to have a baby, and was clearly part of an identification with a missing mother. This is the same as little boys who want to be girls. I can’t think of it as a sexual wish, solely based on a drive.”

Yanof, agreeing with Chused, pointed out that “because there’s a wish that feels driven, doesn’t mean that it’s a drive. Cultural expectations affect the wish for a child.” Kite suggested leaving children’s wishes out of the
discussion: “I came to my conclusion out of a threat to adult women in discovering infertility. Acute frustration and aggression that arises with the temporary, catastrophic collapse of the image of oneself as a woman are unparalleled.”

Before opening the discussion to the audience, Wolfe offered the reporter, Jack Giuliani, an opportunity to respond to the panel discussion. Giuliani thought that the discovery of one’s infertility is an “uncommon misery” precisely because it is experienced as an assault on one’s psychic reality, which from adolescence on includes a view of oneself as capable of conceiving children and of being generative. He felt, as did those on the panel, that the discovery of infertility necessitates a coming to terms with a new psychic reality, with a new view of oneself, mourning the loss of one’s former identity, and reconstructing a different sense of oneself within a different psychic reality. Giuliani said that “the driven nature of the wish for a baby,” a reference to Kite’s paper, may be due to a desperate and frantic attempt to stabilize a fragile sense of self, and to mitigate the panic brought on by the realization that one’s bodily capacities are no longer congruent with one’s sense of self. The intense affects, the guilt and blame, though extremely distressing, may help to organize a disorganizing and frightening experience of ambiguity about one’s body and one’s identity. It must be recognized, then, that what is being mourned with the discovery of infertility is the catastrophic loss of this former identity, along with, but separate from, the longed-for and unrealizable baby.

The first member of the audience to speak commented on how the liveliness and “primitive nature” of the fantasies of very young children dealing with ideas about conception can become difficult and overstimulating. She cited an example of a group of parents and children organized to discuss adoption in which “the fantasy of aggressively getting into the body of the mother comes alive with fertility treatments.”

Yanof agreed that the issue of conception is often difficult and confusing to very young children, no matter what kind of conception we are talking about. Citing Anne Bernstein’s book, Flight of the Stork (1978), Yanof noted that “the earliest questions have to do with where the baby is and the place the baby comes from, rather than what the components are that make a baby.” Chused too agreed, saying that discussing conception can be overstimulating for any child; she added that “we can be most helpful by not just sticking to facts, but by also addressing the discomfort.” The next person to comment from the audience returned to the theoretical controversy emerging from attempts to understand the infertile woman’s pain and
despair. “I’m predisposed,” he said, “to think as Dr. Chused does about gender and drive. Dr. Kite’s idea is more like a third drive. It’s distinct from an erotically charged drive.” This analyst also addressed Kite’s despair at being unable to fix her patient’s problem of infertility: “something gets activated at not being able to fix this that’s different for the male analyst. There’s a difference between female and male sexuality. Maybe it isn’t so possible to separate the wish to be potent from the erotically charged sexuality. Transference and countertransference are very much together. Are we getting at something that gets at a male and female drive?” He then cited an infertile female patient who “was furious at me when my interpretations weren’t working.”

Kite agreed that treatment with a male analyst would undoubtedly be different from treatment with a female analyst. Regarding the possibility of a “third drive,” she noted “an original ambiguity in Freud and a conflation of reproduction and sexual drive.” Referring to her patient Alice, Kite insisted that “by the time she was hell-bent on having a baby, [the wish] was not related to erotic sexuality at all.” Here Chused interjected that “it’s not so much the gender of the person, but the identity that [the person’s] self-representations are built on that will determine the nature of the urgent drive.”

Citing the clinical example of a child born through ART that she encountered in her practice, another audience member raised a question about the nature and implications of the mother’s narcissism. In her experience, the reality of the differences between mother and child can reach levels sufficiently painful for the mother to disclaim the child as her own. Yanof concurred that “similarities and differences have a lot of meaning to parents and children and this can be escalated when differences are perceived as biological differences and get marked in this concrete way.”

Wolfe spoke to the differences and tensions between the child and adult analysts on the panel. She indicated how difficult it may be to avoid moving sideways to look at all the medical and developmental issues, rather than remain reflectively and affectively connected to a discussion of a complex wish for a baby that “never leaves, where the time clock never stops, and where the outcome is lifelong.” Yanof agreed that it is a challenging task to reflect about all the feelings involved, when making decisions and taking action often take precedence. “It is very hard to sit down and talk about very important issues such as reduction of embryos; people don’t think about them, and medical professionals often don’t either.”
Another member of the audience expressed appreciation for Kite’s and Chused’s complex descriptions of the “life drive” in female development as seen from the two perspectives of child and adult analysis. She emphasized that although each individual is unique, and anybody can have the fantasy of having a baby, “it happens more often if you have the biology than if you don’t.” She added that what is at work here is “not a single drive; the death drive is [also] present. There’s bitterness, envy, rage. It’s life against death—something intensely involving women’s fantasies, psychology, biology, all involving life and death.” Reflecting on the earlier comment from the male analyst of a female analysand, as well as on Helene Deutsch’s writings, this analyst emphasized the importance of the psychic representations present at the conception of a child. She pointed to the frustrations due to infertility that reflect aspects of the mother-daughter relationship, with its “intensity, bisexuality, preoedipal complexity, and [fears and fantasies regarding] getting pregnant. It’s between mother and daughter, even though we know men are involved.”

Kite thanked this audience member for introducing the death drive into the discussion, and she agreed that the mother-daughter relationship is part of the complex relationship that women have to infertility.

Another audience member pointed to the cultural influences that help determine what our patients might consider tragic outcomes. He advocated paying close attention to the different reactions in our patients to various reproductive events, since they may differ from our countertransference reactions, as was well illustrated by Kite’s and the previous male analyst’s cases.

Another speaker suggested that the existential question that children ask parents—“Where do I come from?”—is meant to be answered concretely: “From Mommy’s tummy.” She further observed that adopted children don’t come from Mommy’s tummy, so they have to imagine a tummy somewhere else that bore them, whereas the child born through ART did come from Mommy’s tummy. This is a question about the source of life. “It’s knowledge that everyone grows up knowing, that women are the source of life. The mother is the source of life.” Knowing this fact is common to all myths in all cultures, and “is a fundamental part of identity.” When this fact is challenged and lost, due to infertility, we are left with the question “What, or who, am I?”

The final comment came from a member of the audience who wanted to clarify a theoretical point: “A drive is not an experience,” he noted, “but a theoretical concept.” While there may be great intensity and pain
to treating infertility, “the analyst’s job is to be with it, to witness it, and to contain it.” Some problems cannot be changed, “but human creativity can find new ways.” He further noted that “reality can be used as a defense,” and cautioned that “anything that splits nature and nurture is an oversimplification.”

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