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LOYOLA UNIVERSITY OF CHICAGO

AND SHE WOULD NOT BE CONSOLED:
PSYCHOLOGICAL ADJUSTMENT, GRIEF REACTIONS
AND RESOLUTION
GRIEVING THE INFERTILITY LOSS

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS

INSTITUTE OF PASTORAL STUDIES

BY

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CHICAGO, ILLINOIS

MAY, 1994

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To my children
Rebekah Marie and Jonathan James
The milk and honey of the promised land

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CHAPTER 1

INTRODUCTION

Because her children are no more (Matthew 2:18)

Most couples assume they are fertile. We did. At the same time our dreams were just beginning to come true, we were shocked and dismayed to realize that a crisis called infertility was to take us on a journey to the deepest kind of loss. The diagnosis of infertility comes early on, for by definition it is the inability to become pregnant after one year of regular sexual intercourse without the use of a contraceptive. Our hopes were high; we had come into the marriage relationship thrilled at the salve it had given to old wounds we nursed when we met. Family was important to us both, and we longed to share the newness of this love with children of our own. I had come from a family of twelve and hungered to generate some of the joy and fullness I had known as a child. My husband had experienced some poverty of family, and he, too, longed to fulfill his dream of a happy household.

Infertility came like a thief in the night; it was a long time before we could even name what had been taken from us. The silent stigma had set in and we were instantly flooded with costly treatments. The medical community was ready to help, but seemed unaware of the fragile and fragmented couple they were about to poke, prod, and make produce.

We submitted the intimacies of our sexual relationship to their medical scrutiny. The charts that lay by the bedside recorded not only my bodily temperature for ovulation indicators, but it also was marking the demise of a sexual relationship that had been brimming with passion and spontaneity.

As they searched for the etiology of the infertility within us both, we began to experience a range of intense emotional reactions that moved from embarrassment to despair and depression. We were living with a profound loss of control over our lives, which affected body-image, gender identity, and an assault to the marriage relationship.

Four years of infertility treatments ultimately resulted in major surgery for me, which forced us to stop the medical roller coaster. We were threatened

financially, also, as infertility is often treated as cosmetic surgery by insurance companies. The helplessness worsened. We turned to traditional adoption.

Now we were in a different system that also poked, prodded, and sabotaged our hopes and dreams. They would produce a child FOR us. The many agencies we applied to treated the infertility as a part of the evaluation, requiring detailed medical proof of all aspects of the infertility. Many agencies succumbed to the myths about infertility--that we were really seeking adoption so we could get pregnant and were not psychologically capable of enduring the adoption process or parenting a child. The underlying question of the agencies was the result of another myth--that infertility is the result of psychological factors. The truth is that in 90% of all infertile couples, it is a physical condition and very rarely a psychological one. Having proved ourselves worthy, we adopted after three years.

It was in the process of parenting my beautiful twin babies that I realized that I had experienced a profound loss, and that my bereavement had gone on without resolution. I further discovered that these

children who issued from my heart were not given to me by God to be replacements for the children who I miscarried or could not bear because of infertility. They are who they are in their own right, not the resolution of my own losses. They will have their own losses. They are not the desert scars; they are the milk and honey of the promised land.

This revelation has taken many years, and although my grief work has begun, I know it is not completed. But I have been able to name the pain, and bring some resolution to the intangible loss that affected my identity as a woman. I see writing this thesis as another opportunity to bring further resolution to these losses that show themselves throughout the life-cycle.

Hopefully, Pastoral Counseling can, in some way, provide a locus of understanding that can help facilitate the bereavement process for those who are faced with the crisis of infertility.

As I begin this Counseling ministry, I am already very aware of the necessity of the resolution of grief in terms of the infertility loss. So often, as in my own personal experience, adoption, reproductive technologies, or options for child-free living have been

used to bring resolution to this major loss. I hope to show the necessity of grief work toward a healthy resolution--one that can restore control of life and further assist in structuring life-time goals.

Sigmund Freud wrote of his loss:

Although we know that after such a loss the acute state of mourning will subside, we also know that we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. (Viorst 1986, 287)

In this paper, I will identify the problem of infertility in terms of the biopsychosocial stressors that affect both the individual and the marriage dyad. I also plan to describe the grief reactions commonly experienced in the infertility crisis to serve as a basis for normalizing the strong reactions to the myriad of losses. Associated with grief reactions are what John Schneider, a grief counselor, names the tasks of grieving (Schneider 1984). These tasks point to responses and coping mechanisms that are natural when faced with such overwhelming stressors. I will incorporate these tasks as part of the entire cyclical process of grieving infertility.

Resolution of the infertility crisis is two-fold. First, it requires the acknowledgment of infertility as

a part of the whole life experience in all of its stages, from the initial assault to the ongoing process of integration. This is not a linear movement, for its hills and valleys are revisited often during the entire life-cycle.

Secondly, I hope to identify the outcomes of infertility which further resolve the infertility crisis; these are adoption options, assisted reproductive technologies, and the choice of child-free living.

Finally, I will propose some help in the healing of the fertility loss from our Biblical traditions. Perhaps what we have seen in the past as a further stigma to the infertile woman can be viewed in the light of understanding women as bearers of the promise of a New Covenant. The narratives, from Sarah to the Woman in Travail, point to a shift from what is considered the norm to the unfolding of a new and generative people.

CHAPTER 2

INFERTILITY: THE PROBLEM OF IDENTITY

Rachel was well-formed and beautiful (Genesis 29:18)

Infertility is a negative life event that can have an injurious effect on the biological, psychological, and social well-being of both men and women (Andrews and Halman 1992). The severity of the stressors allied with the infertility conflict are acute and have the potential for a loss of inner control over the body, self worth, and placement in a society that values reproduction, sometimes beyond the needs of the individual.

Infertility strikes first at the body. Up until the first unwanted menstrual period arrives, the body has been a precious ally in the goal to generate new life. Even before the medical team is brought in, body-image may be already altered. Many woman speak of their bodies as conspirators in the betrayal against them in terms of an inability to reproduce. Linda P. Salzer, a noted psychotherapist, quotes a woman trying to name the

affect infertility has on body-image:

My body no longer pleases me and the scars from my extensive surgery are a daily reminder of my body's betrayal. I view my body as a traitor in that it has not been able to nurture a pregnancy, nor will it allow me to become pregnant again. (1991, 39)

For a woman, body-image may be further diminished by infertility due to age, weight, and even the woman's contraceptive history. Adrienne Kraft describes what contributes to the biological remembering and making of identity:

A person's identity is shaped around feelings about body-image, physical well-being, and perceptions of physical endurance, intactness, or defectiveness. (Kraft et al. 1980, 623)

Most women are very aware of the clock ticking within their body. Societal issues of age are already difficult to respond to as women gradually creep out of a minority status. Even without a medical work-up, women can look in the mirror and see the first indicator of their infertility. Many couples, very much in control of their lives, purposefully wait to have children, only to find that while they were preparing in terms of security and finance, their bodies may have been on another course, decreasing their chances with time.

Weight may also point to a decrease in body-image

associated with infertility. If a woman is under the recommended weight by more than 10%, the production of hormones can be adversely affected. On the other hand, a woman carrying too much weight may be a candidate for polycystic ovarian disease, a form of infertility disease which carries symptoms of too many male hormones and make it difficult to release the eggs. (Robin 1993)

Previous contraceptive history also contributes to the blow to body-image. Methods of birth control that were once considered a help to planning, become vehicles that contributed to the infertility. Fallopian tube scarring, infection, and other damage is now known to be common with intra-uterine devices such as the Dalkon Shield. Birth control pills work by inhibiting ovulation and may be working far beyond the usage of the pill. All these factors indicate vulnerable body-image, and loss of control is a major issue. The confusion worsens with the fact that until now the woman has perceived herself as "healthy," so the rapid shift carries tremendous implications.

Body-image in the male is also diminished by the reality of infertility, because fatherhood is central

to the idea of masculinity. There is, however, a marked difference in the way men perceive their bodies and their contribution to the make-up of man-kind. Gay Becker, in his book, Healing the Infertile Family, describes it thus:

A man defines his fertility primarily in relation to his sexuality. And his sexuality is a primary means of self-definition and self expression. Central to his sense of self. (Becker 1990, 61)

Male factor infertility touches both the masculinity and sexuality of the husband. It is almost impossible for the male to distinguish between masculinity and sexuality. Carla Harkness recalls the experience of Jim and Lisa:

A semen analysis was ordered for Jim. He balked at the idea of masturbating into a jar and having his sperm graded for quality and quantity. He knew his sex life was normal and assumed that his sperm was too. (1992, 10)

Because the initial testing of the male involves the semen, the core of the male identity is instantly shaken. The very movement to submit the sperm to testing in terms of numbers and motility provide the beginnings of an altered body-image. Becker describes the impact this has on the male:

When a man's sperm have been questioned, everything about him as a sexual being feels under attack--from

his sexual performance to all those qualities that are directly sexual, like physical attractiveness. (1990, 62)

In the recent past the macho image of the male was so predominant that it was difficult to have men submit their semen for testing. This led to inaccurate numbers in terms of how many men were infertile. The psychological climate has now changed and "the idea that men can have fertility problems is now considered more acceptable." (Chinnici 1984, 74)

The emotional response to the sperm diagnosis is so great that the man moves along the bereavement stages from shock to acceptance, showing the magnitude of the loss (Becker 1990). "When a man is forced to deal with...the essence of his manhood, he feels victimized and assaulted." (Becker 1990, 64)

Hearing that the sperm is slow, dead, or of an inadequate number, changes the image the male once had of himself. Although it is very rarely discussed, a man "thinks of himself as whole. Until he finds out there is something wrong with his sperm." (Becker, 1990, 65)

For both the male and the female the infertility begins a metamorphosis of body-image. Reproduction is

one of the most basic life-experiences; the inability to reproduce is often marked by an anger turned inward, to the very heart of identity--the body.

Recently self psychology has helped us to understand how infertility can be a serious narcissistic injury. L. Kolb defines how the presence of a physical handicap from birth can lead to the formation of a limited body-image (Kolb 1959). When the discovery of a defect comes at a later time, it also threatens the stability of a cohesive body-image. It can either symbolize a basic flaw in the personality or it can be determined as a stressful event to be dealt with (Kraft et al. 1980).

Responses vary with individuals, however, as narcissistic injuries most often carry rage reactions and other regressive responses (Neiderland 1965). Adrienne Kraft, an adoption specialist, describes the trauma of infertility in this light:

Infertility may be seen as an injury to the individual's sense of self-cohesion. The injury may lead to anxiety, fragmentation, or more archaic forms of self-organization. But what is focal for the adult who experiences such a trauma is the reorganization necessary to cope with the lost ideal of oneself as a biological parent. (1980, 623)

Kraft identifies three components in the search for

resolution, although some regressive and pathological responses are present. The first of these three components is the need to get in touch with the injury itself by experiencing the grief and pain accompanying the loss of parenthood. Certain psychologists say this need to parent is biologically driven. "Since every genital encounter engages the procreative organs in some arousal and in principle can result in conception, a *psychobiological* need for procreation can, it seems, not be ignored." (Erikson 1982, 67) The second component involves the task of assessing the notion of parenthood and the possibility of compensatory activities. The third component looks to the restoration of the body-image through the emotional acceptance that a physical problem is not the equivalent of a psychological and spiritual defect (Kraft et al. 1980).

In Campbell and McMahon's Bio-Spirituality they describe hope for the adaptation needed to heal:

We need adversity to thrust us beyond the narrow perceptions which blind us to these broader currents. Tragedies, as other mysteries of life, are never solved by our intellect, but are resolved in our bodies through organic inner wisdom. Becoming lost when there are no more rational answers forces us, finally, to launch deeper into ourselves. (1985, 14)

Pastoral Counseling has the opportunity to help

both the male and the female wounded by this revelation which strikes at the heart of their identity. The "focusing" work of Campbell and McMahon can be used as an intervention to reach the "body wisdom" and find meaning in the body itself. Focusing is a way to find a unique life-meaning through a process within the body. This intervention is unique, and may provide a greater connectedness and meaning to all the experiences of infertility. Reconciling the pain and assault of infertility will mean a forgiveness of self and a reframing of the anger and guilt turned within, a journey towards a body that remains guilt-free and whole (Campbell and McMahon 1985).

The psychological stressors involved in infertility are multiple. The three most prominent stressors are isolation, diminished self-esteem, and loss of inner control.

Gay Becker, PH.D., describes the isolated feelings of the couple:

Men and women learn sooner or later that their view of the world is not identical. This discovery is part of the process of personal growth in adulthood. But when it occurs in tandem with the discovery of infertility, it may polarize the relationship. Shocked by their infertility and flooded by feeling of failure and guilt, women and men experience isolation from each other--one of the most difficult

things for them to bear at this time. (1990, 79)

Infertility arises out of the bedroom, the most intimate chamber of the marriage. It is difficult to communicate with others because reproductive losses are invisible. Alienation from others may become acute, as infertile individuals conceal their problem from friends and family. According to B. E. Menning, "Secrecy prevents individuals from receiving support that could be available." (Cook 1987, 465)

Because of the personal nature of this problem, infertile individuals may wish to avoid embarrassment, unsolicited counsel, and other hurtful reactions. Even the initial feelings of the trauma require disclosure capable of threatening self-esteem so important to identity. "Self-esteem has been defined as the extent to which one prizes, values, and approves, or likes oneself." (Blascovich and Tomaka 1991, 115) In most of the literature on infertility, reproduction is regarded as central to identity, and the risk or loss of it diminishes self-esteem.

