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COUPLE THERAPY IN INFERTILITY

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Infertility may lead to a "life crisis" for infertile individuals and their partners, and the psychological consequences can have a negative impact on the relationship. In such cases, professional intervention should focus on helping the couple to cope with the diagnosis and with the problems arising in their relationship. The goal of this paper is to discuss the main issues couples may face as a consequence of infertility and to describe the psychologist's treatment protocol for couples with relationship issues during the phases of diagnosis and treatment with assisted reproduction techniques. Finally, we briefly discuss how the psychologist can help couples who choose other procedures, such as egg donation or adoption, or who opt to discontinue the treatment.
Keywords: *Infertility, couples' issues, couple therapy, psychological counselling*

La infertilidad suele suponer una "crisis vital" para las personas que la padecen y sus parejas. El impacto psicológico experimentado en estos momentos puede repercutir negativamente en la relación de ambos cónyuges. En estos casos, la intervención profesional debe centrarse en ayudar a la pareja a superar el diagnóstico y a afrontar con éxito los problemas ocasionados en su relación. El objetivo de este trabajo consiste en exponer los principales problemas de pareja que suelen ocurrir como consecuencia de la infertilidad así como describir el procedimiento de actuación del psicólogo para el tratamiento de las parejas con problemas en su relación durante las fases de diagnóstico y tratamiento de reproducción asistida. Finalmente, se comenta brevemente cómo puede ayudar el psicólogo a las parejas que optan por otros procedimientos como donación de gametos u adopción así como a aquellas que deciden finalizar el tratamiento sin utilizar dichas opciones.
Palabras clave: *infertilidad, problemas de pareja, terapia de pareja, consejo psicológico*

According to the World Health Organization there are approximately 80 million couples worldwide with problems of fertility or difficulties to conceive a child; that is, some 15 of every 100 couples are unable to take a pregnancy to full term (Parada, 2006). Infertility is defined as the incapacity to conceive after one year of unprotected sexual relations, whilst sterility is considered as the absolute impossibility of conceiving. In Spain, it is estimated that between 10% and 20% of couples are infertile (González, 2000), of which at least 60% take recourse to assisted production procedures in an attempt to conceive a child.

Likewise, researchers agree on identifying numerous factors, apart from strictly medical disorders in both men and women, that directly or indirectly influence increases in infertility or in problems of conception. Such factors would include sexually transmitted diseases, heavy drinking, smoking and drug use, some medicines, eating disorders, stress and anxiety, as well as others related to contraceptive methods (e.g., intra-uterine devices), women's access to the labour market and the trend towards delaying first pregnancy until an advanced age. However, such factors, while possibly affecting fertility, do not appear a priori to threaten the equilibrium and well-being of the couple. Thus, for example, a woman with some alteration in the fallopian tubes that prevents her becoming pregnant, or man with a very low sperm count, may be in perfect health, and enjoy life together with their partner throughout their lives. On the other hand, such factors will become dysfunctional, and can constitute an obstacle to couples, when they decide to have a child and fail in the attempt. It will be at this point that couples experience frustration and failure with regard to their expectations and desires of procreation and of becoming parents.

There is a consensus on the view that the difficulty for having children, where there is a desire to have them, represents one of the most difficult situations a couple has to face throughout their personal history, and affects not only the personal identity of each partner but also the couple's life project (Llavona & Mora, 2003; Moreno-Rosset, 2000a). Thus, the diagnostic procedures and treatments of assisted reproduction tend to constitute an additional source of stress for the majority of couples, which affects diverse areas of their normal functioning. In spite of this, the possibility of conceiving a child represents for these couples a sufficiently powerful motivation to go through

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with what can be an enormous investment of physical, psychological, relationship, financial, social and family resources (Moreno-Rosset, Núñez & Caballero, 1999).

