Léia Cardenuto, Garry Cockburn,
Maê Nascimento (Eds.)

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With contributions by Pye Bowden, Garry Cockburn, Leslie Ann Costello, Vita Heinrich-Clauer, Patrizia Moselli, Guy Tonella and Luigi Zoja

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Content

Patrizia Moselli, in her comments on Tonella's Keynote, reminds us of the power of the "now" in Bioenergetics. She makes us think about the concept of Complexity, as described by Edgar Morin, and challenges for us to embrace both our humanistic roots and a scientific research approach.

And following her, the article by *Pye Bowden* takes us forward from Tonella's proposals and emphasises the role of love in the regulation of the body, grounding this both in Lowen and the work of the HeartMath Institute. But she didn't let it stay "neurobiological", and to help us understand those concepts more deeply, she generously illustrates that with a beautiful and touching personal history.

And last but not least, the article that was not at the Conference but has a great synchronicity with the issues we dealt with there. It is *Leslie Ann Costello's* paper about therapy for women with infertility. This is a problem of the contemporary human being, and it takes a lot of tactfulness to touch such a sensitive theme. Leslie Ann does it with a reflection that brings the body, the culture and the stories, into a very careful setting of powerful healing.

Our sincere thanks goes to the translators of the Abstracts: Claudia Ucros (French), Pablo Telezon (Spanish), Maria Rosaria Filoni (Italian), Maê Nascimento and Edna Veloso de Luna (Portuguese), Thomas Heinrich (German), Olga Nazarova and Alesya Kudinova (Russian).

We hope that you are now ready to start reading this volume. And I hope this inspires you to not only reading but also to writing for this Journal and to open your mind to the community. Guidelines for writing articles to this Journal can be found at the end of this edition.

Léia Cardenuto
November 2019

When My Body Fails Me

Therapy for Women with Infertility

Leslie Ann Costello

Abstracts

This paper discusses the emotional processes that occur when a couple faces a diagnosis of infertility. There are gender differences in how people relate to this problem. Women's experience of infertility may include pregnancy loss, medical intervention, and separation from the creative self. Issues that arise in therapy include the struggle with the diagnosis, coping with social relationships, grief and bereavement, and treatment decision-making. The treatments can alienate women from their bodies. A woman's history of fertility struggles may underlie other reasons for being in therapy. The somatic focus of bioenergetic analysis is particularly helpful to women as they reconnect to the body through expressing a wide range and intensity of feelings. Case examples illustrate some of these points.

Key words: infertility, maternal mental health, pregnancy loss, assisted reproductive technology, mothering

Quand mon corps me met en échec. Thérapie pour les femmes souffrant d'infertilité (French)

Cet article traite des processus émotionnels émergeant lorsqu'un couple est confronté à un diagnostic d'infertilité. Il existe des différences suivant le sexe dans la manière de vivre ce problème. L'expérience de la stérilité chez les femmes peut inclure une perte de grossesse, une intervention médicale et une séparation d'avec le soi créatif. Les problèmes à gérer dans la thérapie incluent la lutte contre le diagnostic, la gestion des relations sociales, la douleur et le deuil, ainsi que les décisions à prendre quant au traitement. Les traitements médicaux peuvent éloigner les femmes de leur corps. Les antécédents de la femme en matière de lutte pour la fertilité peuvent sous-tendre d'autres raisons d'être en psychothérapie. L'analyse bioénergétique est particulièrement utile pour les femmes car elle leur permet de se reconnecter à leur corps en exprimant une gamme étendue et intense de sentiments. Des exemples illustrent certains de ces points.

