The Psychological Aspects of In-Vitro Fertilization

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Full Text: Headnote ABSTRACT: Infertility is a life crisis that affects all aspects of a couple's life. When they enter an in-vitro fertilization program the trauma and emotional stress becomes intensified. The first section of this paper will review the psychological components of infertility. The second section shall focus on the psychological issues which apply specifically to in-vitro patients. In the last section, suggestions for primary care physicians who are directly involved in IVF programs will be made. INFERTILITY: A LIFE CRISIS A life crisis is a stressful event or situation that poses a problem that is insolvable in the immediate future. The problem over-taxes an individual's inner reserves because its resolution goes beyond traditional ways of solving problems. Infertility is a life crisis, not merely a transitory state of stress and anxiety. One's body has betrayed one, and throughout the diagnosis and treatment profound feelings of despair, hopelessness and self-hatred are experienced. One woman described it this way (Menning, 1977, p. 122): It is more than I can bear to think of myself as barren. It's like having leprosy. I feel . . . "unclean" and defective . . . empty, less than dead. Men often feel robbed of their masculinity and sexual identity. One husband described his feelings in these words (Menning, 1977, p. 120): I feel emasculated, I can make love to my wife 10 times a week, but she and I both know I'm only shooting blanks. I'm sterile and that makes me feel impotent. In addition to feelings of being damaged, infertility is viewed as a threat to one of life's most important goals, parenthood. Infertility profoundly affects a couple's relationship in the bedroom. Temperature charts, recording moments of intimacy for the doctor's scrutiny affects a couple's sexual spontaneity and pleasure. Even outside the bedroom a couple's ability to communicate is often severely impaired. Infertility affects them differently. Men are usually more optimistic about the outcome and cope with their pain by keeping it to themselves and focusing on practical, daily activities. Women, on the other hand, frequently cope with their anguish by constantly talking about it to their husbands. The men feel powerless to take away the pain and stop listening. The stress escalates and they retreat further from each other. Now in addition to their despondency over their inability to conceive they have lost their friendship and compassion for each other. Infertility affects a couple's peer relationships. In the initial stages, baby showers and birth announcements become painful reminders of their failures. Whether or not to go visit a friend who has just had a baby becomes a major trauma for an infertile couple. They must constantly juggle the loss of their social relationships vis a vis their anguish and jealousy. As the infertility progresses into years couples find themselves increasingly isolated from their friends who are busy with Little League games and Brownies. Infertility raises concerns about how their own families perceive them. One couple felt that their parents were angry because they robbed them of the privilege of becoming grandparents. They even felt their neighborhood was angry at them because their home was childless and didn't provide kids for the other children on the block to play with. Years of infertility places a couple's life on hold. Job security and advancements are affected by infertility treatments. Promotions are turned down because it might mean moving to another city and leaving their specialist. Women, in particular, experience stressful relations with their employers as they leave repeatedly for medical appointments. Financial burdens escalate as the costs for repeated appointments, inseminations, surgeries and medications soar. Future plans for trips and remodeling are put aside as couples save for further infertility work. Even when finances are abundant, their lives and future are in limbo. One couple put off landscaping their backyard for eight years not knowing whether or not they should include a play area for children or set it up with a large patio for adult parties. They were always saying "Let's see what happens next month." Anger, depression and guilt are salient feature of infertility. Intense rage is experienced as one