People in this situation often find themselves facing a crisis that generates feelings of considerable distress, loss and frustration. Various studies have shown how infertility can give rise to psychological alterations such as high anxiety, depression, low self-esteem, stress, anger, guilt feelings and a sense of loss of control over one's own life (Gerrity, 2001; Guerra, 1998; Moreno-Rosset, 2000a; McQuillan, Greil, White & Jacob, 2003; Sanjuán, 2000). Other studies have concluded that infertility affects couples' quality of life, which is lower (and hence satisfaction is lower) than that of couples without this problem (Schanz, Baeckert-Sifeddine, Braeulich, Collins, Batra, Gebert, Hautzinger & Fierlbeck, 2005; Van der Akker, 2005).

As far as the couple relationship is concerned, it has been found that infertility can generate difficulties not only in the affective sphere, but also in those of communication, sexual relations and even bonding (Leiblum, 1997; Olivius, Friden, Borg & Bergh, 2004). In this line, Burns and Covington (1999) found that infertility altered communication, caused a loss of interest in one's partner, impoverished the sexual relationship and could lead to the members of the couple reconsidering whether or not to stay together.

On the other hand, some research has suggested that infertility strengthens the bond, the love and the support in the couple, and indeed involves an experience of personal growth for both partners (Callan, 1987; Pasch & Christensen, 2000). Factors such as quality of the relationship and adequate marital adjustment prior to the appearance of the infertility problem would appear to explain the maintenance and strengthening of the relationship subsequent to its emergence (Cutrona, 1996; Peterson, Newton & Rosen, 2003).

All of this evidence reveals infertility as a complex problem with a wide range of manifestations, and to which each couple may respond differently. Such variability can be explained, as Gerrity (2001) argues, by the type of infertility presented by the couple, by the way the problem is dealt with and by the role adopted by each partner.

In any case, it is unanimously asserted that infertility is a problem affecting the couple as a unit, and that it should be treated this way in psychological therapy (see Ávila & Moreno-Rosset in this same issue; Guerra, Llobera, Veiga & Barri, 1988; Lechner, Bolman & Van Dalen, 2007; Moreno-Rosset, 2000a; Wischman, 2005; Wischman, Stammer, Scherg, Gerhard & Verres, 2001). Hence, it is likely that those couples with good marital adjustment, a shared view of the problem and adequate communication will cope more healthily with the infertility situation, and even come out of it stronger, as against those for which infertility will constitute a problem of such intensity that it puts the relationship itself at risk. It is this type of case on which we shall focus our interest throughout the present work.

CONSEQUENCES OF INFERTILITY FOR THE RELATIONSHIP

As we have asserted above, infertility constitutes a situation of chronic stress comparable to divorce, the death of a family member, or even chronic illnesses such as cancer or AIDS (Domar, Zuttermeister & Friedman, 1993). Indeed, infertile couples subject themselves to a stressful regime of continual visits to doctors, pharmacological treatments, programmed sexual relations and surgical interventions that place a burden on their everyday life and can affect in different ways their emotional, social, physical and even intellectual life (Moreno-Rosset, 1999; 2000b). It is not surprising, therefore, that this can result in a life crisis which threatens the couple's stability when the relationship between the partners is not sufficiently solid (Mahlsted, 1994).

The scientific literature also includes a large body of evidence on the principal problems for couples associated with infertility. Among those most widely studied are difficulties in interpersonal communication and sexual problems. As regards the former, various authors have found that difficulties of communication within the couple can increase during assisted reproduction treatment as a consequence of high stress levels (Newton, Sherrad, & Glavad, 1999; Schmidt, Holstein, Christensen & Boivin, 2005). Other authors show how communication problems emerge when the couple fail to express their feelings about the infertility in an open fashion, and when they do not have a shared vision of the problem (Pash & Christensen, 2000). Thus, it is common to find couples with communication problems arising from the fact that one of the partners (generally the man), attempting to protect the other partner from further suffering, fails to express his feelings and keeps them "bottled up". Consequently, the woman (as it is in most cases) perceives a lack of attention that leads her to resent her partner, who appears not to be experiencing the same emotions. Such thoughts tend to increase distress and tension within the couple. In these cases, the psychologist should help them to normalize their feelings about the infertility and

teach them to express their emotions openly in order to re-establish the necessary equilibrium in the couple.