Cuando mi cuerpo me falla Terapia para mujeres con Infertilidad (Spanish)

Este artículo discute los procesos emocionales que ocurren cuando una pareja enfrenta un diagnóstico de infertilidad. Existen diferencias de género en la forma en que las

personas se relacionan con este problema. La experiencia de infertilidad de las mujeres puede incluir pérdida del embarazo, intervención médica y separación del ser creativo. Los problemas que surgen en la terapia incluyen la lucha con el diagnóstico, el manejo de las relaciones sociales, el duelo, y la toma de decisiones sobre el tratamiento. Los tratamientos pueden alienar a las mujeres de sus cuerpos. El historial de luchas de fertilidad de una mujer puede ser la base de otras razones para estar en terapia. El enfoque somático del análisis bioenergético es particularmente útil para las mujeres, ya que se reconectan al cuerpo mediante la expresión de una amplia gama e intensidad de sentimientos. Los ejemplos de casos ilustran algunos de estos puntos.

Quando il mio corpo mi tradisce. Terapia per donne non fertili (Italian)

Questo articolo affronta i processi emotivi che si verificano quando una coppia affronta la diagnosi di infertilità. Esistono differenze di genere nel modo in cui le persone si relazionano a questo problema. L'esperienza di infertilità delle donne può includere la perdita della gravidanza, l'intervento medico e la separazione dal sé creativo. I problemi che sorgono in terapia comprendono la lotta con la diagnosi, la gestione delle relazioni sociali, il dolore e il lutto e il processo che porta alla terapia. I trattamenti possono alienare le donne dai loro corpi. La storia di una donna in lotta per la fertilità può accompagnare altre ragioni per essere in terapia. Il focus somatico dell'analisi bioenergetica è particolarmente utile per le donne che si riconnettono al corpo esprimendo una vasta gamma e intensità di sentimenti. Casi clinici illustrano alcuni di questi punti.

Quando meu corpo falha. Terapia para mulheres com infertilidade (Portuguese)

Este artigo discute os processos emocionais que ocorrem quando um casal enfrenta um diagnóstico de infertilidade. Existem diferenças de gênero na maneira como as pessoas lidam com esse problema. A experiência de infertilidade das mulheres pode incluir a perda da gravidez, a intervenção médica e a separação do eu criativo. Os problemas que surgem na terapia incluem a luta com o diagnóstico, o enfrentamento das relações sociais, o luto e a perda, bem como a tomada de decisão sobre o tratamento. Esses tratamentos podem alienar as mulheres de seus corpos. O histórico de luta pela fertilidade de uma mulher pode estar subjacente a outras razões para que ela esteja em terapia. O foco somático da análise bioenergética é particularmente útil para as mulheres, pois elas reconectam-se ao corpo através da expressão de uma ampla gama e intensidade de sentimentos. Exemplos de casos ilustram alguns desses pontos.

Wenn mein Körper mir nicht gerecht wird. Therapie für unfruchtbare Frauen (German)

Dieser Artikel diskutiert emotionale Prozesse die auftreten, wenn ein Paar mit der Diagnose der Unfruchtbarkeit konfrontiert wird. Es gibt Geschlechterdifferenzen darin, wie Menschen auf das Problem reagieren. Die Erfahrung von Frauen auf Unfruchtbarkeit beinhaltet den Verlust von Schwangerschaft, medizinische Interventionen und die

Separierung vom kreativen Selbst. Themen, die in der Therapie auftauchen, sind der Kampf mit der Diagnose, Copingprozesse mit den sozialen Beziehungen, die Trauer und der schmerzliche Verlust sowie der Entschluss zu einer Behandlung. Die Behandlungen können Frauen von ihren Körpern entfremden. Die Geschichte einer Frau, mit Unfruchtbarkeit zu kämpfen, mag andere Gründe mit sich führen, sich in Therapie zu begeben. Der körperliche Fokus der Bioenergetischen Analyse ist besonders hilfreich für Frauen, da sie sie wieder mit ihrem Körper verbindet durch den Ausdruck vieler verschiedener und intensiver Gefühle. Fallstudien illustrieren einige der genannten Punkte.