Determining the cause of the infertility can further influence the perception of self. When one partner is identified as infertile, feelings of

betrayal and fear of abandonment are common (Kraft et al. 1980). In turn, the identified spouse feels more alienated, and stress and isolation increase. Keye, Deneris, Butell, Wilson, and Sullivan, in their study of infertility evaluated the effect on women of various causes of infertility and found that:

Women with ovulatory dysfunction felt inadequate, had a poor body image, and had low self-esteem. Patients with tubal disease often felt guilty and punished. Patients with endometriosis described themselves as feeling helpless. Women whose husbands had a male factor were dissatisfied with sex. Berger (1980) also noted that wives in couples with male factor infertility reported sexual dissatisfaction, as well as alternate rage and protectiveness toward their husbands. (Rosenthal 1987, 6)

Another psychological effect of infertility is the reduction of inner control. Langer, in his article "The Psychology of Control," clearly defines inner control:

The term "control" refers to individual's beliefs about who or what determines outcomes in their lives. The extent to which individuals believe that they personally determine what happens in their lives reflects their sense of inner control. (1983, 34)

Inner control is strongly associated with "positive affect, life satisfaction, and improved performance, while a lack of control is associated with negative affect and impaired performance." (Abbey and Andrews

1985, 409) Couples experiencing an inability to procreate feel helpless in terms of their bodies, their plans, and even their future. Infertile individuals frequently feel as if they have relinquished control of their lives to a physician (Mahlstedt 1985). Loss of control is further exacerbated by infertility treatments. Many couples feel victim to never-ending suggestions from the medical community to try the latest assisted reproductive technology, which carry greater stressors in terms of religious beliefs and ethical considerations.

In the past, infertility was perceived as the result of an intrapsychic conflict. Since the work of Erik Erikson, a developmental psychologist, infertility is seen today as a precipitating factor of a developmental crisis, and also a series of situational crises (Anderson 1989).

All the strengths arising from earlier developments in the ascending order from infancy to young adulthood (hope and will, purpose and skill, fidelity and love) now prove, on closer study, to be essential for the generational task of cultivating strength in the next generation. For this is indeed the "store" of human life. (Erikson 1982, 67)

The first stage of adulthood Erikson calls intimacy versus isolation. Intimacy is the potential to

have a tender, open and supportive relationship with another without the fear of losing one's own identity in the process (Erikson 1982). Each member of the dyad is supported by the intimacy, through both cognitive and affective components. The intimacy of the relationship also permits the disclosure of feelings and promotes the development of ideas and planning for the future.

Intimacy, then, suggests a level of ego development in which the person's individual needs are met through the satisfaction of another's needs. Intimacy also provides the readiness to commit oneself to others, specifically to children and parenting (Lindell and Dineen 1986).

Erikson describes the adulthood stage of generativity as encompassing "procreativity, productivity and creativity." (Erikson 1982, 53) Erikson sees the stage of generativity as the "generation of new beings, as well as of new products and new ideas, including self-generation concerned with identity development." (Erikson 1982, 67)

Developmentally, infertility can represent a failure to achieve one of life's milestones. Erikson believed that the primary task of young adulthood was to move toward generativity, and that "having children was

the first, and for many, the primary generative encounter." (Butler and Koraleski 1990, 130)

Erikson also noted that when there is failure in this generational enrichment, "regressions to earlier stages may occur either in the form of an obsessive need for pseudo-intimacy or of a compulsive kind of preoccupation with self-imagery." (Erikson 1982, 67)

The inability to produce children, then, can be a block to ego development and, for some, "the lack of children can make everything they work for seem pointless; material comfort or attainment of career goals cannot fill the absence of a wanted child." (Corson 1983, 8)

Parenting is a normative contribution to adult development. Although it carries extreme amounts of stress and is full of conflict and challenge, parenting also "generates the kind of conflict that promises an enormous potential for personal growth." (Newman and Newman 1991, 536)

Nurturing children provides a context that gives the adult an opportunity to see the continuous consequences of their endeavors in the development of their children. "Psychosocial growth requires a willingness to engage in tasks that may increase stress, uncertainty, and complexity." (Newman

and Newman 1991, 537)

Erik Erikson's field of studying the life-cycle gives an enlightened look at the adult stage of generativity. Infertility can be regarded as a crisis in the developmental stages of growth. However, the crisis itself can become a "call or awakening to the new task or movement of growth. If the individual responds, he or she moves on." (Brewi and Brennan 1991, 9)

The biological and psychological characteristics of infertility are multiple in the response to this crisis. The social stressors from family and the medical community also give the crisis an added dimension, with the major impact on the marital relationship.

Infertility was once viewed as primarily female-related. Today, however, with the revelation of the physical causes of infertility, it appears that 40% of infertility problems are female factor and 40% are attributed to the male. In the remaining 20%, couples share the problem or the causes are unknown (Shapiro 1992). Even though the etiology of infertility is more balanced in the couple, there remain decisions, demands, and gender differences that can create discord and problems between the couple.

The multiple decisions infertile couples must address is the most challenging. At the onset, for example, the couple must decide who to tell and how to talk about the infertility. With so many unknowns about what the problem actually is, they are faced with confusion and often fear. "Decision-making is complicated because infertility decisions often have important consequences for careers and other life-time goals." (Williams et al. 1992, 316) Constant evaluation is needed because of the dynamic nature of the infertility. It involves lifestyle, finances, and the stamina needed for treatment. Conflict resolution skills become a necessity, along with the ability to honestly communicate the myriad of feelings experienced. Decision-making is an important aspect of infertility, as it has the potential to empower the couple with their own goals for their altered lives.

Infertility impacts negatively on the couple's sexual relationship. "For many couples sex becomes primarily goal-oriented towards procreation rather than pleasure." (Shapiro 1982, 388) Sex can become the most damaged part of the relationship due to infertility.

Last year we decided together to take a vacation from treatment to allow our sex life to become

normal again. I don't think though, that sex will ever be the same for us again. It has become mechanical and goal-oriented, and neither of us certain as to how we might change it. (Salzer 1991, 111)

Sex, which could be a major release from the pain, becomes the very symbol of the hurt and frustration. In the bedroom, performance is on demand, leaving a negative affect on the sexual relationship. "Although reproduction and sexuality are not the same, society often equates them, so that the inability to reproduce is a negative reflection on the person's personality." (Salzer 1991, 112)

Not every couple begins infertility treatment with a textbook sex life. Couples who have had some problems previously with their sexual relationship will experience greater stress during the infertility treatment. "Those who do not have a solid base of open communication, trust, and sexual enjoyment must work to develop it at a time when the pressures from infertility are immense." (Salzer 1991, 117)

Sexual problems are most often difficulties in communication. An ability to express needs and desires sexually assumes a trusting relationship, and infertility is often an assault to trust. Passion can

dissipate quickly when reproduction dominates the bedroom.

Infertility can carry a good amount of unresolved anger. Coming from either spouse, anger can lay to rest a sexual relationship. Doctors' demands have to be met, so emotionally forced intercourse follows, doing more harm to the sexual relationship. For a woman, this is not necessarily obvious, for even without sexual desire a woman can have intercourse or even conceive. If a man has difficulty with his sexual performance it is immediately apparent, and he is further marginalized (Salzer 1991). A man may become temporarily impotent if he is asked to perform on demand for a woman who seems to be primarily interested in conception and not in him (Cook 1987).

In both the male and female, fear can be an obstacle to sexual fulfillment. In men, it commonly shows in anxiety about being able to hold an erection. In a woman it often involves inadequacy feelings about giving or receiving pleasure (Salzer 1991).

Invasive infertility procedures can also be brought into the bed. They carry intrusive measures into the body, seeking the cause of the infertility. Couples, at

times, have some *remembering* at the time of sexual intercourse and equate their partners with the same procedures. This not only disallows satisfaction, but can invoke the pain of infertility right into the body. One of my Pastoral Counseling clients told of her experience:

There were so many tests that I was given. The procedures were painful and intrusive. And then to bed! I had trouble differentiating. Was it my husband or a laparoscopy?

Sexual difficulties often are the result of guilt experienced individually or as a couple. "Miscarriages can also evoke guilt, as can past abortions, perceived wrongdoings, or transgressions." (Harkness 1992, 30) "Current events trigger new feelings about old experiences." (Conway and Valentine 1988, 43) Menning (1980) noted that feelings of guilt take the form of atonement. Couples look feverishly to their past sexual histories and find "causes" for the infertility. At times couples will try to atone in the bedroom by not giving themselves permission for enjoyment because they are *guilty* of infertility. "Partners with the diagnosis of infertility may be trying to break up their marriages so as to free their partner." (Mahlsted 1985, 335)

All of these negative feelings of guilt, fear and inadequacy contribute to how each couple member feels about him or herself as a sexual being. The infertility often leaves them vulnerable, and the feelings of unworthiness may generalize to every area of life (Menning 1980).

The stress of infertility for the couple also infiltrates beyond the bedroom. The plans and dreams of a lifetime together are severely threatened, as they try to adapt to such a devastating diagnosis.

The longer infertility is present, the more the couple will view fertility as the answer to all difficulties within the marriage. "A baby of our own" becomes the projection of all that needs healing and nurturing in the marriage. Carla Harkness speaks of it this way:

In reality fertility in itself does not guarantee a loving, lifelong marriage. The divorce courts are filled with couples who had no problem at all. And those who have birthed a child after infertility can affirm that marital stress does indeed continue after parenthood. (1992, 37)

However, the crisis of infertility may also become an opportunity to renew the commitment made to one another as first lovers and companions. Although often

deflected and detoured through the crisis of infertility, the marriage may appear stronger, with a renewed bond.

The family and extended community may also add to the stressors of infertility. Well-meaning family and friends who say, "Don't you have any children yet," although thoughtless, are emphasizing the expectations society places on married couples to have children. These pressures are often the result of social, cultural and religious values. Within these pressures to have children comes a paradox that Barbara Higgins points out:

It is ironic, but while some societal values encourage couple to have children, others have led many men and women to postpone marriage and child-bearing until they have achieved occupational and financial security. This delayed childbearing is often identified as one of one of the factors responsible for rising infertility rates. (Higgins 1990, 83)

Infertility rates are on the rise and moving to epidemic proportions. In the United States, of every six couples of child-bearing years, 18% are infertile (Sadler and Syrop 1987). Sadly, as infertility rates rise, alternatives to childlessness decrease. Because of the acceptance of single parent births, children born out of wedlock today are no longer

available for adoption in great numbers. Other societal factors include the ethical and legal conditions surrounding options to infertility, such as surrogacy and in-vitro fertilization. Financial considerations are also great and can decide instantly whether further options will be available through insurance (Higgins 1990).

The physical environment also influences the problem of infertility. Environmental conditions involve exposure to certain drugs or pesticides. DES (Diethylstilbestrol), a well-known example, has affected fertility in both men and women (Higgins 1990). Ironically, this drug was once given to woman to allow then to carry a child to birth. The child then becomes infertile. Radiation exposure also impacts ovulation in women, and sperm motility in men. Anne Sadler identifies the prevalence of infertility in the last decade:

Infertility has increased as result of numerous factors, including the increased incidence of sexually transmitted diseases, work and environmental hazards, medicated usage, and delayed childbearing. (1987, 1)

Religion also impacts the couple struggling with infertility. It can become a major source of coping, or

it can trigger even greater pain. Procreation is viewed by most religions as necessary to the completion of marriage. Religions often teach that the role of women lies only in her ability to conceive and bear children, and God help her if she cannot.

Serenety Young points out that the roles of male and female are essentially symbolic and gain meaning when they are immersed in society. (Young 1993) Religion has a great role in that it carries the authority of the divine, and it brings the residue of ancestry and tradition. Our religious beliefs have carried gender and its meaning into narratives, rituals and laws. In the creation myths can be found our tradition's understanding of gender such as "Adam tills the soil and Eve bears the children." (Young 1992, 20)

Pliny, a first century Roman historian and author taught that menstruation, or any connection to it, did great harm. It had the power to rust iron and bronze, and even blight in crops. "From the male point of view menstruation was seen as a powerful time, in the sense that it gives women power over men." (Young 1993, 20) However, for the women, it was a time to rejoice in her

own fertility and to learn from the other women the rituals of childbirth.

For the infertile woman, the archetypes work in reverse. The menstrual blood, for her, reflects both elements of our feminine heritage. The negative power over the generativity of life, and the menstrual rituals of rejoicing in fertility become cyclical grieving times for the barren.