surrenders one's body and entire fate over to others. Often the fury is projected onto spouses, family members and physicians. At other times the anger is repressed and they become depressed. Guilt is common for infertile couples. They are constantly asking why. Why did this happen to me? Many believe they are being punished for wrong doings in the past, particularly instances of premarital sex and abortions. Infertility represents the loss of the fantasized child. One couple put it this way (Menning, 1977, p. 110): Death ... Death before life ... before we even knew our child, because he never existed. The hardest part of this kind of death is the fact that it is the death of a dream. There are no solid memories, no pictures, no things to remember. Our society has no rituals to mourn potential losses, only actual ones. When menstruation begins, the couple grieves alone. IN-VITRO FERTILIZATION: THE PSYCHOLOGICAL ISSUES Let us now look at some of the unique psychological aspects of invitro fertilization. Every step of the process represents a major obstacle to be overcome, each initiating new stresses and anxieties. To start with, there is concern over whether or not a couple will get into a program. Many rVF centers have long waiting lists and various prerequisites. Once a couple becomes accepted into a program, the treatment becomes all consuming. Medical visits and procedures that were previously scheduled monthly or even weekly become daily rituals. There is little time to think about or do anything else. For the women, there are daily blood tests to measure estradiol levels and ultrasounds to monitor follicle growth. One is lucky if she can get an 8:30 appointment for the blood work and an ultrasound by 10:00. By the time they are finished it is almost noon. Juggling medical appointments and work responsibilities becomes a stress laden chore that after a month or two becomes virtually impossible for women who are not self-employed. Explaining why they are chronically late to employers is so anxiety provoking that many women either quit working or end up leaving the IVF program. Administering the shots of Pergonal becomes another stress particular to IVF. Many patients find it an exceedingly difficult task to master. One patient who was placed on a schedule of Pergonal where she had to give herself a shot at work became obsessed with concern over who was watching her sneak into the bathroom to inject herself. She would wait until almost everyone had gone out for lunch, run into the bathroom, sit on the floor in a corner crying and praying for the strength to push in the needle. Calling the laboratory at the end of the day for the results of the morning's tests becomes an additional trauma. Are the estradiol levels rising? Are there enough follicles to proceed? Just getting to the laparoscopy becomes a major triumph. Embarrassment and humiliation are endogenous to all infertility treatments, but none is quite as embarrassing as the in-vitro laparoscopy. Often the patients are prepped fully awake and not anesthesized until the last moment. rVF patients report an overwhelming sense of shame as they lay nude with only a sheet covering their breasts as masked strangers poke and prod their most private parts. The insertion of the Foley catheter has been described as the ultimate dehumanization. Patients awake from the laparoscopy anxious about whether or not they passed the next obstacle. How many eggs did they retrieve? Were they good eggs? Was my husband able to produce a specimen? Was it a good specimen? Next, they become concerned about whether or not the eggs will fertilize and divide properly. There is much stress put upon the men who must produce a specimen immediately after the laparoscopy. It is not uncommon for husbands to become impotent the day their wives are scheduled for a post-coital test or they are scheduled for a semen analysis. Post-coitals and routine sperm counts can always be postponed, but not being able to perform after one's wife has undergone surgery-that is an entirely different matter! One husband was so traumatized he left the hospital while his wife was in surgery and didn't return until it was too late. The embryo transfer is another embarrassing moment for women in an in-vitro program. The knee chest position commonly used causes even more humiliation. In addition, women find having to lay on their stomachs for six hours without getting up to use the bathroom quite an ordeal. The ten days following the embryo transfer are filled with alternating feelings of optimism and gloom. rVF patients become emotionally attached to each little soul that was placed inside their bodies. One woman who had three healthy embryos transferred vacillated between glorious fantasies of triplets to nightmares in which none of her babies survived. During the wait, a constant battle rages between the good and evil psychic forces. If the initial pregnancy test is positive patients must wait even longer to see if it is a real