Когда мое тело меня подводит. Терапия женщин, страдающих бесплодием (Лесли Кейс) (Russian)
В данной статье рассматриваются эмоциональные процессы, которые возникают в ситуциях, когда пара сталкивается с диагнозом бесплодия. Существуют гендерные различия в том, как люди относятся к этой проблеме. Опыт женщин с бесплодием может включать в себя смерть плода во время беременности, медицинское вмешательство и отделение от творческого сэлф (творческой самости). В терапии поднимаются такие темы, как борьба с диагнозом бесплодия, решение проблем, связанных с социальными отношениями, горе, переживание утраты, необходимость в принятии решений, связанных с лечением. В результате лечения у женщины может возникнуть ощущение отчуждения от своего тела. История борьбы женщины за свою фертильность (попытки родить) может скрывать за собой другие причины для терапии. Соматическая направленность биоэнергетического анализа оказывается для женщин особенно полезной в процессе того, как через выражение самых разнообразных чувств и разных по интенсивности чувств они вновь соединяются со своим телом. Некоторые из приведенных высказываний будут подкреплены конкретными примерами.

Introduction

Most psychotherapies attempt to resolve problems and relieve symptoms. However, bioenergetic analysis is a system of psychotherapy that also seeks to help people make changes in their fundamental relationship to themselves and the world. Infertility affects one in eight women in North America ("Fast facts about infertility", 2017), and many of these women seek psychotherapy for help with the emotional distress that may accompany problems with infertility.

Traditionally, analytic models of human development have focused on the mother as actor in the infant and child's life. The newest literature on pre-and perinatal psychology emphasizes the foetal experience, though the events preceding pregnancy are also influential (Fauser, 2015). That is, circumstances surrounding

the pregnancy are relevant and what happens to the mother in her life and her intersubjective world will affect her mothering experience and hence her child. If a woman has spent years, thousands of dollars, and has had multiple losses, including failed attempts at pregnancy and miscarriage, in order to achieve this pregnancy, this baby will be imbued with layers of meaning that are independent of the child's own characteristics (Ehrensaft, 2005).

In the psychoanalytic literature on treating women's fertility, consensus is scant, but the existing body of work is rich and provoking. Freud theorized that that female infertility was primarily psychogenic in origin and he confirmed this assumption by observing the link between depression symptoms and infertility (Giuliani, 2005). More contemporary work has deemed the woman's struggle with fertility was likely to be the cause of her depressive symptoms (Berg & Wilson, 1991; Ramenzanzadeh et al., 2004).

Bioenergetic literature includes few papers about infertility. However, there is literature that is specific to women's sexual and reproductive experiences. Michele Dupey-Godin's work on women's experiences of their abdomens offers insight into methods for helping women to find and articulate the body's messages about fertility (Dupey-Godin, 1987). Christa Ventling has written sensory awareness exercises for pregnant women to influence the post-natal mother-infant attachment (Ventling, 2007). Within the narrower domain of infertility, Vincentia Schroeter shares her personal process on dealing with her own reproductive trauma. Her experience moved her to create an infertility focus in her clinical practice to support women to voice their inner experience and deep feelings related to their infertility (Schroeter, 2002). Infertility impacts the physical and psychological experience of women, making body-oriented therapy a sensible choice, and bioenergetic therapists have the tools to help a woman navigate the journey.

My professional introduction to reproductive trauma came while working in a hospital-run prenatal clinic. The agency's lack of resources to appropriately support women after miscarriage or stillbirth became painfully obvious. To fill this need, we sent nursing and case management staff for training, and implemented a program to support bereaved families. My interest in parental bereavement persisted and led me to research family reconstitution after infant loss (Grout & Romanoff, 1999). As a bioenergetic therapist, my interest in reproductive mental health was oriented to postpartum mood and anxiety disorders, but I quickly became aware of the importance of being attentive to the fertility stories underlying client experiences. I did an assessment on an eight-year-old girl for anxiety. During the parent feedback interview, her mother disclosed her history of eight pregnancy losses before this child's pre-term birth. This history had created a parenting context in which the child's anxiety was a reflection of her mother's enduring grief and fear. Another client, Anna, came to therapy to adjust to her diabetes diagnosis. Unbeknownst to Anna and to me, the adjustment was really to a future without motherhood, with infertility a by-product of her diagnosis.