Page Dubois notes that almost every major religion associates women with evil (Dubois 1988). In Christianity, it is Eve who constitutes to be the scapegoat for all evil and who continues to make primordial mistakes. Young tells it this way:

All of this service to justify the control of women by men, a justification that is perceived to be given divinely in most sacred law books. Essentially women are represented as inadequate moral agents who, for their own protection and the protection for their victims (men), must remain under the moral supervision of men. (Young 1994, 29)

Menstruation taboos are common all over the world. While menstruating, Muslim women are not allowed to pray. In the Jewish law, menstrual blood can render a man unclean and unable to participate in rituals. The Orthodox couple today is forbidden to have intercourse

during a menstrual cycle or for the next seven days during the cleansing rites of "niddah." All of this interferes with ovulation timing and conception. The pain is intensified by the fact that the Rabbi must approve it if there is any change in this rite. The embarrassment and rejection makes it very difficult for the Jewish couple seeking to conceive (Salzer 1991).

For Catholics, the ban on contraception makes infertile couples appear to be "living in sin." They suffer from the added stigma of appearing unfaithful to their traditions and appear, to the ignorant, selfish in not desiring children or disobedient because of their effort to empower themselves through assisted reproductive technology. The isolation is even more painful because it comes from the community that has been taught to bear one another's burdens.

Options for treatment also almost always mirror the doctrines of the couple's religion. Strict Catholics would find artificial insemination by a donor difficult because it is viewed by the Church officials as a sophisticated form of adultery. Masturbation, an integral part of the male's treatment is considered sinful by many denominations. The more

drastic options, such as in-vitro fertilization, surrogacy, and embryo transplants cause greater problems because of the strong views about manipulation of human life and tampering with the marriage sanctity.

Mormons also find conflict in religious teachings relative to infertility. Pressures are created because the emphasis on family is directly related to their strongest belief system. "Our children our jewels in the crown of eternal life." (Probst 1982, 5) This sums up the main tenant of the Mormon faith: Family. All women in the Mormon tradition are given lessons in motherhood from the pre-teens and beyond. Adoption is handled through the Mormon Community, making the standards for adoption quite rigid (Salzer 1991).

The medical community also has a profound effect on the couple facing infertility. Since 1974, infertility has been a recognized subspecialty of gynecology, but not all obstetricians and gynecologists are trained in infertility, in terms of diagnosis and treatment (Harkness 1992). The highly charged issues surrounding infertility make an informed and educated view of the infertility specialists a necessity. The initial outreach to the medical community is, for many,

already filled with fear and apprehension. One woman's experience:

I remember the first time I saw the sign on the door. "Joe Jones, M.D. Obstetrics, Gynecology and Infertility." I felt my heart and spirits sink. I hated admitting I was infertile and that I needed medical help to get pregnant. (Harkness 1993, 50)

Stressors are apparent throughout the infertility crisis, but poor choice of medical personnel can exacerbate it. Even doctors often believe the myths that infertility is really about neurotic or immature patients.

Although the medical interventions give the couple hope, the medical procedures themselves often add a new layer to this already present crisis. Ellen Piel Cook calls these medically induced stressors "iatrogenic stressors" because they are inherent to the procedures themselves (1987, 466). Iatrogenic stressors can become so emotionally charged, and may be so serious, that many doctors caution against initiating medical procedures too soon because of the couple's vulnerability to the emotional problems the medical procedures can cause (Taymor 1978). "The actual physical intrusion upon one's body can be

experienced as assault or injury...as the genitals and reproductive system are primary areas of dysfunction." (Kraft et al. 1979, 621)

The treatment for infertility involves procedures that further embarrass and threaten the couple. (Siebal and Taymor 1982) The constant interviewing about sexual activity, involving timing, positioning, and satisfaction, is a contributing stressor. Couples are asked to submit to examinations immediately following intercourse. There is blood work for the monitoring of hormonal levels, which can involve injections, sometimes on a daily basis. For some, the day is begun by the monitoring of bodily temperature charts. For many women, reconstructive surgery may be suggested. For men, the collections of semen samples are humiliating, and are often gathered through masturbation (Shiloh and Larom 1991).

Another aspect of the stressors caused by infertility procedures is the situational crisis it creates. Each time a procedure is attempted, there is the monthly emotional roller-coaster of hope and despair. "This constant hope makes infertility an open-ended situation which is harder to accept and cope

with." (Greil et al. 1989, 213) It is ironic that the very treatment needed for the physical resolution of the infertility can, in itself, be a hindrance to conception. Harrison, Callahan, and Hennessey describe it in detail:

Treatments are stressors either by being so burdensome as to decrease a couple's compliance with the demands of the treatment, and/or by disturbing reproductive processes which are highly susceptible to stress in both men and women, probably through pituitary and adrenal pathways and neuroendocrine functions. (1987, 633)

Communication between the couple and the physicians is of critical importance for the understanding of treatments and their meaning, in terms of physical and psychological consequences. To effectively cope with the enormous stress of the infertility treatment, there is a constant call to keep in mind all aspects of the health of the couple seeking conception. It is also necessary to remember the meaning treatment has for couples, in terms of "personal needs, to personal values, to personal conceptions of what constitutes quality of life." (Gochman 1988, 409)

Infertility's impact on the identity of both the male and the female, is complex as seen in the multitude of biopsychosocial stressors it engages.

Biologically, the physical intrusion into the reproductive system, can be experienced as a injury. Psychologically, infertility constitutes a crisis in the life cycle with the potential for serious developmental impact. This thwarting of the parenting role brings numerous psychological tasks which seek resolution in order to continue the generativity stage of adulthood. Socially, infertility places major stress on the marriage relationship, for the couple is constantly threatened with the reality of being unable to conceive. This vulnerability adds considerable distress, and ripples throughout the couples' support systems of family, religion, and medical caretakers.

All of these stressors set the stage for a complex series of reactions which describe the crisis of infertility. This crisis situation "creates a problem that is perceived as a threat, a loss or a challenge." (Rapoport 1962, 211) The major reaction is mourning-- the mourning of those never to be born.

CHAPTER 3

Infertility: Grief Reactions

Give me children or I shall die (Genesis 30:1)

Infertility is also about grieving that which has not come to pass. It is an intangible loss, which makes acknowledgment difficult and mourning perennial. Even before the loss of fertility is apparent, women have a universal fear of not being able to conceive (Mazor 1978). The crisis, then, is augmented by the awareness that what was anticipated is quickly becoming a reality. Schnieder suggests that these losses are beyond time and therefore involve complex cycles of grieving (1984). The grieving is made more difficult when a loss is perceived as not having occurred.

Menning noted that the grieving process is a difficult passage for the infertile couple because it is experienced as a potential loss (1980). Abstract losses differ from the losses surrounding a death, in that there are no rituals in place to provide a socially supportive network. "When there is no opportunity for the expression of emotions, all of the usual social

avenues through which life events are legitimized are blocked." (Becker 1990, 140) Furthermore, the infertility loss is an intimate one, and the couple may not have the courage to share it with anyone (Frank 1984). The nature of the loss makes grief work difficult because there is nothing in place to mediate it. "Infertility is not as concrete and identifiable a sadness, but the pain is real." (Stigger 1983, 12)

Judith Viorst describes some of the experience of losses beyond the death of a loved one:

For we lose not only through death, but also by leaving and being left, by changing and letting go and moving on. And our losses include not only our separations and departures from those we love, but our conscious and unconscious losses of romantic dreams, impossible expectations, illusions of freedom and power. (1986, 2)

There are a myriad of losses associated with infertility. At the Resolve Symposium in Chicago on November 6, 1993, Patricia Irwin Johnston outlined six aspects that cover the major losses of infertility. Each of these losses carry many surrounding and significant losses. Johnston calls the first loss as a consequence of infertility, the "loss of control over many aspects of life." (Johnston 1992, 20) Those who suffer infertility today have inherited the birth

control power, which promotes the idea that fertility can be regulated. This power is the avoidance of pregnancy as well as regulating the timing of child-bearing. Infertility was never considered a part of the birth-right environment. Therefore, a severe trauma to self-esteem is brought about by losing something one's peers take for granted. The infertility experience also signals a loss of control over the sexual relationship. Both men and women undergo a lack of control over their reproductive capacities. Moreover, if they choose, any acts of sexual intimacy are turned over to the medical team. "The strength of the relationship prior to bereavement, and what each partner brings to the situation in the form of earlier experiences in dealing with frustration and defeat, heavily influences the denouement." (Berezin 1982, 34) Treatment implies major changes in calendaring. It affects finances, job related activities, and social life.

Also, infertility means a loss of "individual genetic continuity." (Johnston 1992, 20) Children represent a thread sewn from the distant past into the promise of a familial future of families. Life and death experiences are the most basic of human events.

Fertility is honored by almost all cultures. "It is the bridge between generations, rich in symbolism and central in human experience." (Notman 1990, 13) For most women and men, having children is a greatly anticipated goal. The Population Survey of 1985 found that only 10% of American women, ages 18-34, did not expect to have biological children in their lifetimes (US Bureau of Census 1986). The expectation that bloodlines be carried into the future dominates many cultures. Some families have extremely strong feelings about bloodlines and find grafting, through adoption or other means, unacceptable. Others honor a milieu of acceptance, despite genetic heritage. Either way, couples facing infertility already know the patterns of family building they inherited, and they feel the loss of continuity with their own and with their future (Johnson 1992).

Infertility may alter the couple's perceptions of family, enmeshing loyalties between the family of origin and the spouse, because there are no children (Burns 1987). Or, on the other hand, infertility can lead to the avoidance of family and friends, because of the enormity of the loss and misunderstanding that can be

generated (Valentine 1986). Valentine notes that when there is positive networking and support from families of both spouses, it can help the couple to effectively cope with the assault of infertility.

The third named loss on Johnston's list is "the joint conception of a child with one's life partner." (Johnston 1992, 20) Many dynamics affect the marital relationship. Each brings their individual intrapsychic processes, including their identity issues about being male and female. They also bring mutual inter-relatedness, which carries thoughts, feelings, and past experiences. The two partners come together, bringing the self and all that is contained in that to the relationship (Becker 1990). This is the sharing of the most intimate of gifts:

This child who represents the blending of both the best and the worst of our most intimate selves also represents a kind of ultimate bonding of partner to partner. In giving our genes to one another for blending we offer our most vulnerable and valuable sense of ourselves. (Johnston 1992, 22)

Those who experience infertility also suffer the loss of the "physical satisfaction of the pregnancy and birth experience." (Johnston 1992, 20) Loss of the experience of pregnancy and birth impacts both men and women. Although the physical challenges of carrying and

birthing reside primarily with the woman, it is the couple that grieves the loss of fulfilling of their potential as male and female. This loss begins with reproduction, but the residue reaches to areas of physical competence and sexual maturity.

Women are acutely aware of the special status pregnancy confers on a woman. When conception is impossible, many women experience feelings of a two-fold failure. The first is the loss of the bond which would physically unite mother and child. The birth of a normal child can reaffirm ones' femininity or masculinity and a good self image. Infertility may destroy this image (Shapiro 1986). The loss is of carrying within her body the child she and her husband dreamed of and created. Second, is the loss she feels for her husband. Despite the etiology of the infertility, women are deeply affected by the loss of providing a womb environment. "Sometimes a childless woman even contemplates divorce so her husband could remarry and have children more easily, regardless of the husband's devotion to her and the commitment to the marriage." (Kohn and Moffitt 1992, 32) Other couples view the infertility of one as the loss for both, making

the move toward adoption a joint effort to parent.

Many women grieve over this bodily function, which they perceive "failed" them. A great measure of adjustment is necessary, as a woman attempts to let go of the idea of carrying a child within her (Reed 1987).

American culture today places great emphasis on the birthing and bonding experience. Johnston finds this emphasis somewhat exaggerated, and a reaction to our fear that the American family is disintegrating (1992). She describes this bonding experience as a kind of imagined "magical superglue without which many fear that families would cease to be." (Johnston 1992, 22) The expectations of the experience are great, and those who will not know this kind of bonding are experiencing a situational loss. Johnston names this loss "emotional gratification of a shared pregnancy." (Johnston 1992, 20)

The final loss that Johnston names is the threat to "the opportunity to parent." (Johnston 1992, 20) In adulthood, the major developmental goal is generativity (Erikson 1982). Parenthood provides an opportunity to relive, correct, and reframe one's own developmental stages (Kraft 1980). To become a parent is an

accomplishment of great magnitude and the denial of it can place the marital relationship into disequilibrium (Salzer 1991). The developmental and life cycle literature view this crisis as a opportunity to grow or regress. "Expectable crises in the life cycle of the family traditionally are organized around events that relate to child-parent interactions." (Shapiro 1982, 388) Infertility is not an expectable crisis. Since it is unanticipated, most couples have difficulty responding to the narcissistic pain that is inherent in the futile efforts made to conceive, bear a child and to parent. Mourning becomes inevitable, as Melba Colgrove describes in her poem "Limbo Losses":

My life has fallen down
 around me before
 lots of times
 for lots of reasons
 usually other people.

And most of the time
 I was fortunate enough
 to have a large lump of
 that life hit me on the head
 and render me numb
 to the pain & desolation
 that followed
 And I survived.
 And I live to love again.

But this,
 this slow erosion from below
 or within

it's falling down around my life
because you're still in that life
but not really.
And you're out of that life
But not quite.