pregnancy or just a chemical one. Again, even after a second positive blood test they must wait for the pregnancy to be confirmed by ultrasound. If the in-vitro process fails and menstruation begins, couples experience, not the loss of a fantasized child, as in other forms of infertility treatment, but the loss of a real child. They were pregnant and the baby they worked so hard for is dead. Intense mourning and grief follows. In cases where several embryos have been transferred and only one takes, women grieve for the babies that did not survive. Another issue specific to IVF relates to the physician's control of ovulation and fertilization. Some patients rejoice that they no longer need to monitor ovulation with temperature charts and time sex accordingly. Others, however, feel totally helpless as their last vestige of control gets taken away. One patient struggled with her helplessness by reading the medical journals and challenging her doctor about whether or not her HCG shot should be 24 or 36 hours after her last dose of Pergonal. Magical thinking is another means of combatting their impotence. One patient at Jones clinic told the author that she went shopping with two other IVF patients while they all waited for their estradiol levels to rise. At the department store they separated, her two friends went off to purchase some perfume while she bought some eye liner. When they returned to the clinic, her friends found out that they were ready for laparoscopy while she had to wait several days longer. In addition, she noted that they ate lobster tails the night before their embryo transfers while she ate lamb chops the night before hers. Her friends got pregnant and she didn't-so on her next trip to West Virginia she went back to the same department store and bought the same perfume and made sure she ordered lobster tails the night before her transfer ... and this time she got pregnant! Magical thinking is not restricted to patients. Physicians and invitro staff members are just as prone to use this mechanism of gaining control over the unknown. One IVF specialist told the author that he always uses room number seven for the transfers because his first three successes occurred there. Another significant psychological issue relates to the "last chance" aspect of IVF. Many couples make tremendous financial sacrifices because they view in-vitro fertilization as their last opportunity for biological parenthood. Even those who long ago resolved the grief of infertility experience waves of longing for a pregnancy and a genetic child. One woman verbalized her feelings this way (Menning, 1977, p. 117): My infertility resides in my heart as an old friend. I do not hear from it for weeks at a time, and then, a moment, a thought, a baby announcement or some such thing, and I will feel the tug-maybe even be sad or shed a few tears. And I think, "There's my old friend" It will always be part of me. .. . Couples who went on to adopt or remain childless are seeking out IVF programs. In the process they are opening up old emotional wounds and stirring up new sources of turmoil. One woman asked herself repeatedly why after adopting two lovely children did she feel so compelled to give IVF a try. The finality of each cycle is another factor which sets IVF apart from other forms of infertility treatment. One cannot hope as menstruation begins that maybe it will work next month, it won't! SUGGESTIONS FOR IN-VITRO FERTILIZATION PROGRAMS Now that we've looked at some of the psychological aspects of IVF treatment, let's explore some ways in which physicians and other staff members can help alleviate the turmoil that accompanies all infertility treatment and in particular, in-vitro fertilization. To begin with every IVF program should include a preliminary psychological assessment before medical treatment commences. Some key issues that need to be explored are their feelings about their diagnosis of infertility and how they have responded emotionally to previous treatments. Patients need encouragement to openly discuss some of the psychological issues discussed earlier. In addition, couples need to be told explicitly what to expect at every step of the program. Secondly, the results of the daily laboratory tests should be conveyed to patients at a specified hour by someone who knows them personally and is knowledgeable about the tests and what the results mean. Furthermore, they must be comfortable talking on the telephone. When disappointing news must be conveyed, the caller should give the information clearly and concisely in terms the patient can understand. The caller must also assess the patient's emotional response to the news and be able to, and have the time to do some crisis counselling on the phone, if necessary. A third suggestion relates to the laparoscopy and embryo transfer. Patients must be forewarned about how embarrassing it can be. Letting them know what to expect, why they are not anesthetized until the last moment and why they must be in the knee chest position for the

transfer goes a long way in alleviating their humiliation. With regard to the sperm specimen, the men should be treated with the utmost respect at this delicate moment. They should not be led to a room with a sign on the door announcing to the world "Do not enter, sperm collection in progress." One patient told the author about his embarrassing experience as a nurse waited outside the bathroom and kept shouting in "Are you finished yet?" Another patient who was unable to produce a specimen for the initial screening process brought in some magazines for his next attempt. He said he wished the doctor had had the foresight to suggest it, or even provide them. Everyone on the in-vitro team must be able to discuss their particular aspect of the treatment in layman's terms. This is especially true for the biochemist. IVF patients want to know explicitly the fate of all the eggs retrieved. They want to know which ones fertilized, how they look and how many cells are developing. It is ideal if the biochemist can keep them informed daily. The warmth and concern of the primary care physician is invaluable. One patient reported that as she awoke from her laparoscopy her doctor came rushing into the recovery room, took her hand and told her that they had retrieved five good eggs. His own enthusiasm was contagious and his use of touch conveyed much more than words. When the results are less fortuitous, physicians must be sensitive to the significance of the news to the patients. Feelings of grief, anger, jealousy and depression are such an integral part of infertility and of IVF, in particular, that all treatment centers must provide a safe haven for couples to ventilate their anguish. Primary care physicians should not presume that because their patients do not weep openly in their offices, they are doing just fine. All IVF patients should receive counselling. SUMMARY Throughout this paper the emotionally difficult aspects of in-vitro fertilization have been stressed. From a more positive perspective, let us not forget, that in addition to helping patients conceive, IVF programs have the unique opportunity of helping their couples learn new ways of coping as they gain mastery over one of life's most painful crises, infertility. References REFERENCES Mahlstedt, P.P. (1985). The psychological component of infertility. Fertility and Sterility, 43:335. Menning, B.E. (1977). Infertility. New York: Prentice Hall, Inc. Seibel, M.M., &Taymor, M.L. (1982). Emotional aspects of infertility. Fertility and Sterility, 37:137. AuthorAffiliation Nancy Hurwitz, Ph.D. AuthorAffiliation Address correspondence to Nancy Hurwitz, Ph.D., Clinical Psychologist, Private Practice, 914 Dewing Avenue, Lafayette, CA 94549

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