Women describe the experience of infertility like being lost in an unfamiliar place. In this new land there are no natives and only unwilling immigrants. The language is unfamiliar, the landscape foreign, and there are no roadmaps. Nobody arrives by choice. For most couples, the time spent in infertility is the first prolonged crisis of the relationship and the diagnosis of "infertility" is the first encounter with a significant medical problem (Watson, 2005; Burns, 2005).

Infertility is a medical diagnosis that is assigned when a couple has been trying to conceive for a year without success or has other medical problems that interfere with fertility. As a medical problem, there are a number of potential treatments under the broad label of Assisted Reproductive Technology (ART). Infertility can have a cause or can be "cause unknown." There is also "secondary infertility," in which the fertility struggle occurs after a child has been born. This is no less difficult, though the struggles are often dismissed by people with primary infertility. Gay and lesbian clients are also affected by reproductive complications.

There is much shame and/or embarrassment around fertility issues, perhaps because fertility is related to sexuality. Couples' shame and embarrassment can leave them alienated from others, particularly after several failed cycles without conception. They may not tell their families or friends and may keep treatment a secret. The shame is automatic and often not identified and couples don't seek support from the usual sources. Often, infertility becomes a family secret or part of a hidden story.

Gender and Infertility

Struggling to have a baby is a couple's wound, but when a couple is unable to conceive they may find it very hard to talk about with each other. Men and women experience infertility differently. For men, fathering a child is an accomplishment and an achieved status. Not being successful may cut into a man's sense of himself as an adult. Men also often perceive infertility to be about sexual dysfunction, and view it as emasculating and damaging to the ego (Clarke, Martin-Matthews & Matthews, 2005).

For women, the cut is different and deeper, perhaps because a woman's body is often implicated in the original problem of infertility and always implicated in interventions. Women bring their characteristic defensive and coping styles to this crisis. Regardless of the source of infertility, a woman's body is involved, particularly her abdomen. Infertility may highlight an already-present feeling of powerlessness (Dupey-Godin, 1987). The failure to conceive may be seen as a failure of the body to "work correctly," or a failure to give her husband something that he wants. As Clark et al. (2005) found in their interviews with infertile men and women, the body as a whole may be seen and felt as "shameful and inadequate" (p. 103). Most profoundly, the inability to conceive "intensifies the perceived

alienation of the self from the body" (p. 103). Another gender difference lies in socialization to adulthood. Many women have been socialized to anticipate motherhood. This socialization to motherhood happens early and is repeatedly reinforced by social values. Thus, for many women, the image of adulthood is synonymous with motherhood. Her sense of self-to-be carries an expectation that she will create a family. Once a woman begins the active process of trying to conceive, the images of self-as-mother become prominent and active.

Women are the people who initiate therapy when fertility is an issue, and women who bear the major treatment burden. Even when male factors are causal, if in-vitro fertilization (IVF) is indicated, the woman is the one who will take hormone injections to ripen her eggs, will have her eggs harvested, will have the procedure to introduce the embryos and will continue to take hormones to support the pregnancy. Thus, women take on the painful interventions even when the source of the infertility lies with her partner. Even in "male factor" infertility, women's bodies continue to be the locus of interest and the woman often takes on the shame and stigma as if her body is the causative factor.

After Susan and Jerry experienced three failed intrauterine insemination (IUI) procedures, it became clear that the problem was likely in the sperm. The choice that arose for the couple was between IVF and the more complex, more expensive intracytoplasmic sperm injection (ICSI) which maximizes the likelihood of fertilization. Logic suggested that the ICSI procedure was more likely to be successful. However, choosing it made clear that sperm quality was a factor in their infertility. Susan wanted to protect her husband from confronting that he might be the source of their infertility, as she felt that realization might be too difficult for him.