(Colgrove 1991, 3)

Infertility is a traumatic event, which involves a major adjustment of one's life. This unanticipated crisis may find those suffering lack the coping mechanisms needed to respond to the magnitude of the loss. Grief is a normal emotional response to a significant loss. These reactions have a particularity of grief and are dependent on family attitudes toward suffering, learned patterns of coping with stress, and the social acceptance of emotional reactions to loss (Mitchell and Anderson 1983). Although there is always subjectivity to grieving, which, as pastoral counselors, we need to keep in mind, there are phases of emotional grief that emerge as common and significant to bereavement.

In 1969, Elisabeth Kubler-Ross identified five stages of awareness associated with death and dying. Kubler-Ross's stages begin with *denial and isolation*, move to *anger*, then on to a *bargaining* stage, reach a *depressive* phase and then *acceptance* (Kubler-Ross 1969).

Following Kubler-Ross's work, Barbara Menning, founder of Resolve, a support network for infertile couples, named seven stages of socio-emotional consequences that provide a comprehensive look at the at the bereavement movement within the infertile person (Menning 1977). She expands Kubler-Ross's stages in terms of the infertile couple.

Menning named *surprise* as the first of her seven stages. This is stage not often described in the research literature, because this phase of grief may have already passed by the time the couple reach the clinician's office (Matthews and Matthews 1988). Since most people assume fertility, few are prepared for the shock infertility incites.

When I was 26, we decided to exercise our option to have children. Nothing happened. Not until I was confronted with possible infertility did I realize just how concrete was my assumption of the child I would bear. Without intentionally considering it, I had created an "assumption child." (Stigger 1983, 22)

The *surprise* stage is impacted more because of the great value society places on control over one's own life. The discovery of infertility may come as quite a surprise for those who are achievement-oriented, and who believe any obstacle is surmountable (Menning 1977).

This surprise stage marks the beginnings of a loss of control over one's life and continues throughout the various stages of infertility reactions. This loss in itself is acute; life is no longer going according to the major plan, goals are being delayed, and dreams are dying.

Menning's second stage is *denial*, the grief reaction that most often follows diagnosis. Menning sees denial as functioning as a defense mechanism, especially in cases of absolute infertility (1977). When the diagnosis is rapid and abrupt, such as sterility, denial serves to protect "individuals from those feelings which are so painful it is necessary to deny them." (Weihe 1976, 29) This period of denial is also dynamic, in that it allows the couple time to integrate the information and hold off any treatment decisions (Berk and Shapiro 1984).

Denial can vary greatly in terms of time and intensity. "As a part of the denial, couples may also tend to isolate themselves--to retreat into feelings of helplessness at having lost control over their lives." (Shapiro and Berk 1984, 41) Some infertile individuals become "experts" on the subject, keeping the diagnosis

at a distance (Mazor 1984).

For most couples, this initial denial normally ends with the acknowledgment that infertility exists. Denial, which is normative, is useful and softens the assault of infertility, but when it is prolonged, it can block needed coping and prevent resolution (Stigger 1983). Clinical support for existence of the denial stage was noted by vanKeep, who observed:

That personal happiness decreases when one cannot produce a child, but increases once medical advice is sought for the problem. All too often this period is made unnecessarily long by the couples' unwillingness to admit even to themselves that something may be wrong. (vanKeep et al. 1975, 47)

A characteristic reaction throughout all the stages of the infertility crisis is *anxiety*. Each month, when the hope of conception rises and falls, the anxiety intensifies (Kraft et al. 1980). Infertile couples worry about the long term effects of the treatments. Pregnancy success is also a large area of concern for those being treated for infertility. Kraft found that the most anxiety is generated by the close scrutiny of the couples' "most vulnerable selves" during the medical interventions (Kraft et al. 1990).

Menning describes the third stage as one of *anger*. Anger as a grief reaction emanates from feeling out of

control. Most frequently anger is a response to the powerlessness over life choices. The anger associated with infertility can be directed inward or toward others, or it can contain both. Menning identified three focal points of anger (1977). First is the anger directed at the pain and inconvenience of the infertility testing, which leaves the couple feeling more vulnerable and less in control. Anger is also involved in the social pressure that comes from family and friends. The constant remarks and unthinking insults of people spouting off on childlessness fuels the fire of anger. Menning's work with hundreds of infertile couples found that there was also an almost irrational anger focused on broader targets such as abortions activists, pregnant teenage girls, and those who easily reproduce. Third, Menning discovered a great focus of anger is the fertility specialists, nurses, and adoption workers (Matthews and Matthews 1986). This anger often disguises the intense pain infertility begets. The infertile couple feels cheated out of life's most precious option and is left with a personal sense of injustice.

Feelings of confusion at this stage are common for

those who have difficulty expressing anger. The anger becomes intellectualized or is denied. Both vehicles lead to anger that is displaced and goes underground (Stigger 1983). Linda Salzer quoted one client:

My husband told me he hated what the past few years had done to me. He said he watched me turn into an angry, bitter, hateful person. It was a long time before I understood what was eating me up inside. I was basically angry with myself and realized after a while that I was developing all kinds of self-punishing behavior. I really felt someone should be angry with me. (1991, 98-99)

When infertility causes anger to move underground, the hidden anger surfaces in the marriage relationship. In order to gain some control, many couples direct all energy into timing their sexual activity to coincide with ovulation times. "The desperation and purposefulness that are associated with sexual activity often are unrecognized sources of anger for couples who enjoyed spontaneous sexual activity." (Shapiro 1986, 389) Some couples feel they are no longer entitled to intercourse and have sexual activity *only* during fertile periods. Catholic attitudes can easily reinforce anger, with the stress Humanae Vitae places on human sexuality and how it "can never be a question of arbitrarily compiling one's own agenda for human happiness." (Merkes

1991, 2) A great deal of energy, needed to cope with the shared problem of infertility is used in anger.

One of the responses to infertility associated with anger is what Martin Seligman calls "learned helplessness":

In some individuals the anger is directed inward, against the self, resulting in depression and emotional isolation. The phenomenon of learning helplessness, of an individual's belief that no effort can result in a favorable outcome is a frequent response to infertility. (Shapiro 1982, 389)

The couple finds that not only have they been disillusioned by the lack of control over conception, but are further thwarted by the fact that the all-consuming effort to try to achieve conception is in itself disruptive (Shapiro 1982).

Recent studies that follow the impact of infertility on the marriage relationship, found that marital stress and anger is not symptomatic in all infertile couples. Couples who exhibited "ongoing mutuality" viewed the problem of infertility as shared difficulty, regardless of who carried the physical impairment (Kraft et al. 1980, 624). Interestingly, marital tension arises more from the medical treatments than from the couple's experience of infertility

(Christie 1980).

Expressions of anger are helpful and cathartic, yet the large number of foci of the anger make it extremely difficult, and may project the couple further into isolation. The infertile couple faces the paradox that the focus of their anger is also their network of support.

Menning places *alienation and isolation* as the fourth stage of major reactions to the crisis of infertility. Not only does this form of isolation add to the helplessness, but it has been shown to be a significant obstacle to coping with the crisis. Childless couples experience themselves as separate and apart from family, and from a society for whom child-bearing is normative (Goodman and Rothman 1984).

The alienation extends itself into the marriage relationship and can severely threaten it. When parenthood is prevented in a marriage, whether it has been discussed or not, couples experience a weakness in the marriage contract (Matthews and Matthews 1986). This is brought about by the threat of infertility, as conception may occur in the future. Even if a couple is able to resolve through conception, the alienation

has left its mark (Burns 1987).

Alienation is further enhanced for the infertile couple by the determination of etiology of the infertility. When one spouse is fertile and the other is not, the one who is fertile feels alone, and, out of place with the spouse who has been diagnosed as infertile.

Lastly, the problem of isolation is experienced differently according to gender. Women immediately see infertility as a major and serious crisis; men often find it a disappointment initially, but not a crisis of emergency (Lindell and Dineen 1986). One spouse may misread the needs and reactions of the other. One study shows:

The majority of female participants expressed a desire to increase the time spent talking to their husbands about the infertility, while the husbands reported that although they wished to be helpful to their wives, their conversations increased, rather than decreased their own stress. (Butler and Koralski 1990, 157)

Childless couples feel alone and are estranged from family, friends, and a society that does not readily accept childlessness but, simultaneously, does not care for its children. This grieving in isolation is disorienting and can give the individual and the couple

occasion for a loss of perspective (Stigger 1983).

Menning names *guilt* as a fifth phase of the grief cycle and also a pervasive negative feeling manifested throughout the infertility crisis. It is the anger directed at oneself and may be manifested as an "organizer for previous narcissistic injuries." (Kraft et al. 1980, 623) The current crisis may bring about unresolved feelings of emptiness and rage. (Kraft et al. 1980) Menning found that, in many couples, the feelings of unworthiness have the possibility of generalizing to all aspects of a person's life (1980). Low self-esteem and guilt are often present in both partners, yet the partner diagnosed with the infertility is in particular jeopardy. The partner without the diagnosis carries guilty feelings about their grief and anger (Berger 1980).

Although sexuality and fertility are separate issues, the two become greatly enmeshed in those who blame themselves for this outrageous pain. "One looks for cause and effect: 'What might I have done to bring this on myself?' Timing and technique of intercourse are scrutinized, in case sexual ineptness is the fault." (Stigger 1983, 25) Guilt-producing feelings are also

present in those who suffer from secondary infertility-- the inability to have a child after a live birth.

Dausch writes of the guilt associated:

I spent a great deal of time reflecting back on my life to see where I had gone wrong to merit only one child...My emotional state, I believe, suffered even more as a result of having a child. I could never tell myself that my infertility was an act of fate or something possessed from birth. I felt I must have done something after his birth to cause my infertility...I kept looking for what I had done to destroy this. (Lasker and Borg 1987, 26)

Guilt feelings may also cause the female spouse to seek verification of one's desirability, and, in the male, a confirmation of his potency. Extramarital affairs and flirtations can be the means to remove the inadequacy feelings, at least for a time (Keye 1984).

Many couples associate the guilt with the Judeo-Christian belief that infertility is a punishment by God. The Talmud states that "He who has no children is as if he were dead." Roman Catholic tradition emphasizes that the sole purpose of intercourse is procreation. Menning found that many couples feel as though they are being punished by God and seek atonement and restitution (1980). The guilt-grieving occasioned by infertility implicates the whole of the person-- physically, psychologically, and spiritually. The

considerable distress lays the groundwork for the sixth stage, *depression*.

Ultimately the denial, rage, and isolation and guilt become replaced with an even greater sense of loss. This loss involves a depressive reaction, which takes into account all the impending losses. Elisabeth Kubler-Ross describes the state of depression as "a tool to prepare for the impending loss of love objects and to facilitate a state of acceptance." (Kubler-Ross 1969, 87) In the grief involved in the former stages, there is dynamic movement, as the person tries to deny, understand, and scream at the notion of infertility. In many ways, the former stages correlate with Kubler-Ross's "preparatory grief," which is about all the losses of the past or even of the present. (Kubler-Ross 1969, 87) "This is the time when the person begins to occupy himself with things ahead rather than behind...it is a silent time in comparison to the first type." (Kubler-Ross 1969, 88)

Parents who are bereaved in this way may experience a mild or severe depression (Panuthos and Romeo 1984).

When my period comes, I get into bed and just stay there. I lose my ambition and ponder the futility

of life. I think about death a lot for the first time. I'm not even enthusiastic about buying our first home. (Salzer 1991, 29)

Mild depression is characterized by tearfulness, loss of interest in activities, and a generalized feeling of sadness. Social situations are a great effort and provide no sense of pleasure, as in the past. Some infertile individuals feel disorganized and apathetic, leaving things of normal care and importance by the wayside. Infertility may leave a person with feelings of sexual inadequacy, incompetence, and a defective with generalized emotions of undersireability.

When a feeling of gloom and hopelessness predominates, severe depression can occur. This is often accompanied by physical illnesses, and people can become listless, rundown, and extremely fatigued. Insomnia is characteristic, along with anxiety symptoms of agitation and shortness of breath. In Surviving Infertility, Linda Salzer describes the depression accompanying infertility:

Serious depression can hide other strong emotions that the person is unable to handle. It is not unusual, for example, for the depressed person to be plagued by guilt or an intense sense of unworthiness. (Salzer 1991, 30)

Long-term depression can become a part of the

infertility crisis because the condition is so inexact and without clear-cut endings. Depression is common during the major treatment phases of infertility, but is dangerous if it becomes chronic and long-lasting.

Getting up in the morning was futile. Why? Our dreams were dying with each failed treatment. My job, my family, even my husband can't take away the emptiness inside me. It feels like it will be forever. Empty. (Interview-Client)

Menning found that couples who had a proven diagnosis of sterility, had a clearer picture of the loss and were able to express their grief more openly (1977). On the other hand, 15% of couples who were unable to discover the causes of the infertility were torn between mourning what they cannot have and looking toward what they may yet achieve (Menning 1977). Because of this finding, Mazor suggests that couples may *only* be able to grieve appropriately when they are ready to stop treatment and call a halt to further investigation (1979). Menning further proposes that many women will only be able to solve their feelings of grief about their infertility when they reach menopause (1977).