On the other hand, the couple's sex life also suffers as a consequence of infertility, the quality and frequency of sexual relations often decreasing sharply. Various authors have reported that infertility leads to a reduction in sexual desire, problems of ejaculation, difficulties for reaching orgasm and sexual dissatisfaction in general (Daniluk & Tench, 2007; Read, 2004; Wirtberg, Moller, Hogstrom, Tronstad & Lalos, 2007). It would seem that having to programme sexual relations on specific days of the cycle, or the necessarily purely "reproductive" nature of the relations means a loss of spontaneity, which is one of the principal problems affecting couples, and for which they seek professional help and intervention (Moreno-Rosset, 1999). In other cases, however, sex becomes a painful experience due to the inability to conceive. Faced with such problems, the professional's brief will be to help the couple recover pleasure, satisfaction and affective communication, as well as dealing with cases in which there is sexual dysfunction.

Up to now we have looked at how infertility is a stressful life event that has a strong emotional impact on the individual and which can threaten the relationship. Hence, couple therapy is recommended in those cases in which the equilibrium of the relationship has been altered as a consequence of the infertility and also in those in which, although there are no problems at the outset, the couple could be at risk of encountering them.

The procedures most widely used in psychological treatment for infertile couples are those deriving from cognitive-behavioural therapy. Such techniques have shown their effectiveness both for coping with the infertility diagnosis and during the treatment for it (see Ávila & Moreno-Rosset and Campagne in this same issue; Moreno-Rosset, 1999; Pash & Christensen, 2000). The goals of couple therapy in these cases are: (1) teaching coping skills with respect to the situation of infertility; (2) improving the quality of the communication and interaction within the couple; (3) teaching skills for resolving conflicts within the relationship brought on by the infertility; and (4) helping in the search for solutions and alternatives in the face of a possible future without children (Stammer, Wischmann & Verres, 2002).

COUPLE THERAPY DURING THE DIAGNOSIS AND TREATMENT OF INFERTILITY

According to Moreno-Rosset (2006), psychological treatment of the infertile couple should begin as soon as they become aware of the problem, since the diagnostic phase tends to involve a "life crisis" accompanied by feelings of guilt, impotence, lack of control, stress and, in sum, a considerable emotional burden (Witkin, 1995). At this time it is frequent for the couple to experience emotions that can have a negative effect on their relationship (Parada, 2006). Among the commonest reactions are (Read, 1995):

- State of shock: for many couples, infertility is a reality that is difficult to accept, and some people react with feelings of disbelief. In this phase it is frequent to find intense emotional reactions and even feelings of emotional numbness.
- Denial: the couple think the diagnosis is mistaken, and many request other medical opinions.
- Guilt-blame: these feelings are extremely common in people with problems of fertility. In an effort to determine the "reason" for their infertility, one member of the couple might think that his or her previous behaviour has caused the problem. Frequently, the infertile member of the couple feels that he or she is depriving the other partner of the possibility of having children. In other cases one or both partners blames the other for the inability to conceive, showing resentment and anger towards them.
- Loss of control: the discovery of infertility in the couple breaks down people's feelings of control over their own lives, other aspects of individual and shared life being sidelined to focus intensely on the treatment.
- Social isolation: it is common for the couple to seek to isolate themselves as a way of protecting themselves from feelings such as anger or envy towards relatives or friends who do not have the same problem.

Thus, for certain couples, the infertility diagnosis can mark the beginning of a problem that extends to all areas of their life, including their relationship itself. As we suggested above, the quality of the relationship prior to the diagnosis is a factor that cushions the potentially strong emotional impact of the diagnosis (Pash & Christensen, 2000). Other factors that contribute to adequate coping are personal resources, such as the "resistant" personality style or social support perceived by the couple, both from family and from friends.