A woman's alienation from her body, in which she experiences her "self" as separate from her body, is a source of suffering in infertility. When the body and self are not connected, and in fact are experienced as in conflict, the woman feels "not herself." She believes, at times, that only a baby will help her to retrieve her lost self and seeks desperately for a solution to the problems of infertility. The sojourn in the strange land of infertility is temporary, though it does not feel like it. Whether a woman emerges as a parent or creates other ways to make meaning of her experience, her re-connection to herself is a major goal of therapy. While people are unique, there seem to be four areas that emerge in working with women in this struggle. They are the struggle with the diagnosis, coping with social relationships, grief and bereavement, and treatment decision-making. Each of these is discussed below.

The Struggle with the Diagnosis

For women, the diagnosis of "infertility" can offer relief because it implies a solution and treatment options. However, the problem of infertility itself is

unbounded. Each intervention might offer an end solution but also carries simultaneous uncertainty. With each failed intervention, new decisions must be made. As difficult as infertility may be, it is often helpful to know that infertility is not a permanent situation and can be resolved through a number of avenues to parenthood or choosing not to parent (Domar & Kelly, 2004). For one of my clients, just to hear that infertility would not be forever gave her a sense that it was okay to continue treatment.

Coping with Social Relationships

Women's social lives suffer when they are struggling with fertility and they may not share the degree of their suffering with their spouse. In addition, the shame and private nature of the problem often means that women do not share their feelings with family or friends. Women are confronted with other people's pregnancies, baby showers, baby pictures, and complaints about parenthood. Women express feelings of anger, rage, and confusion regarding their strong responses to others' pregnancies and children. Family members can be insensitive, and a woman may often prefer to avoid social situations that exacerbate her feelings of emptiness and grief. Women struggling with infertility risk increasing social isolation, but avoidance is understandable when connecting with family and friends results in increased suffering.

Some exposure to other people's babies is unavoidable, and the lack of sensitivity for the infertile woman can have a staggering impact. After her second round of IVF, Nadine miscarried twins at nine weeks gestation. Shortly afterward, an employee of Nadine's became unexpectedly pregnant with twins and was vocal about her frustration and anger. Nadine could not escape this employee's complaints about her pregnancy. Nadine arranged for the employee to report to another supervisor for the duration of the pregnancy, thus making it possible for Nadine to work. In therapy, she expressed the rollercoaster of emotions she was experiencing.

In therapy, a woman can express the rage, sorrow, fear, grief and guilt that accompany the diagnosis of infertility and the struggle to keep her footing when her peers all seem to be pregnant or parenting. Expression of deep feeling may create space for her to be able to make use of social supports and can also be helpful in developing scripts for managing unexpected social challenges.

Grief and Bereavement

More than anything else, infertility brings bereavement. Much of the work of therapy is to support a wide range and intensity of feelings about the losses. These losses are multiple and cumulative, and it might not be obvious to the woman

that her unhappiness is related to her infertility. One woman came in to see me presenting symptoms of depression. After several sessions, she shared that her specialist told her she would not be able to have children. She and her husband had passively absorbed this information and didn't discuss the ramifications of this news. They did not acknowledge the emotions surrounding the news and did not address the loss of the expected parental self, loss of the anticipated child, loss of the acknowledgement of adult status that comes with the announcement of a pregnancy. There is a loss of the joy and pleasure of sharing good news with family and friends.

There is also the monthly loss of pregnancy unachieved. That is, from the moment of trying to conceive, each month brings the possibility of a baby. When a woman who is trying to conceive feels menstrual cramps or sees menstrual blood, she feels a strong experience of loss. For many women, the only place to acknowledge this loss is in therapy. This imaginal loss is deeper and more meaningful than simply not getting an object you desire. It is also a loss that contains hope for the next month and the next cycle. As the months pass and the losses mount, the hope shrinks.

"I don't feel like myself," is a common statement, and there is loss of the "self-as-usual," particularly when one is in ART treatment. This statement is suggestive of alienation from the body-as-self. A woman loses personal control when she embarks on ART treatment. Her menstrual cycle becomes of great interest to others including medical professionals, her sexual behaviours are monitored, her adherence to the treatment regimen is tracked and charted, and she herself is drawn into looking at her body as an object in the treatment process.