Mahlstedt (1985) identifies the infertility experience in terms of all the losses which have the

most significance in the etiology of depression such as health, status, relationship and the losses surrounding symbolic value. Each loss could trigger a depressive state; infertility most often involves all of them.

Couples experiencing infertility may be at risk for what Crosby and Jose call dysfunctional coping methods of "avoidance, obliteration and idolization." (1983, 76) Most often these coping defenses are reported in families following the death of someone in the family.

However, the crisis of infertility carries the same type of grieving, and *avoidance* may be assumed in order to divert thoughts and feelings away from the loss and stay in the denial stage for longer periods. Mahlstedt (1985) identified the loss of fertility as much the same as a soldier missing in action. Hope remains and grieving is set aside to avoid the pain. Infertility without direct causes is particularly susceptible to this *avoidance* mechanism.

Idolization is the fantasized process of making the intangible child more perfect than any child could be realistically. Idolization is dangerous because it can infiltrate every area of ordinary life. Hallowed nurseries, clothing and endeared articles are

saved and given greater significance with time. The emptiness and loss will remain unless the couple come to terms through grieving the "idols" they have lost (Sadler and Syrop 1987).

Obliteration is the opposite of idolization. It makes an attempt to destroy and dispose of all memory and fantasy about the child, even failed child-bearing attempts. This mechanism causes great havoc even if only one partner is doing the *obliterating* (Sadler and Syrop 1987).

All three dysfunctional coping systems can leave the one or both partners in a depressive state. Resolution is mandated in order to separate childbearing from sexuality and self-esteem and continue the ongoing development of adulthood.

Menning names the final stage of her model *resolution* (1980). Menning seems to integrate the acceptance phase of Kubler-Ross with the her resolution stage of infertility:

It is not a resigned or hopeless "giving up" or a sense of "what's the use" or "I just can't fight it any longer...He will have been able to express his previous feeling, his envy for the living and the healthy, his anger at those who do not have to face their end so soon. He will have mourned the impending loss of so many people...(Kubler-Ross 1969, 112)

Just as Kubler-Ross learned from the dying that it is possible to make peace with the past through the painful work of grieving, Menning found that the infertility crisis parallels this process, for it feels like a deathless death. (Carter and Carter 1989)

The resolution phase involves the passage through surprise, denial, anger and anxiety, guilt, depression and grief, and its culmination in a decision to end the treatment and the investigation process. Some couples go through these phases quickly because of the treatment or lack of it. The phases of grieving leading to resolution are fluid because overtime they encompass multiple losses (Schneider 1984). Reproductive losses are powerful and bring about major changes. But the resolution does not lead to death, it is a conduit that can lead to a transformed and fulfilled life.

Resolution is different for each spouse, depending on how they have progressed through the developmental stages of childhood and adolescence, and through their character development. With a positive sense of self that is integrated, the response to the crisis of infertility can elicit an adaptive reaction that moves appropriately from shock to acceptance. One study

indicated that individuals with a cohesive sense of self and nontraumatic childhood were successfully able to grieve their infertility (Kraft et al. 1980). Further study showed that when husband and wife both originated from strong and consistently caring parenting, they were more open to the alternative options to biological parenting, such as children who are ethnically different. Kraft found that these couples easily moved into bonding with a child and were focused on mutuality without narcissistic gratification (1980).

Kraft's study also found evidence of unresolved feelings about infertility in those who originated from homes where emotional availability was inconsistent. "Early defects in the spouse's character development handicapped them in relation to later crises." (Kraft et al. 1980, 627) Samples for this study were taken from adoption agencies, where they found a number of conflicts of unresolved infertility (Matthews and Matthews 1986).

When asked about their fantasies as to why the biological mother was giving up her child, they repeatedly focused on the mother's possible delinquency, drug use, or physical defect. Their concept of child as a "bad seed" seemed a projection of their own sense of being defective and therefore in some ways bad. (Kraft et al. 1980, 625)

For those who were experiencing unresolved infertility, there appeared to be consistent need to work through intrapsychic issues. Resolution of infertility involves successfully acknowledging, expressing and dealing with the emotional responses to infertility (Menning 1980). The Menning model of grieving is a valuable resource in responding to the deathlike loss of infertility. John Schneider proposes to carry the parallel further, because the end in the Kubler-Ross model is death and gives a specific focus for grieving (1984). The end in infertility is an ongoing loss, with many focuses for the grief. Schneider suggests an approach to grief work that broadens the definition of grief to include stress reactions. "Stress is any stimulus requiring an organism to adapt to that stimulus." (Carter and Carter 1989, 43) Stress is normally that which makes one respond to something. Daily we handle stress in order to accomplish our everyday demands and responsibilities. Schneider names a different kind of stress, called a "life-change stress," which evokes a grief reaction. All "life changes" can involve loss, even the good and life cycle losses. (Carter and Carter 1988, 44) Judith Viorst identifies these life-time losses as not only

present, but necessary for growth:

For the road to human development is paved with renunciation. Throughout our life we grow by giving up. We give up some of our deepest attachments to others. We give up cherished parts of ourselves. We must confront in the dreams we dream, as well as in our intimate relationships, all that we will never have and never will be. Passionate investment leaves us vulnerable to loss. And sometimes no matter how clever we are, we must lose. (Viorst 1986, 3)

Although grieving is a normal response to a loss, it comes as a surprise, in both the good and bad losses. Awareness of the gamut of losses and their response is important. It is most important when faced with a negative *life-change*, such as infertility. The losses associated with infertility become instantly apparent. To reframe these losses in terms of "life-changes," which will *naturally* indicate a grief response, can engender healing and harbor understanding of the tremendous amount of grief involved.

Schneider names three tasks of grieving which add a dimension of understanding and the potential to turn this immense loss of fertility into a gain. Carter and Carter see these tasks as important in terms of turning these gains into new life opportunities, which may include adoption and child-free living (1989). The first of these tasks Schneider names "limiting the

awareness of the loss." (Carter and Carter 1989, 44) It brings about two responses that help the person deal with the immensity of the hurt. These are the denial strategies of *letting go* and *holding on*. In *letting go*, the person tries to minimize the hurt, in order to cope. To keep the loss at a distance, the person will often negate its importance or detach from it completely.

I hurt so much that the only way I could deal with it was through denial. I didn't tell anyone and my husband and I rarely discussed it. When we did, I always ended up crying and feeling as if I was losing my mind. At that time there was no definitive diagnosis, so I continued to ignore the problem and cope. (Salzer 1991, 17)

In *holding on*, the person tries to channel energy elsewhere so as to limit the life-change and avoid the impact of the loss.

Schneider discusses how both strategies are necessary for a time, but avoiding the loss doesn't allow the person to grieve.

For infertile couples, these denial defenses can become further means of isolation. If one spouse is holding on and the other letting go, the miscommunication can mire the couple in this first task of limiting the awareness of the loss. "For an

infertile couple, grieving must be a mutual act. They must allow for real communication, even if it does hurt, to get out of the denial phase." (Carter and Carter 1989, 48)

Schneider describes the griever's second task as "gaining some perspective on the loss." (Carter and Carter 1989, 44) When the task of *limiting the awareness* is complete, the time for facing the loss emerges. Schneider relates this phase as one of mourning. At times the awareness of the loss floods the person; at other times, episodes of denial recur. The salient part of all Schneider's work is that it is *natural* to mourn and feel isolated, depressed, and hopeless. Here lies the place to make peace with the loss. "This acceptance is usually passive, beginning with a resignation in the face of the inevitable. It is a matter of gaining some perspective on the loss, the ability to see both the positive and negative aspects of it." (Carter and Carter 1989, 49)

I stare at the ghost of the bassinet
My ghost arises,
Lifts you, holds you, feeds you, smiles at you.
...Do you know I have to get over you
for the sake of my love and my life?
Well, not exactly get over you.
Just not dwell on you so much.
Do you know there will soon come a time

When we can't go on meeting like this?

Marion Cohen

"Good-bye" (Berezin 1982, 60)

The third task of Schneider's grieving phases is "finding the opportunity for gain in the loss." (Carter and Carter 1989, 44) This stage occurs in two degrees. The first he calls the *reformulating the loss*. A step beyond acceptance, reformulation of the loss means reframing the loss. John Schneider summarizes this phase:

It is taking the understanding and the energy that one finds in acceptance and shifting perspectives from focusing on limits, to focusing on potential; from coping to growth; and from problems to challenges. (Carter and Carter 1989, 50)

Reformulation for the infertile couple can mean a new attitude about the loss itself. In the acceptance of this major life-change, the couple or individual finds a renewal of energy. It can provide a framework that gives meaning to the suffering and understanding of its pain and reality.

The actual "transformation of loss into gain" is the final phase of Schneider's grieving process. (Carter and Carter 1989, 51) *Transforming loss* involves the person identifying the loss in terms of growth, life

cycle, and the idea that grief is a unifying rather than alienating experience (Schneider 1984). This final phase has the work of taking the griever beyond the denial, beyond mourning the loss, and even beyond acceptance. Transforming the loss can bring the bereaved to perceive the loss in terms of gain and growth. Schneider again names the connections that take place when one's grief bring him or her to a new perception:

People are connected to all things by means of love, commitments, and cycles of continuity with past, present and future. Instead of seeing the loss in terms of the disruption of lives, we come to see it as connecting us to the larger forces of life. (Carter and Carter 1989, 51)

Transformation is the opportunity to see infertility as an occasion for growth. Schneider's grief work makes the most sense in terms of the resolution of infertility. Like Barbara Mennings phases of grieving, it moves from shock and denial to acceptance and on to transformation.

This added dimension to the grieving process has the potential to release new control over the lives of the infertile couple. The multiple choices, having to do with technical treatment, adoption, or child-free living, can be made with communication and mutuality.

The crisis of infertility presents a unique and painful challenge. Laying to rest the hope for birth children is a long, and even, dangerous process. Grieving emerges as the initial diagnosis of infertility is heard. But mourning may return, as the wounded ones try to transform the losses into gains.

CHAPTER 4

Resolving the Infertility Loss

And God remembered Rachel (Genesis 30:22)

Resolution occurs at many levels. Resolving the grief associated with the reproductive losses is crucial. Resolution also means connecting lines broken by infertility. It means creating a future different from the one in the dream. It means making a new ending to the fairy tale, looking at the scars that infertility has left, and believing life can go on.

The experience and the struggle of infertility are not resolved by a child in the nursery. The emotional effects of infertility cannot be erased, because they have become "necessary losses." (Viorst 1986, 3)

I do know...from other wounds, that healing means only that--that it is healed; that it is healed does not mean that it never happened. The scar is always there; the broken place is vulnerable and may ache on bad days. I know what it was like before; and I will never be the same. (Salzer 1986, 293)

Resolution involves putting the past in perspective in order to find future peace. It is "teasing out the new self that lies in rethinking how generativity

applies to one's own life." (Becker 1990, 246)

Resolution inherently involves finding the place children will hold in life's newest challenge, but the place may be different for each person. Generativity entails much more than the issue of children from our own bodies. Becker describes the fuller process:

Generativity is what we make it. We re-create ourselves by passing to others our storehouse of beliefs, of knowledge and our values. Our ability to share our life experiences with younger generations gives meaning to our lives. (Becker 1990, 242)

At this time in the drama of infertility resolution, couples are provided with an opportunity to look again at the motivation for parenthood.

Infertility has the unique property of confusing reproduction with sexuality, and pregnancy with parenting. Resolving infertility involves separating these concepts in order to come to terms with one's own issues. Some partners may be invested in the pregnancy experience. If so, many of the assisted reproductive technologies may be more appealing. This is also a loss, and must be grieved before parenting options are seriously considered.

Others may find adoption the most ideal option, as parenting remains the major goal (Menning 1977).

When couples are faced with remote chances of producing a child, or with medical treatments that border on the miraculous, it is time to look anew at the meaning of parenthood or the possibility of proceeding with other options (Daniluk 1991).

To determine their own resolution identity, each partner has to review his or her own needs and values. The cognitive and affective aspects of the goals toward parenting need to be named, shared, and evaluated in the light of the couples' present situation. Couples need to examine their own feelings and desire to parent. This can become a vulnerable and sensitive process, for the infertility crisis often alters one's feelings toward parenting.

Mazor found that in this stage of resolution, a new energy and sense of perspective emerges, putting infertility in its proper place in life (1979). Mazor noticed a return to optimism and even a sense of humor. Menning cautions, however, that the painful feelings of infertility are never laid to rest forever; they may be reactivated at family gatherings, or anniversaries of losses, wounds, and other crises (Menning 1977). "A complete or final resolution of the infertility is not

absolute. As in mourning due to death, the issue continues to reverberate and can be revived even though it is essentially worked through." (Kraft et al. 1980, 622)

Resolution can be very difficult for couples who have unexplained infertility. The desire to conceive may be strong, but at each step along the way to conception they must ask themselves if it is worth continuing. Some couples continue the search for a biological child long after adoption. Some are still not ready for resolution, waiting for a new technique that will become available for them (Lasker and Borg 1987).

