

## **EXPECTANCIES OF MOTHERHOOD AND DISRUPTIONS OF FERTILITY: THE ROLE OF THE INFERTILITY COUNSELOR**

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Be fruitful and multiply—the first commandment in Genesis 1 and passed on down through the generations. In good times and bad, Jews around the world throughout all ages are reminded of procreation as a solemn duty. This paper addresses the role of the reproductive counselor during the infertility journey. Several clinical examples from the Orthodox and secular Jewish communities are presented.

Preconceived notions of reproduction have changed radically in the past twenty-five years as biological and medical technologies transform the life cycle. Demography forecasts the number of women with impaired fecundity increasing from 5 million in 1995 to 6 million in 2020 (Stephen, 1996). Concomitant with this trend is the assumption that the number of women seeking infertility treatment and psychological help will rise dramatically. As a result of Assisted Reproductive Techniques (ART), data for 2001 births from The National Center for Health Statistics show a three percent increase in twin, triplet or greater pregnancy to live birth rate from 2000.

As Assisted Reproductive Techniques become advanced and offer more hope of success, so too, do the physical and emotional sequelae. Alice Domar (2002), a leading researcher in the psychological dimensions of infertility suggests that, “women with infertility have levels for depression and anxiety that are as high as women who are facing life-threatening illness. (p. 28). As Eck Menning stated in her seminal work, “Infertility does not merely cause stress and anxiety to those affected. It represents a major life crisis.” (p. 95)

As humans, we are programmed to have children and pass on our unique humanity “L'dor vador.” Erikson (1950) referred to “generativity” as the discrete stage following childhood when we marry, have children, and move into a life stage devoted to rearing the next generation. When stymied at this stage, he theorized that adults end up in a stagnated state. Fantasies of self-fulfillment are predicated on the wish to be a parent. Little girls playing with dolls grow up with the expectation of becoming a mother. When this developmental rite of passage goes awry, the pain can be unbearable. Parenthood is both a societal expectation and an intrapsychic drive to relive, transform, or repair one's childhood. From a psychoanalytic perspective, childbearing allows for the emulation or competition with the same-sex parent. “Pregnancy and motherhood is a passage into the world of mothers as well as an acceptance of the aging process as reflected in women's bodies.” (Domash, p.94)

Reproductive loss of various types; albeit miscarriage, stillbirth, infant death, and infertility (primary or secondary) are accompanied by various degrees of shock, denial, anger, depression, guilt and grief with the ultimate endpoint being resolution. (Kubler-Ross, Eck-Manning). Self-esteem, body integrity, sexuality, and self-image inflict narcissistic injury or re-traumatize old intrapsychic wounds.

Day-to-day life stressors which interfere with daily living and thereby compound emotional suffering include: (1) physical—the trauma caused to the body by the assault of treatment and the reproductive systems failure may be compounded or exacerbate other physical problems; (2) social—the pain and envy of seeing one's friends and/or family becoming pregnant and having babies; (3) work—juggling time for procedures with work responsibilities, jeopardizing one's career and relationship with employers when cooperation is needed for early runs to the doctors office; (4) family—holiday encounters and feelings of guilt or grief affecting parents who fantasized becoming grandparents; (5) financial—managing the high costs of infertility treatment including non-insured medications or procedures; and (6) spiritual—the questioning or undermining of faith as a stabilizing force.

Reproductive counseling or psychotherapy provides tools to demystify the process by addressing self-blaming feelings, improving coping skills, creating a sense of cautious optimism, reasserting old ways of experiencing pleasure—sexually and interpersonally, and assisting individuals and couples in making decisions to attain resolution. First, it is important that the professional have a knowledge base in reproductive health and the various procedures and options available. As Bruce & Thatcher (2000) state, "Therapists who specialize in infertility have the advantage of familiarity not only with the crisis but also with its treatment. Therapists might also employ specific behavioral medicine techniques such as relaxation training, biofeedback, and cognitive-behavioral therapy. These instruments serve to relieve adverse reactions as well as help couples cope with upcoming medical procedures. In addition, therapists can work with couples on relationship issues." (p. 281). Research indicates that women who have psychological intervention while trying to conceive are more likely to have increased pregnancy rates (Boivin, Greil). Second, that the therapist understand the religious and spiritual practices and choices which may have bearing on resolution. A Jewish infertility counselor with understanding of the religious and cultural underpinnings of the Jewish individual or couple, can better fulfill these factors. It is not imperative that these clients be seen by a Jewish mental health professional, but that choice can often make the difference between continued despair and feeling truly understood.