Therefore, as an initial step, and with the aim of identifying couples who would benefit from psychological treatment, the Psychology Interest Group of the Spanish Fertility Society (*Sociedad Española de Fertilidad*, SEF), set up in 2005, recommends the application of screening instruments whose results can serve to determine risk

groups and to guide interventions in couples with problems. In this context, the Questionnaire on Emotional Maladjustment and Adaptive Resources in infertility (*Cuestionario de Desajuste Emocional y Recursos Adaptativos en infertilidad*, DERA; Moreno, Antequera & Jenaro, 2008) constitutes an extremely useful tool for this purpose, since it provides the information necessary for assessing the couple's degree of adjustment and their resources for coping with the situation of infertility. Thus, couple therapy can be recommended to those who score highly in emotional maladjustment and have scarce adaptive resources. The DERA, then, helps to identify the priority areas of intervention with the couple.

An important focus of the psychologist's intervention concerns helping the couple to normalize and legitimize the feelings and emotions associated with this difficult period. It is important to listen to the couple's initial complaints, contain them and normalize al the emotional reactions they may be experiencing. To this end, the therapist must pay attention to everything the couple tell him and transmit to them a profound empathy through active listening and non-critical acceptance of their experiences and perception (Moreno-Rosset, 2000a). It is therefore very important to build a good therapeutic relationship with the couple, so that they feel welcome and there is a pleasant climate of trust. A good climate will help the couple to express themselves openly and freely and to communicate their emotions and thoughts, as well as their doubts and concerns about the future (Read, 1995).

Next, the psychologist must help the couple to identify their problem and integrate it in their life and their project as a couple. The therapist should take advantage of this moment to explore the communication and interaction between the partners (Moreno-Rosset, Núñez & Caballero, 1999; Moreno & Guerra, 2007). For this purpose, he or she will ask both to express what the infertility means for them in their lives. As referred to above, having a shared vision of the problem helps couples at this time. However, it is often the case that the partners do not have the same conception of the problem, so that one of them is experiencing the infertility with more stress than the other. In this line, Guerra and Tirado (2007) note, for example, that many women see infertility as a personal disability, and blame themselves for not being able to have children spontaneously. In such cases these authors suggest asking the person what they think about the development of their abilities in other areas of their life (such as work), what their partner's opinion is, what the advantages and disadvantages of maintaining such thoughts are, and finally, whether they think it is fair to judge oneself for something for which one is not responsible.

In cases of dysfunctional communication patterns, the therapist can teach strategies of assertive communication, so that the members of the couple learn to accept the experiences and perceptions of their partner without resentment, even though they do not correspond to their own. The partners must learn that each one has his or her different form of experiencing the problem. It will be necessary, therefore, for each partner to express his or her pain and needs, listen to and take account of the concerns and worries of their partner and accept the other's experience as valid, without trying to change it (Guerra & Tirado, 2007). Likewise, the psychologist must try to encourage dialogue and active communication between the two partners through active listening and the use of turn-taking, or by turning to other techniques (such as modelling and role-play) when their interactions are not appropriate. Furthermore, the professional should offer information to the couple about the situation they are experiencing and the changes that might occur in different areas of their usual functioning, related to, for example, their personal relationship, their emotions, their self-esteem or even their sexual relationship (Moreno-Rosset, 2000a). It is highly important to teach the couple how to discuss their own emotional responses, with a view to avoiding false expectations about the other partner's behaviour.

As far as sexual relations are concerned, one of the main problems that can affect the couple during the diagnosis concerns the loss of interest in sex and a reduction in the frequency of sexual contact. As already mentioned, the stress and strong emotional impact this period involves can be the cause of such difficulties (Read, 2004). It has also been shown that both the diagnostic procedures themselves and the different treatments can interfere in the couple's sex life (Raval, Sald & Lieberman, 1987; Moreno-Rosset, 2000a). In this regard, it should be borne in mind that until the confirmation of the infertility problem, couples may have spent a considerable period focused on the reproductive aspect of their relationship, restricting the frequency of their sexual relations to coincide with points of the menstrual cycle, and even abstaining from sex at certain times, especially in the days immediately prior to the diagnostic tests (Moreno-Rosset, 1999). For all of these reasons, the naturalness and spontaneity is quite likely to have disappeared from the couple's sex life, with sexual desire only maintained by the motivation to procreate. The problems can be exacerbated when one of the partners experiences a loss of satisfaction. In such cases, the professional must help

the couple to "rediscover" their sexual relationship and the pleasure that can be associated with it. Moreover, it will be necessary to place the emphasis on those behaviours that go beyond mere genitality and to encourage couples to express their affect in other ways, through caresses, embraces, kisses and the exploration of other pleasure zones (López, 2000).