Others who have worked resolution through, and are satisfied with choices they made years earlier, may have old wounds reopened, perhaps because of the media, with its constant barrage of publicity for new technologies. The longings return, as they hear of ovum transfers and IVF babies. Biological parenthood is difficult to lay to rest, especially for those who live with the unknowns of infertility. Resolution is needed to regain control and find peace in their lives.

Resolution of infertility is a life-long process,

and both husband and wife need to work through the loss that infertility represents, or the mourning can interfere with the success of options they may want to pursue (Shapiro 1982).

When the couple reaches Menning's *resolution* stage, options begin to surface, with new potential for disappointment and grief.

Assisted Reproductive Technology

One of the first choices presented to the couple is the decision of whether or not to seek pregnancy through assisted reproductive technology. Currently the legalization of abortion and the decline in the availability of children freed for adoption has seen couples vigorously pursue technological help. Couples often turn to old and new reproductive procedures for help. These techniques can include artificial insemination (AIH) with the husband's sperm or artificial insemination with the sperm of a donor. (AID) In-vitro fertilization (IVF) is also an option, as are embryo freezing for future transfer, embryos transferred from one woman to another, donor eggs, and even surrogate motherhood (McDaniel et al. 1992).

The multiplicity of options makes the resolution to

infertility seem like an unconstrained journey, but each one has complex physical and psychosocial, and often moral and legal consequences. McDaniel sees the technologies as a danger to couples:

As a couple moves up the ladder of technological interventions to achieve a pregnancy, each new procedure represents an increased amount of physical invasiveness, increased expense, and decreased success rate. (McDaniel et al. 1992, 113)

Nontraditional methods of responding to infertility can cause enormous stress. The pain caused by the medical work can engender new injury to body and psyche.

The technologies themselves bring about tremendous discrepancies in who will even be able to have access to the treatments. Biotechnical intervention to reach pregnancy is costly and usually available to only the upper-middle class. For example, one in-vitro fertilization procedure costs about \$6,000. Pergonal, the most famous infertility drug given to women to increase ovulation costs over \$1,000 for a month's supply (McDaniel et al. 1992, 114). Many other infertility drugs carry side effects and risks for those ready to try anything to become pregnant. Frank and Vogel candidly state:

While the health care system allows the wealthy to

conjure up babies out of petri dishes, the same system affords little care to poor infants who have been conceived without medical intervention. (1988, 125)

Money is not the only threat to the medical treatment to the couple. There are exhaustive time commitments perilous to family and job. "The average time a couple spends in treatment before achieving pregnancy or abandoning the effort is 2-3 years, with range of 10-15 years." (Patterson 1990, 1)

The agony of infertility increases as some people look to surrogate mothers and donors to aid in the conception of a child. Questions of all kinds arise in terms of the relationship, the experience, and the aftermath of these choices, not to mention the ethical, legal and medical ramifications.

Many women experience grief reactions following the failures of the treatments. The original infertility wound reopens, even as one tries to heal. In-vitro fertilization has a very high failure rate, with intense and prolonged grief reactions. Greenfield points out that these grieving periods mirror the acute grief reactions women have following pregnancy loss and spontaneous abortion. These include depressive symptoms and preoccupation with guilt (Greenfield et al. 1988)

The Yale University study also found that these reproductive processes increase the attachment to the fetus at a much earlier time, causing an unrealistic expectation of the pregnancy. The failure of the treatment then triggers even greater mourning. Again they have lost the expected child.

Access to Pastoral Counseling is important for those who face the many complicated facets of reproductive technologies. "The changing reproductive processes offer at once opportunities for liberation and enslavement." (Lee and Morgan 1989, 1)

Counseling needs to be responsive to those seeking resolution to infertility through the power of biomedicine. Couples require assistance in prioritizing these issues. The couple can be serviced with an infertility support system, beginning with a counseling milieu attuned to the rigors and mortifying processes they have chosen. The success, as well as the failure of the treatments, infers the need for counseling in order to help couples cope with the frightening and painful aspects of the attempts (Holbrook 1989). Skilled counseling is warranted for all phases of the reproductive course. "Extreme technological

intervention encourages a system of values that devalues involuntary childlessness." (Holbrook 1990, 336)

Strategies for working with couples in this stage of the infertility crisis include acknowledgment and grief work of the latest losses. Ritualizing the ongoing losses can place markers on the journey, helping couples own where they have been and perhaps clarify where they choose to go.

High-tech processes have the potential for couples to reexperience the trauma of infertility and further isolate and alienate from one another. Quality of life in the infertility regime must be refocused, as there are life-long implications to many of these high-tech choices. Susan Holbrook clarifies the role of therapy:

When they are motivated to pursue treatment, therapy moves along a process of negotiation and renegotiation between the partners about what has been determined so far and what should be done next and when to end treatment. (Holbrook 1992, 114)

These new reproductive technologies bring a host of ethical, emotional, and spiritual issues to seeking a pregnancy. The complexity of the full range of impact of reproductive services is not my purpose here. Rather it is to recognize that infertility and its stressful responses of mourning are woven throughout

assisted reproductive technology.

Childfree Living

Childfree is very different in meaning from childless. "*Childfree* describes the positive potential in living without children." (Carter and Carter 1989, 29) *Childless* carries connotations that something or someone is indeed missing. The most important task in making the transition to childfree living is understanding that it is a choice. Those who suffer infertility experience a major loss of control over their lives. This loss of control can generalize far beyond the reproductive system into all areas of the couples' lives. The power of choice is a major movement in helping couples find new energy and ownership of their lives. It is active participation in the making of a life decision. The power of decision-making is the human power to take responsibility for our lives over and over again (Carter and Carter 1989).

As the infertile couples tries to gain this control, a new identity may come to light. Pfeffer and Woolit speak to the discovery of this new identity:

Creating a new identity without children is an important part of asserting control over your infertility. This involves trying to think

beyond children and deciding what you want for yourself. It involves giving up your desires for a child while not regretting the time you have spent on the quest. Creating a new identity does not mean abandoning your reasons for wanting a child. Just as those reasons shaped your infertility experience so they affect the form that your resolution takes. (Carter and Carter 1989, 34)

A new identity process is the labor of all who have been touched by the infertility loss. Role readjustment is an important movement for this new identity construction. "To have an identity is to join with some and depart from others, to enter and to leave social relations." (Matthews and Matthews 1986, 646) This process of identification toward childfree living will necessarily involve an acceptance that one is not likely to bear children and is moving toward a new vision of what that role may entail. Judith Viorst names it:

And in giving up our impossible expectations, we become a lovingly connected self, renouncing ideal visions of perfect friendship, marriage, children, family life for the sweet imperfections of all-too-human relationships. (Viorst 1986, 366)

In Carter and Carter's book, Sweet Grapes, three strategies for this process of role adjustment are described.

The first strategy the Carters found helpful in their personal quest for childfree living is to image what life was like before the infertility dominated.

This can capture an essence of who the married couple really is, separate from the infertility crisis. Our wounds speak of our experience, but they do not wholly define us.

The second strategy the Carters name is "finding new outlets for the motivations that make you want to have children in the first place." (Carter and Carter 1989, 34) Nurturing can be found in all aspects of daily living, in helping others to grow, develop, and expand. Carter and Carter suggest a deliberate quest to find those opportunities and incorporate them into the new role identity. Making a difference in the here and now can be an invaluable way to be remembered.

The literature shows that women have a greater difficulty in creating an identity without the directly parenting children (Carter and Carter 1989). Pfeffer offers some tender comments to women who have been hurt by this all pervasive loss:

Coping and coming to terms with it means coming to see yourself as all right again. Like other women without children who have chosen not to have them, or like older women whose children have grown up, you are a person who can be loved, liked and lusted after. Children in themselves do not make you any more likeable, womanly, able to relate to other people or productive in other areas of your life. (Pfeffer and Woolit 1983, 1)

Redefinition helps infertile persons take control again by giving new meaning to hurtful parts of life. Infertility involves years of grieving and pain. Reframing the painful events in terms of childfree living can change the pain from bad to neutral, and, hopefully, even to good (Carter and Carter 1989). This third strategy can redefine the couples' lives and bring children back into their lives with harmony and even joy. This strategy can also redefine family, giving the childfree a stake in the children of all mankind, while remaining a complete family of two.

Childfree means no longer trying to become pregnant, and living with the choice to do so. It is not resignation; it is an active choice to gain control over the most important part of life, which is family. Childfree means delving into the sadness and pain the infertility has caused and retrieving a creative and meaningful life. It has the power to make a statement about the care and nurturing of all people. Erik Erikson describes what could be a goal for childfree living:

A new generative ethos may call for a more universal care concerned with a qualitative improvement in the lives of all children. Such new *caritas* would make the developed populations offer the developing ones,

beyond contraceptives and food packages, some joint guarantee of a chance for the vital development as well as for the survival--of every child born. (1982, 68)

Adoption

When resolution of the infertility crisis continues to show that the parenting of children is the most viable option, adoption becomes a realistic life-choice. Couples begin to seek adoption in order to find the parenthood identity (Stryker 1980). Becoming an adoptive parent can be seen as an alternative way to seek the identity of parenthood. "This shift in identity occurs as a result of certain turning points or 'critical incidents,' which signalize new evaluations of self." (Daly 1988, 45) This identity transformation is a process that occurs in three stages.

The first stage is the assumption of fertility, which lies at the basis of all family identity. The expectation of biological parenthood is continually shaped by pressures from a culture that says parenting is normative. Even with the increasing rates of voluntary childlessness, there remains a persuasive leaning for married couples to become parents (Veivers 1980). Expectations to become parents can come from

familial, cultural, and intrinsic sources. Resolution of infertility enables the couple to find their own set of values, "so that they modify cultural values to be congruent with their own life experience." (Becker 1990, 247) Often these pressures regarding biological parenthood become so internalized, it is difficult to determine one's own set of parental identity values. Becker calls this a process of "destigmatization" (1990, 248) It calls for a rejection of the stigma associated with infertility. It looks towards new choices which enable couples to reconnect and find the self that has been undermined by infertility. A different kind of parenthood identity may emerge.

The second stage of the shift from biological parental identity to adoptive parenthood has to do with "problematic incidents" in trying to achieve pregnancy. (Daly 1988, 49) Couples sometimes receive a partial diagnosis or no clear diagnosis for their infertility. This uncertainty creates a sense of confusion and aimlessness, which places the parental identity at a distance. (Daly 1988)

Couples who have a definitive diagnosis are often relieved when they find the medical target, instead

of the *wandering* questions associated with their physiology failing them. The relief opens new avenues of alternatives.

For many, not only the diagnosis, but the continuous monthly rituals with no pregnancy are incidents which help the couple internalize the idea that "biological parenting is indeed problematic." (Daly 1988, 50) Jim, a 34-year old described how the couple's parenthood identity was a shared experience:

After every month we would get hopeful. We were hopeful but every month she would get her period and we got really depressed.... it really shakes you up as couple. (Daly 1988, 51)

Finally, the medical workups can contribute to the problematic image of biological parenthood. The chances of successful diagnosis are always there, which makes moving from biological parenthood difficult and, for some, even impossible. One husband tells the tale:

I think we are almost there. Not just physically, but it is emotionally draining. It's what it does to her. Not only does she look like all these zippers when she takes her top off, but it has been emotionally costly. (Daly 1988, 51)

Gradually it begins to dawn on the couple that the prospect of having the infertility medically rectified is becoming an illusion. The extended medical treatments move the couple to take a look at the

importance of parenting and decide if it is a "salient identity" in their lives. (Callero 1985, 43)

Daly found that the critical incidents, from the variations in diagnosis to the disillusionment of the medical treatments, form the beginning of a role transformation, which may see the couple shift from a biological to an adoptive parent identity. Daly describes the interaction:

It was this dialectical interplay of letting go of biological parenthood on the one hand and identifying with adoptive parenthood on the other hand that was the essence of the identity transformation experience. (1988, 55)

The last stage of this transformation Daly calls the identifying with adoptive parenthood through decision making processes. This gives the infertility resolution a more practical focus. Infertility, with its unknown properties, does not give way to clear cut decision-making. Couples often set deadlines for the treatment process and mutually agree on the termination. However, as the deadline approaches, there is the temptation of newer avenues of treatment. This pattern of reverberation helps the couple relinquish identification with biological parenthood, for the constant decision-making emphasizes the importance of

the parenthood identity as a shared construction (Daly 1988).

As the prospects for biological parenthood diminish, the couple begins to consider the possibility of realizing the parenthood goal through adoption. However, this decision necessitates the relinquishment of biological parenthood and often triggers a renewal of grieving. Resolution work can be in process, but resolution itself is a gradual and life-long journey. Acceptance may be indeed present, but each stage sheds new light and evokes new pain from the infertility loss.

The decision to parent through adoption means that there has been a consensus in the couple, but this consensus is hard to come by, as the infertility has affected the male and female in different ways. Nancy describes the different reactions in each spouse:

Originally, he had more reservations about adoption. I am a little nervous about--that they will reject me or that they will take the baby away. So we have reversed--I was initially keen and am now anxious. He was initially reserved and is now keen. (Daly 1988)

These subtle differences in the marital couple's approach to adoption can be an alarm that brings back

the isolation and alienation of the initial grieving of infertility. Resolution involves a constant integration of losses, and a reframing in terms of hope and the future. The process of integration leads to enabling men and women to live beyond the roadblocks to intimacy and friendship that are created by fertility problems.