The losses of infertility are deeply contextualized within the extended family. What infertility means to a woman is influenced by her relationship with her own mother. In becoming pregnant, she may seek to connect to her mother, to give her mother a grandchild, or to achieve adult womanhood in her mother's eyes. When a woman contemplates becoming a mother, there are complex layers of experience, memory, and the meaning of mothering to explore (Stern, 1995; Stern & Bruschweiler-Stern, 1998). When motherhood is not readily available, these layers take on heightened significance. In the therapy office, client and therapist can gently explore the meanings of fertility, motherhood, and the way she takes her place in the intergenerational cycle of her family.

Pregnancy loss is a label that comprises a range from early miscarriage through full-term stillbirth, including ectopic pregnancy, severe birth defects, and, at times, therapeutic abortion. Family support for these kinds of losses is often limited and may not be helpful. Women experience losses and grief differently and a woman's response to a loss cannot be predicted. One client I saw had six early pregnancy losses after the birth of her first child. She appeared unfazed and did not consider it of therapeutic concern. The thought of not having another child disturbed her, but she planned to keep on trying until it "worked." The seventh

pregnancy resulted in a daughter. Another client miscarried at seven weeks and after two years continues to suffer from the loss, which is exacerbated by her difficulty in conceiving again. Her persistent infertility gets in the way of resolving the grief of the loss of her first pregnancy. As seen in these women, the grief of infertility, like the grief of pregnancy loss, is highly individual.

In its essential form, infertility is about a failure to create something that has great meaning to the woman. This is more than feeling "less than" other women, or even "less than" the person a woman thought she would be. This is a feeling of being diminished, perhaps smaller or less substantial than expected by herself and possibly others. Some women who struggle with infertility and particularly with pregnancy loss report an aching emptiness in the belly or in the arms, as if they were are longing to hold someone that doesn't even exist (Glaser & Cooper, 1988).

Treatment Decision-Making

Each decision a couple makes has various consequences and each step represents movement down a path without any guarantees. The nature of the treatment leaves women and men with the power in the decision-making process (Clark, et al, 2006). A man may defer to his partner since she "has to go through it." However, ART treatment is expensive, much of the cost being out-of-pocket, and many couples must decide between ART and other investments in their lives. The financial pressure can become a source of conflict in the relationships, particularly when one spouse is more invested in having children than the other.

ART treatments can be ranked by invasiveness and range from administration of hormones to adjust cycle length to the use of a gestational surrogate with donor egg and sperm. In therapy, the nature and meaning of the different treatments can be fruitfully explored. The therapist can help the client to feel and articulate the meanings that each intervention has for her. The choice to use gamete donors or surrogacy is particularly complex and those decisions evoke emotion and raise questions about the importance of biological/genetic connection to the child.

A woman desires to make good decisions for herself, her partner, and the children she hopes to have. In therapy, a woman can be supported to experience her feelings when making these decisions. Many interventions are unpleasant, uncomfortable, and likely to violate her sense of personal dignity and efficacy and it is important to address the thoughts and feelings that surface. Men will often be less willing to move forward on some of the treatments because they don't want to feel responsible for "putting her through" an uncomfortable intervention. Women who desperately want to have a baby may become very stoic about the inconvenience and pain associated with the treatments. Since the woman has made the decision to move forward, she may feel constrained in expressing any negative

thoughts or feelings about the process or what she is experiencing. Therefore, therapy becomes a safe place where she can express the strong feelings that can arise.

Shawna's and Tim's Story

Shawna and Tim came for a single session in preparation for using a donor egg procedure. They had married in their late 30s, a first marriage for both. Tim was happy with his life and planning to build a new house. However, Shawna could see this new house as meaningful only if their family included a child. The therapy session with me was mandated by their medical provider and the goal was to examine the couples' perspective on using a donor egg, how they planned to choose a donor, how they would inform their families and how they would inform their future child. This couple were typical and were focused on achieving a pregnancy. They had not begun to think about parenting a child from a donor egg procedure. They had been through failed IVF and poor embryo outcomes that were attributed to Shawna's age, hence the referral for donor egg. For Shawna, getting pregnant was the primary focus.