When solving the problem requires the application of Assisted Reproduction Technology (ART), the couple should be provided with detailed information about the techniques applicable in their case, and about the advantages, disadvantages and potential risks (Moreno-Rosset, 1999). At this point the psychologist should help the couple to explore all possible alternative responses to their problem, so that they can make informed decisions about the treatments they could undergo and about when, how and why they should select a particular treatment, and so that they can draw up a plan. It is also at this juncture that the professional might suggest some kind of group therapy, so that they can get to know other couples in the same situation and start to normalize their experience (Moreno & Guerra, 2007).

Once the couple decide to embark on ART treatment, there begins a long and constant process of decision-making that also tends to involve high levels of emotional stress. Indeed, numerous studies have found that the level of stress experienced during this period affects the couple's quality of life and can have negative consequences for the relationship (Guerra et al., 1998; Moreno-Rosset, 2000a; Wischmann, 2005). In this context it is recommended to work on communication skills and problem-solving strategies with the couple. They must be taught how to make calm and reasoned decisions about the possible treatments and how far to persevere with them, maintaining awareness and a realistic attitude in relation to their situation of infertility.

In general, and regardless of the assisted reproduction procedure or technique applied, infertility treatments tend to go through different phases: a first one of "pharmacological treatment", involving ovarian hyperstimulation for generating as many ovocytes as possible in a cycle, thus increasing the possibilities of fertilization, and hence of pregnancy; a second phase in which the corresponding AR procedure is applied (artificial insemination with or without semen donor, or one of the variants of In Vitro Fertilization); a third phase of waiting for results; and a final phase in which the results are obtained (Moreno-Rosset, 2000a).

Different authors have found that during the AR treatment process the couple experience a sense of loss of control that can be exacerbated by other feelings, such as those of personal failure or guilt (see Llavona in this special issue). The couple enter a new world, in which decision-making becomes an integral part of their everyday life. Frequently, as the results of the treatments continue to come in, and with successive failed attempts, the confusion in the couple increases and the decision-making changes direction abruptly. It is at this point that the couple begin to explore other possibilities never considered before, such as gamete donation or adoption. At these times, and throughout the treatment process, there will appear doubts and hopes about the results, fear of failure, social concealment of the problem and other types of feelings, such as anxiety, depression and social isolation. All of this can further increase the problems in the couple's relationship, especially when the treatments fail.

The psychologist's work with the couple at this time should include cognitive restructuring, whose goal will be to reduce negative thoughts and irrational beliefs in the couple associated with the treatment results. The couple should be taught how to substitute distorted negative thoughts for others, more rational and positive. In addition, the professional can use stop thinking, self-instructions training and response prevention, which are extremely useful techniques for facing the possibility of failure in the treatment cycles and the receipt of bad news (Guerra & Tirado, 2007; Moreno-Rosset, Antequera & Jenaro, 2005).

Also, during the treatment process and as successive cycles come and go, the infertility crisis becomes prolonged and communication within the couple tends to become impoverished, mechanical and devoid of emotional charge. Therefore, it is essential to support the couple in the construction of an effective communication framework in which both partners feel they are able to express their thoughts and emotions without fear of reproach. Likewise, the psychologist might recommend the couple to tell their family and immediate social circle about the problem, in order to receive support from them and free themselves of the burden of being the only source of emotional support for one another.