The identity transition from biological parenthood to adoptive parenthood is a task that can be facilitated by the resolution process of infertility and its acceptance of functional sorrow. Katherine Anderson describes functional sorrow:

Evidence suggests that major life stresses such as miscarriage and infertility lead to states of chronic sorrow in which the stress situation is not forgotten, but periodically remembered and mourned. (Anderson 1989, 10)

Once the transition from biological parenthood to adoptive parenthood has been realized, or maybe just fantasized, the couple seeks the adoption process. Biological parents are never required to open up to as much public questioning and scrutiny as potential adoptive parents. Very often applicants are subjected to assessments, with criteria over which they have no control, such as age, health, family background, and financial stability.

Agencies are expected to do this, but the couple is in the midst of a serious life-change and crisis. They may again perceive themselves as not *good enough*, and begin comparisons to other couples that are unreal and idealized (Rosenberg 1992). This evaluative process can become raise the infertility issues, with failure and blame prominent.

Mourning reappears. The adoption placement process highlights the loss of the idealized child. Most couples have already begun this bereavement long before they reached this reality place in adoption. However, the process facilitates new grieving, as the relinquishment of the biological child becomes a reality. Necessary throughout the entire process is understanding the need to mourn. Rosenberg describes the danger if this loss is not taken seriously:

The difficulty arises when an idealized child is not recognized and mourned and is unconsciously imposed on the real child--adopted or biological--who can never be seen and appreciated for who he or she is. (Rosenberg 1992, 64)

Rosenberg presents the developmental stages in adoption. Each one of these phases, from placement to later adulthood, has content and process that affect the adoption life-cycle. These phases can also reveal the

elements that trigger mourning and further resolution of infertility.

After the immediate placement of a child, the adoptive parents experience a euphoria of excitement and joy. So much has been invested in the homecoming that it is difficult to admit to any ambivalence in feelings. Instant parenting is difficult, and adoptive parents may feel they do not have license to relate the fatigue they feel. Often family and friends tell adoptive parents that they shouldn't be tired because they did it "the easy way." The household changes instantly and adoptive parents may be looking back to times when they were without such tremendous responsibility. These responses are normal, but the thwarted self-image of the infertility crisis has left a mark and may prevent the needed disclosure of such feelings.

There is evidence to associate unresolved infertility feelings and their role in family functioning. Anger, guilt, and blame can have a negative effect on family life when they concern infertility (Smith and Miroff 1987).

Family life may be infiltrated by the loss and

deprivation unresolved infertility brings. An atmosphere of tension can surround the adopted child and family when these unresolved feelings dominate the family system. Lawder's research examined the relationship between attitudes about infertility and the adoptive outcome. It found that the ability of the adoptive mother to openly discuss her feelings about infertility were directly related to the adoption outcome. The father's ability to share feelings of infertility showed a connection between parental functioning and infertility. These outcomes pointed to the suggestion that resolved infertility feelings can help both the adoptive child and the adoptive parents cope with the adoption life-cycle (Lawder 1969).

As the life cycle continues in the adoptive family, unresolved feelings about infertility may manifest themselves in many ways. Smith recounts the list in

The Adoption Experience:

Possible indications are prolonged denial of feelings of disappointment; sadness or resentment in observing a pregnant woman; reacting with annoyance or irritation to "normal" children's play; avoidance of family reunions where children are expected to be present; obsessive fears that the child will not measure up to family standards; anxiety about discussing adoption; repeated joking remarks about the child's parents, looks and behavior; bringing up the child's adoption under

any circumstances; feeling compelled to tell the child how the parents "took him in"(the rescue notion); fantasies about one's imagined biological child; a persistent, nagging, feeling about being cheated, leading to a "not fair" response; and unabated resentment toward the agency social worker. (Smith and Miroff 1987,36)

These situations give insight into unresolved feelings related to infertility. It is necessary to work toward resolution because, through adoption, infertility may continue to affect the couple, with the child added to the family scenario.

The adolescent who struggles to separate from his or her parents may occasion unresolved feelings of infertility in the adoptive parents. "For adopted adolescents, the search for identity is complicated by the triadic family structure." (Rosenberg 1992, 78) It is the time when adolescents consciously or unconsciously take inventory of who they are from a biological and psychological point of view. "You are not my real mom" are words adopted parents dread hearing. One mother comments, "I knew it was as real as it gets, and I knew he knew it too. I felt for him---in terms of what he was struggling with, it did not have to do as much with me as a mother and as a person." (Rosenberg 1992, 79) This mother was clearly

understanding the developmental stage of her adolescent son. For other adoptive parents, this statement may deeply hurt and devastate. The insecurities of infertility that have not been resolved will again emerge, causing greater conflict between the adolescent and the parent. The child's separation issues may become renewed abandonment and alienation for the adoptive parent who has not fully grieved the loss of fertility.

As an adopted child approaches adulthood, adoptive parents may again feel the onslaught of unresolved infertility. The adult child "is a whole person, one who is the combination of heredity and environment; a continuity to the family." (Rosenberg 1992, 84) At this time, the adoptive parent has relinquished most control over the emerging adult. Again a separation issue is apparent, but this time it impacts the parent more than the child. Parents whose resolution work is not yet completed find that they may revisit their past fantasies. "Perhaps the idealized biological child was the spitting image of his dad, the son who was to work by their side...there may be emerging pangs of disappointment." (Rosenberg 1992, 83)

Unresolved grief in the infertility pain is not the same as the shadow grief that arises at different times. Letting our children go and be themselves is a necessary and natural loss. Judith Viorst speaks to this loss:

For consciously or unconsciously, even before they are born, we dream many dreams of what kind of children we want. ...Our image of our newborn may be so compelling that "a mother might need to give up the fantasy of the very different baby she had hoped to have and to mourn the loss of that idealized baby, before she can mobilize her resources to interact with the baby she actually had. (Viorst 1986)

Smith and Miroff define the *entitlement* issue of adoption as the process that begins in dealing with and acknowledging feelings about infertility (1987).

"Families that are built by adoption need to engage in the life-long process of building a sense of vested rightfulness between parents and children." (Johnston 1992, 92) As entitlement takes place, both parent and child come to believe that they belong to one another and deserve to belong.

"Entitlement is a multi-step process, beginning with recognizing and dealing with feelings about infertility." (Johnston 1992, 92) If the infertility crisis is not resolved, entitlement cannot take place.

The adopted child will become a substitute for the unresolved issue. Adoption is not the answer to the infertility crisis, rather, infertility resolution is only the beginning of the precious process of adoption.

CHAPTER 5

Infertility: Theological Implications

Rachel weeping for her children (Matthew 2:18)

The infertility story is not a new narrative. *Barren*, from the beginning of time, has been both a punishment and a promise. The three prominent patriarchal couples of the Old Testament, Abraham and Sarah, Isaac and Rebekah, and Jacob and Rachel, were baffled by the reality of barrenness and the promise of posterity.

Infertility, with its pain and unending loss, still carries the ambiance of arid identity and limited value. Women especially bear the added burden of patriarchy-- the "religion of the planet" (Daly 1978, 10). "The Bible has been written, translated and interpreted for centuries in cultures that were patriarchal." (MacHaffie 1986, 5) Religion, including our own faith traditions, can further marginalize women because of their infertility.

As pastoral counselors, we have the task of

reaching within our tradition and finding "the neglected side of biblical faith." (Brueggeman 1972, 7) We need to accept the offer of Elisabeth Fiorenza and approach the scriptural texts with hermeneutic suspicion, and endorse a hermeneutic of experience critical to understanding the texts (Fiorenza 1985).

Too long the *barren* motif has dominated our thought, adding anguish and despair to already wounded women. Too often our grieving sisters are met with pity and whispers, instead of the empathy and grace that belongs to the community of believers.

The theme of the barren woman has immense metaphorical power. Jerusalem is compared to a woman without children, the city known for the children of Israel, who did not dwell there.

A voice is heard in Ramah,
Lamenting and weeping bitterly:
It is Rachel weeping for her children
Refusing to be comforted for her children,
Because they are no more. (Jeremiah 31: 15-16)

The narratives of the barren woman speak not only to the suffering and longing of individuals, but express the core relationship between God and his people. The covenantal courtship, the exile to Babylon, and the eschatological return--all portray the

intimacy of Israel and her great lover, Yahweh.

This is a narrative about a God who delivered his bride from bondage. It is about a God who forged a people into a community, protected them from danger, and demanded faithfulness (Humphreys 1979). This story is at the heart of the Jewish and Christian beliefs. The narrative is remembered and empowers those who internalize it.

Covenant

The courtship between Yahweh and Israel begins with a covenant based on what God had already done.

I gave you a land which you had not tilled and cities which you had not built, to dwell in: You have eaten of the vineyards and olive groves which you did not plant. (Joshua 24:13)

This is the divine intervention. The covenant relationship was affirmed on the basis of what Yahweh had done for his people (Humphreys 1979). God communicated with his people through a bilateral covenant. When God "cut" the covenant, he was not creating something new, but raising what was already present to a higher plane (Ellis 1975). Contracts with neighbors, for the ancient Israelites, were bloody, but graphically understood, agreements. Cutting a bird or animal and walking together through the parts signified

the cementing of the oath. The Hebrew covenant was unique in that it was made with a God who would be totally faithful to his promises. Yahweh alone would pass between the dismembered animals and, in doing so, fulfill the promises unconditionally. Ellis describes the uniqueness of the covenant:

It must be noted however, that Israel and God do not make this covenant on equal terms. God is bound by his promises only because he makes them. He is bound to himself because he cannot be false to his promises. (1975, 22)

The covenant made with Abraham restores the first covenant made to Adam, in which Adam was promised immortality. Adam's losses had to do with infertility: the land would be barren and women would bear children in great pain (Genesis 3: 17-19). Abraham is promised a great posterity:

I will make of you a great nation,
and I will bless you;
I will make your name great
So that you will be a blessing...

To your descendants, I will give this land.
(Genesis 12: 2, 7)

The covenant made with God is "absolute, unconditional, and eternal--perfected and fulfilled in the New Testament." (Segal 1986, 24) Not only is Abraham promised posterity, but Palestine as well.

"Offspring and homeland have paramount importance."
 (Segal 1986, 7) This covenant carries extraordinary blessings for Abraham and his inheritance. "I will render you exceedingly fertile." (Genesis 17: 6)

But the promises of Yahweh could not come about without Sarah, and Sarah was not officially part of the covenanted community. Circumcision was the sign of the covenant, and women were not circumcised. McGrath describes the religious position of women in ancient Israel:

Sarah was refused any part in the cultic life of the community, as administrator or cult member. She is guest at any religious function she may choose to attend and as such, sits at the rear as would any stranger. (McGrath 1972, 13)

The Jewish cult is unkind to Sarah, but not God. The covenant made with Abraham was made with his house. It was not made for Abraham alone, but for the family who will descend from him. This can only come about through Sarah, for from Sarah issues the promises of the covenant. Tavard confirms this:

It is not any son of Abraham who will do for God's purposes. If so, Ishmael, son of Hagar the concubine, would do as well or even better, as being older than Isaac. But it is not just the son of Abraham, but the son of Abraham's wife that counts with God. (Tavard 1968, 5)

The name changes, of Abram to Abraham and Sarai to

Sarah, clearly show that both were active participants in the covenant they made with Yahweh.

Sarah's infertility is at first perceived as a curse and "a sign of God's displeasure." (Gold 1988, 28) In the Bible, fertility was a command that was an integral part of the Adamic covenant. "Be fruitful and multiply." (Genesis 1: 28) God makes a covenant with Adam, promising him "integrity, immortality, and the fruitfulness of the garden of paradise." (Ellis 1976, 23). The disobedient responses of Adam shattered this covenant. The restoration of it begins in Abraham, as God calls the wandering Aramean and promises him and his *house* prosperity and numerous descendants.

But as soon as the covenant is sealed and the excitement of the promise begins to take hold, Sarah is found to be infertile. Abraham and Sarah begin to look into alternatives and, in compliance with the custom, Sarah gives her maidservant, Hagar, to Abraham so that he may have a child and also have the rights to succession. "Have intercourse then, with my maid, perhaps I shall have sons through her." (Genesis 16: 2)

Much is asked of Sarah. She is infertile at a time when barrenness was considered a punishment for some

moral relapse. She accepts her husband's relations with Hagar after living with her own barrenness for more than 10 years. Hagar becomes pregnant instantly and uses the fact to further distress Sarah, while Sarah responds with anger and outrage, making Hagar the focus of the fury and pain of her infertility.

But what of the covenant made with Yahweh? Abraham and Sarah were ready to have it issue through Hagar, but Yahweh had something even more marvelous in mind for Abraham and Sarah. The promise remains intact. Nothing is impossible with Yahweh; neither a withered womb nor laughter in the face of God's plan can destroy the eternal covenant.