More than a year later, Shawna contacted me for a follow-up visit. She had been through two very difficult miscarriages after IVF using the donor eggs. Her reason for coming to therapy was to get support in deciding whether to try a final time for pregnancy, as there were two embryos left from the donor egg procedure. She came alone for two sessions. She expressed both her fear of another miscarriage and her deep desire to carry a child. Despite her two traumatic miscarriages, her desire for a baby was still very strong. She expressed to me, "After what I have been though, I know I can handle whatever happens to me. I know I can go through anything." Shawna also could imagine being happy in a childless future.

In contrast to the couples' first visit, this time Shawna was very much on her own. She reported that she thought Tim had given up on the "baby project." He had thrown himself into building the house. She was able to acknowledge both his need to step away and her own need to keep trying. She left her second session confident that she had explored her own feelings and thoughts about the choice in front of her.

I was struck by Shawna's willingness to persist in trying to give birth to a child. The process of pregnancy and birth was critically important to her. In our individual sessions, Shawna appeared strong in her body and in spirit and I admired her strength and determination after extremely difficult pregnancy losses. She was certain that she could survive anything, including childlessness. Even though Tim's energy for having a child had flagged, she was willing to move forward. A year after our last session, I got an email from Shawna with a picture of her two-month-old son. Receiving this picture was a poignant moment for me. I was touched by Shawna's willingness to include me in the joy of her motherhood.

If a couple choose to stop striving for a pregnancy, they are faced with a question of whether to be childless or to adopt children. Some families start the adoption process as soon as they become aware that pregnancy may not be easily achieved. This can be adaptive; where I practice, adoption takes about eight years. One of my clients started adoption proceedings simultaneously with the treatment for her endometriosis. A married lesbian woman started adoption proceedings at the same time that she started IVF. She was clear that if her IVF was not successful, and she and her spouse would have an advance start on the eight-year wait.

Deciding to adopt is a complex process, quite different from deciding to proceed with fertility treatment. One obvious difference is that children may be adopted at any age. One client is certain she could only adopt an infant though her spouse states that she would love a child or a young teenager. My client with endometriosis can imagine welcoming and loving a child of any age. For couples who move toward adoption, there are long waits and large expenses. Many families spend savings or go into debt for infertility treatment: the financial demands of adoption may be impossible to meet after years of ART. Some people fear that they may not be able to bond to an adopted child. Others are concerned about adopting a child who doesn't look like a member of the family. Parents who have biological children may be concerned about introducing an adopted child into the home. These reservations may bring guilt and shame, but creating a therapeutic milieu that facilitates opportunity for expression of fears and concerns can aid the decision-making process.

After many years of fertility treatments or after seeking adoption, choosing childlessness can seem an obvious solution. There is a difference between resigning oneself to not having a child and choosing to be childless. The first engenders collapse under some great weight and the second is using personal power to decide on one's own behalf.

As a therapist, I have encountered people whose presenting concerns masked a history of fertility struggles. I have learned to screen for pregnancy losses and early postpartum experiences, gently checking on how these impact the person. Unintegrated, losses can persist, subtly and not-so-subtly influencing a woman's life. Integrated into the context of family life, these experiences can provide a richness of texture and story that support a woman's sense of herself.

Cynthia's Story

Cynthia, age 47, a police officer, sought treatment for work-related post-traumatic stress disorder. She also had a history of pregnancy losses, including a first-trimester abortion, a complex early miscarriage, and a twin pregnancy that resulted in a stillbirth and a healthy baby. Each of these experiences carried its own weight and intense emotional burdens with a complex array of feelings including

anger, shame, grief, and guilt. In the context of her work-related injuries it would be easy to miss these issues in therapy. However, her history of pregnancy losses asserted itself in dreams, intrusive thoughts, and emotional flashbacks. Cynthia worked hard in therapy to resolve her losses using journaling, ritual, and allowing herself to experience her feelings about her abortion, her miscarriage and the death of her son. After many months of working on resolving these issues, she arrived in session one day to show me, with delight, her new tattoo. She had three sets of angel wings marked on her left arm closest to her heart.