Sexual relations may also undergo changes during the treatment phase; they can deteriorate on being no longer necessary for conception, and also as a consequence of certain myths and irrational beliefs the couple may have (such as that the possibility of pregnancy will be increased if they refrain from sex during the phase of waiting for results). The psychologist can help them to identify and

question the irrational thoughts, and should also re-educate them to recover the functions of pleasure and communicative interchange associated with the sex act. It is advisable to recommend the couple to programme pleasurable activities that they always liked doing and had neglected or given up because of the infertility.

During the phases of waiting for results, and also throughout the entire treatment course, the couple tend to have feelings of anxiety and depression that can increase with repetition of the treatment cycles and after successive failed attempts. In the therapy sessions all these feelings should be explored, and their emotional expression facilitated. Training in relaxation is also recommended for these couples, with the aim of increasing their self-control over the emotional and physical changes (Guerra & Tirado, 2007). Another point to bear in mind is that, during the waiting phase, it may be that the couple's attention becomes focused exclusively on the infertility treatment/results, and that there is no other topic of conversation. In such cases it is recommended to restrict the amount of time spent talking about the infertility and to programme distractory and gratifying activities (Moreno-Rosset, 1999).

Finally, in the wake of the failure of certain AR treatments, psychological help should be offered to those couples who decide to use assisted reproduction treatments involving donation of gametes or who opt for adoption. Help and support should also be provided to those who decide to cease the treatment without using these other options. As regards gamete donation and adoption, the psychologist should help the couple to determine whether this option is valid and acceptable for them, and whether donation or adoption really fits in with their conception of parenthood (Tirado & Dolz, 2007). Likewise, the therapy will focus on assessing the way the infertility and its treatment have affected each partner and the couple as a unit. The couple should also be helped with decision-making, with the discussion of specific issues arising from the alternative solutions (e.g., telling the child about its origins), with the development of positive forms of coping, and finally, with the expression of emotions. In all cases, and especially in those just mentioned, given their high emotional impact, it is essential to create a good therapeutic relationship from the first meeting with the couple. Also, these options must be proposed as possible alternatives. Thus, depending on the situation in which the couple finds itself at this point, there are three options: donation of gametes, adoption, or a life without children. Reaching the stage of choosing between these options certainly involves suffering and loss, since it means renouncing having biological children. It is good, therefore, for the couple to think and reflect on what is the best option for them in this case. It is important for the couple to understand that the decision should always be shared, and should never depend solely on what one of the partners decides (Tirado & Dolz, 2007).

In cases in which the couple decide to call the treatment to a halt without using these options, they should be helped to construct a new identity as a couple without children. In this context it is highly beneficial for them to recall the qualities they found attractive in one another and the current reasons for their continuing to function as a couple. In any case, they should be aware that life doesn't end here, and that they can have plenty of reasons for leading a full and happy life without children, since there is no empirical evidence that childless couples are less happy or less stable than those with children. Relevant in this regard is the study by Moreno-Rosset and Martín (2008), who compared two groups of women: (1) with primary and secondary infertility, and (2) fertile with or without children. The infertile women without children presented higher levels of anxiety than the fertile women without children. No significant differences were found between the fertile and infertile women with one or more children. What was surprising was that the group of fertile women with one or more children obtained the highest scores in anxiety. The reflections of the study's authors are of considerable interest: on the one hand, it is confirmed that having children is a stressful life event that can increase levels of anxiety; on the other, the fact that the infertile women without children are more anxious than the fertile women who have not yet desired or attempted to have children suggests that *the desire for maternity combined with knowledge of the impossibility of having children* may act as a stressor, and that (as we noted at the beginning of our article) this affects not only the personal identity of each partner in isolation, but also the life project of the couple.

In sum, without taking for granted that the situation of infertility necessarily implies a maladjustment in the couple, it certainly does constitute a stressful life event that requires a re-adaptation and places couples in a situation of vulnerability. Adequate assessment (see Jenaro, Moreno-Rosset, Antequera & Flores in this special issue) followed by the appropriate intervention (see Ávila & Moreno-Rosset, also in this issue) will enhance the coping, adjustment and well-being of the couple.

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