Abraham and Sarah will have a child, and this child will become the new sign of the covenant that God made with his people. The infertility is no longer a curse, but a pause in the plan that further extols this God who is forever faithful to his promises.

The covenant is continued in Isaac, the child of Abraham and Sarah, and a new generation of fertility difficulties continues. "Rebekah, Isaac's wife, like all the ancestral mothers was barren and could only conceive by the power of God" (Blenkinsopp 1971,

104) The scripture narratives about Isaac are transitional, linking the Abraham stories with the offspring of Rebekah. Contained in the narrative are God's hidden arrangements of events: Isaac's wife will be one designated by God himself, thus fit to transmit the promises made in the covenant, and she must come back to the land of promise (Humphrey 1979). Again the narrative carries both promises of the covenant: a fruitful land and a people to dwell in it.

The Talmud adds another interpretation of the Isaac-Rebekah story. "Isaac pleaded with the Lord on behalf of his wife, because she was barren; and the Lord responded to his plea and Rebekah conceived" (Genesis 25: 21) Rebekah gave birth to Jacob and Esau when Isaac was sixty. A twenty year gap suggests that Isaac, not Rebekah, was the infertile one, for just as Abraham and Sarah looked into the concubine solution, so could have Isaac and Rebekah (Gold 1988). The Talmud answers that Isaac was praying for God to save him from the curse of sterility:

There is a hint of Isaac's infertility in the language of the Bible. It says that "Isaac pleaded in the presence of his wife." He understood that he was, at least partially, the cause of the infertility. (Gold 1988, 34)

This narrative helps us to see that infertility is a couple's problem. It is not a judgement or an indictment of the physically infertile partner. The binding of Isaac seems to continue here in the infertility as it did when his father bound him for sacrifice. But Isaac was saved then by God and he will again be saved so as to continue the blessings of his inheritance. Isaac and Rebekah participated in the promise of a God who will "continue to oversee the destiny of the people descended from Abraham." (Segal 1986, 7) Isaac and Rebekah carry a force of life and blessing to their twin sons, but the fertility of the promise will come from Yahweh, the faithful one.

A third generation of infertility arises in the story of Jacob and Rachel. Rachel was the beloved of the two wives of Jacob. Leah, her sister, deeply felt the rejection of Jacob and cried out for divine mercy. "When the Lord saw that Leah was unloved, he made her fruitful, Rachel remained barren." (Genesis 29: 31) The rejection identity of Leah is manifested through the children she is able to bear for Jacob. Her son's names focus on her cry to Yahweh to be loved by Jacob. "She named him Rueben, for she said, it means,

The Lord saw my misery; now my husband will love me."

(Genesis 29: 32) "The Lord has heard that I was unloved and therefore has given me this one also; so she named him Simeon." (Genesis 29: 33) Leah bore four more sons Levi, Judah, Issachar and Zebulon and a daughter, Dinah, each one a grateful prayer to God of her longing to have Jacob love her.

Rachel, although barren, was always the beloved of Jacob, but the love of Jacob did not soothe the pain of her infertility. Her cries are understood well by those who know the losses of being called barren. "Rachel said to Jacob, give me children, or I shall die." (Genesis 30: 1) "On the basis of Rachel's words, the Babylonian teacher Joshua b. Levi said that to be without children is a kind of death." (Gold 1988, 35) Rachel's infertility comprises all of the stages of grief, as we have described. From her anger and jealousy towards her sister, Leah, to her isolation from Jacob, Rachel suffers the infertility loss. Rachel even tries the mandrake intervention, the root of an herb thought to promote conception at the time (Genesis 30: 14). Eventually, Rachel does conceive and bears two sons, Joseph and Benjamin. The covenant continues.

But, Biblically, infertility is never the end of the story. Infertility becomes a precious place for the creative acts of God. The infertility of Rachel takes us beyond the story of an empty womb. The narrative speaks vividly to the pain of Rachel, who was infertile, and also to Leah, who was unloved. Reproductive abilities are secondary to a faithful response to the covenant.

The patriarchal themes of barrenness tell the tale of a God who is faithful to the covenant. Fertility is important to Yahweh, but it has to do with the issue of a people, a people who grow in an intimate familiarity with the covenanted one.

I will make my dwelling among you. I will not reject you. But I will walk among you as surely as I am God; I will be to you a God and you will be to me a people. (Leviticus 23: 3-13)

Exile

Infertility is a crisis that effects individuals, as we see in the families of Abraham, Isaac, and Jacob. Infertility also mirrors the dark and powerless feelings of the people of Israel.

The bondage of the Babylonian exile (597) also parallels the terror and powerless feelings of infertility. The Hebrews were brought to Babylon on a

400 mile death march around the fertile crescent. All they had cherished was taken away; the holy city of Jerusalem was burned and the Temple destroyed.

By the streams of Babylon,
There we sat down, yes we wept,
When we remembered Zion,
Upon the willows in the midst thereof
We hung our harps. (Psalm 137)

Exile denotes a temporary state and a hope that the end will come. The separation is painful and the exiled place their identity in a homeland and await the day they will leave the alien land. In a sense, they are nowhere. Babylon was a place to wait and weep. When they looked back, they saw nothing but what could have been. And yet they continued to grieve the lost hope and the dreams that died.

Diaspora denotes acceptance. It implies that their condition was becoming more tolerable with time. It points to a people who want to take root and make the temporary place a home (Humphreys 1979).

Build houses and live in them;
plant gardens and eat their produce.
Take wives and have sons and daughters;
Take wives for your sons and give your daughters
in marriage....But seek the welfare of the city
where I have sent you in exile, and pray to Yahweh
on its behalf, for in its welfare, you will find
your welfare. (Jeremiah 29: 5-7)

The themes of exile and diaspora can name the

places one is brought to through the process of infertility and wrenching losses. The pain of infertility leaves a couple alienated from all that is familiar. They find quickly they are strangers in a strange land. They experience isolation and are quickly "deported" to a place they do not want to be. The old songs, stories, and dreams which defined and named them are no longer the same. Others are now in control, and they are ushered away. They long to take their identity back, but even the holy places of who and where they have been are burned or lost and cannot be retrieved. To be childless strikes at the very heart of their lives. There are periods of violent upheaval and crushed hope.

Then there are the "diaspora" times, when looking to what might have been is no longer necessary. A condition nearing acceptance sets in. It means affirming oneself in the decision to stay in the present situation. It can mean a diaspora of dreams that are elsewhere, and a resolution of what is here and now. It can mean new options and decisions in a land that is now looking familiar. It can mean building a new house without the architecture of the old one.

Infertility can take a couple into the most oppressive of Babylons. Here they can openly mourn the losses of children. But the winds do change, and the couple may find a new home with new songs, new dreams and the making of new narratives.

See I will bring them back...
I will change their mourning into gladness
comfort them, give them joy after their troubles
Thus speaks Yahweh. (Jeremiah 31: 14)

The Passion Story

The covenant relationship continues into the Jesus story. Jesus is the intimate presence of the covenanted one dwelling with his people. But Jesus does not escape the terror and pain of being exiled from his father. "He had become like us in every way." (Hebrews 2: 17) The passion, death, and resurrection of Jesus gives us a sacred script to hold on to when in the throes of suffering from infertility.

The *passion* begins instantly, as one discovers the the plan for a family is thwarted in such a humiliating way. It is deepened by the injustice of infertility, which doesn't discriminate between those who long for children and those who do not care to have them. There is no apparent blame and so infertile persons rely on guilt, the blame within, to sustain them. Meaning

loses its impetus when one finds that having a child is an insurmountable task. The passion continues when one tries and is dehumanized by the process of achieving so lofty a goal. The loss of control runs rampant. A paradoxical question arises: "Am I really choosing life, or has the roller-coaster been moving so fast that I forgot about my own safety in the process?" Jesus makes this choice in the very midst of his passion. "They are not taking my life, I am laying it down." (John 10: 18) Jesus helps remove the victim status of the infertile wound and look hopefully towards a time beyond barrenness.

The suffering occasioned by infertility is unique in its *deathlike* pain. Just as the desire for children arises from different dreams and desires, so too the singularity of the loss. The context is different for each person, which can leave the marital relationship at risk. The alienation runs deep and, for some, there is no respite from the suffering and strong feelings of abandonment. Family and friends shrink from the pain of a loss they cannot realize or understand.

Jesus screams at God to help him as he suffers the indignity and pain of the cross. "My God, my God, why

have you forsaken me?" (Matthew 27: 46) This is not a cry of despair; it is a cry of one abandoned and unsupported in suffering (Kung 1969). "Jesus died forsaken by men, but absolutely forsaken by God. Jesus was utterly abandoned to suffering." (Kung 1969, 341) Hans Kung further describes the death of Jesus:

This was not a humane death, coming gently by hemlock poisoning, after seventy years in ripeness and repose. It was a death coming all too soon, breaking off everything, totally degrading, in scarcely durable misery and torment. A death not characterized by lofty resignation, but by absolute and unparalleled abandonment. (1969, 341)

This is a paradigm unparalleled in facing the trauma generated by infertility. Infertility is about the continuity of life; it is about the future and the hope of all. When it is grieved and processed in terms of one who has known the suffering all too well, hope emerges, and new life seems a possibility.

Infertility begs for resolution. When it comes, it has the dynamic to promote healing, and also the possibility of new and different horizons. For those who reach it, the other side may be childfree living, with the care of the community made visible. For others, it may be the parenting of children through adoption, exchanging blood ties for mutual bonds of

love, aware of the paradoxes and the gratification it holds.

The Easter stories reflect what we are called to when we have grieved the infertility loss. The helplessness disappears, for it has been turned over to the author of life and the vision is new. However, it is not life as we knew it before. The womb is still empty, as is the tomb, but there is power--not in the cave that held the dead, but in the one who now lives. "He is not here...He is going before you into Galilee, it is there you will see him." (Mark 16: 7) It is in Galilee where the disciples meet and the announcement of the good news is released. It will be in a sort of Galilee where the wounds of infertility are shared and told along with a story of hope and newness of life. Jesus was not without his wounds in the Easter narratives. His wounds begin to take on new meaning as an integral part of the story. "Look at my hands and my feet; yes, it is I indeed." (Luke 24: 39) Like the Easter stories, what is essential is not the empty or even the opened womb, but the *experience* which brings one to a new and *risen* life.

CHAPTER 6

Conclusion

The infertility diagnosis comes as a shock and precipitates psychological crises. Although a medical condition, infertility presents itself as a crisis in adult development for some and a block to ego development for others. It is also considered a series of situational crises which affect body image, gender identity, and relationships within the marriage and family.

The response to the trauma of named infertility involves grieving phases which parallel the bereavement responses to the death of a loved one. These are surprise and shock, denial, anger, isolation, depression, and resolution. These stages may appear linear at first, but infertility losses are severe, making the grieving process more fluid and mourning present far beyond the infertility diagnosis. The stages of grieving infertility are about intangible losses and more difficult to locate and therefore own.

In order to continue the adult development, it is

necessary to resolve the infertility issue. Generativity is an integral part of the growth process. "It encompasses precreativity, productivity and creativity, and thus the generation of new beings as well as new products and ideas, including a kind of self-generation concerned with identity development." (Erikson 1982, 67)

Medical procedures for the treatment of infertility maximize chances of gaining pregnancy and, ironically, are the cause of iatrogenic stress. The treatment experience can run the gamut from stressful experiences of embarrassment to serious sexual dysfunction. Paradoxically the strain of the treatment itself can disturb reproductive systems vulnerable to stress.

Resolution of the infertility crisis is achieved when a couple has had some time to name and own the infertility loss and thus place their options for further resolution in perspective. Grief work is therefore mandatory. High-tech pregnancy, adoption, and child-free living are the second tasks of resolution of the infertility crisis. Each one involves emotional and moral pressures. These resolution tasks have tremendous margin for disappointment and can easily trigger anew the patterns of mourning and loss. Pastoral Counseling

can begin to help in this crisis not only by aiding in the grief work described, but also by providing a more holistic view of our biblical traditions. *Barrenness* can be reframed as a place where God works within God's people for the promises to be fulfilled. We, as pastoral counselors, can provide a locus of understanding that can dispel the judgements and whispers about those unable to bear a child. We can offer those bereaved in this way compassionate responses that befit a community of sisters and brothers.

There is life beyond the infertility crisis. Letting go of old hopes and dreams can make room for the new. Infertility is a profound life experience and can exact change from all those who undergo its rigors. The pain and grief of the experience can clarify the difference between the need to be fertile and the need to parent. The infertility experience can open a place above the womb for a child who generates life. It can speak of caring and loving beyond blood-ties and into universal genes. It tells couples they are not bound by fallopian tubes, but are free to move and love much farther than the boundaries of body allow. It shouts that Love is not only within us but permeates without

us.

Infertility, integrated into the whole of life, becomes a power. Its layered losses are allowed to take over for a while, but not forever. Remembrances and anniversaries may draw on the pain, but a new day will dawn, full of promises for a new *life*.

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VITA

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APPROVAL SHEET

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts in Pastoral Counseling.

4/11/94
Date

Dr. Ann O'Hara Graff
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