Tara's Story

Even without pregnancy loss, marking the loss of the dream of a family can help a woman to see her way forward. Tara came into my office knowing only that there was something she wanted to talk about. She and her spouse purchased a four-bedroom house with the intent of having a family. After several years and a number of failed attempts to get pregnant, they decided together that ART or adoption were not options that they wanted to utilize. The couple enjoyed traveling and the financial burden plus the uncertainty of these interventions made both options unacceptable. Tara and her husband agreed to this decision. However, she had difficulty in working with her real estate agent to sign the documents to sell her house. Tara was analytical and logical. She knew that selling the house was the right decision, but she avoided completing the paperwork and couldn't understand what was getting in the way of doing what she thought she wanted to do.

In therapy, we explored the meaning of the house. Tara shared with me her dream of having her own children and a home. Tara's sister and two nieces lived next door, and the sisters dreamed about raising their children together. Tara loved being next door to her little nieces, but the couples' new chosen lifestyle no longer consisted of owning a large home in the suburbs. In fact, they had already chosen a condominium. Tara and I discussed creating a symbolic ritual that involved saying goodbye to the dream and the family that the house represented. She and her husband developed a ritual to allow them both to release this dream of children to make room for the new life. In her next session, Tara reported that she felt less encumbered and ready to move forward. I suspect that she only needed to acknowledge that she was saying goodbye to her dream of children for the shift to occur in her life.

Making Use of the Experience

Part of reconciling oneself to a different future than parenthood is the acknowledgement of an ending. Often, there is a next step beyond marking the ending

of the dream of parenting a family. This step involves making use of the time she spent in infertility. Whether a woman becomes a mother or opts to be childless, her experiences in infertility offer great richness to her lived experience. Women who have gone through infertility have confronted obstacles to a deeply desired creation. They have experienced their own strength and vulnerabilities, felt their despair and endured suffering. Living a creative life means constructing a way to encapsulate that richness from the past into the next endeavour. As a woman leaves the shore of infertility she must incorporate all she has learned. Sometimes the experience of infertility helps a woman to see others with greater compassion. She also knows that she can endure much more than she ever knew. Some women use their experiences to reach out a hand to others through opening conversations or even facilitating support groups. No matter how a woman constructs her experience, it will become the essence that she can incorporate into the ongoing creation of herself.

Conclusion

Discovering that the dream of parenthood is challenged by infertility is often an emotional blow. Women are deeply affected because their bodies are implicated no matter the cause of infertility, and because of their socialization around motherhood. Assisted reproductive technology offers treatments but no guarantees, and is expensive, often painful, inconvenient and difficult. After the diagnosis of infertility, women struggle to cope with social demands to appreciate other people's babies, with their own relationships to their mothers and with the ongoing decision-making about treatment, or about whether to adopt or choose childlessness. Therapy can help a woman to express all of the feelings that arise, support her to consider her own needs in the decision-making process, and to help her to reconnect to the body that has failed her in her striving for motherhood. The experiences garnered during the time of infertility can be integrated to be a valuable part of her ongoing creative self.

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About the Author

Leslie Ann Costello, Ph.D., CBT, is a psychologist, former university professor, and Local Trainer with the Atlantic Canada Society for Bioenergetic Analysis. She brings a developmental perspective, with training in infant and perinatal mental health, attachment, and child-parent psychotherapy in addition to her bioenergetic training. She offers workshops for therapists and clients in New England and the Canadian Maritimes. She is in private practice in Fredericton, New Brunswick, Canada, where she specializes in perinatal mental health and trauma.

lesliean ncostello@gmail.com