As a consequence of a significant rupture in attunement with my own psychotherapist following the second of two miscarriages and finding no support services available, I began Infertility & Miscarriage Counseling Services (later known as Women's Health Counseling & Psychotherapy) in Teaneck, New Jersey twenty-five years ago. The first thing I did (and recommend to anyone interested in this field) is to become educated in the fine points of reproductive endocrinology

and the clients being served. Mental health professionals have research-based interventions and experience to deal with the increased levels of distress including depression, anxiety or both; marital and psychosocial stress, and day-to-day coping difficulties. It is considerably more effective when a patient says that she wonders if Clomid is making her feel like she's losing her mind or Lupron is causing migraines when you know that those, indeed, may be side-effects. Additionally, I learned more about important religious rituals such as niddah or ways to deal with masturbatory prohibitions. Normalizing such experiences can be exceptionally relieving to the patient.

In the United States, organizations such as the American Society of Reproductive Medicine, RESOLVE (the National Infertility Association and the American Fertility Association, have yearly meetings, which when attended regularly help solidify knowledge in the field. Fertile Hope assists cancer survivors and the mission of A Time (A Torah Infertility Medium of Exchange), similar to Israel's PUAH Institute, is to assist Orthodox Jews going through the process. Some of these organizations have subgroups specializing in mental health, sexual health, and gender which further enhance one's professional credentials.

Medical practices and infertility programs fall into two categories. First, are those focused solely on the medical process and who tend to be disinterested in their patient's emotional well-being. There are relatively fewer of these than twenty years ago. Secondly, and more numerous, there are programs which include a mental health professional or consultant to whom they can refer for support groups and individual counseling. These physicians, generally, are more amenable to mind-body adjunctive practices such as acupuncture, yoga, and relaxation techniques. Although not on sound Western medicine scientific footing, complementary and Eastern practices have been found to be efficacious. Referrals to my practice often come from these physicians, attuned obstetrician/gynecologists, nurse practitioners, RESOLVE, and individuals who have gone through infertility and recognize the value of psychotherapy during this stressful life crisis.

Decisions to utilize financially, emotionally and physically expensive procedures create conflict for even the most stable couple. Quite often individuals seek psychotherapy when they can no longer contain their inner feelings. Desperate to quell the anxiety, depression, and "rollercoaster" of emotions which accompany monitoring the menstrual cycle in minute detail and the sequence of rising hope and dashed dreams month after month an individual places the phone call for an initial visit.

Regardless of religious orientation, infertility is a profound shock for the woman wanting to have a child. Two major problems are: religious infertility affecting the Orthodox community and delayed childbearing affecting the secular. One's physical identity is tied to the assumption that having children is a choice to be exerted at will and to discover that the desire to parent is at risk is a blow to self-esteem and self-identity.

For some people, questions of faith arise for the first time; for others, infertility confirms that there is no God. A woman may try to find the hidden meanings of her experience and wonder, what is the message God is trying to convey. Feeling that, “I did all the right things, why me?” abound. Conversely, an abortion, which seemed to make so much sense in young adulthood, becomes the focus of guilt now demanding God’s retribution. Often, a patient speculates what else she did to displease God or why God is torturing her. She wonders about God as a benevolent supreme being now having transformed His power into malevolence directed at her. A patient will reflect on feeling small, helpless, and infantilized in the face of God’s inattention to her wishes. The strong, idealized, paternal imago (a mentalized image) is similar to what a father represents to a toddler. When father gets angry, thereby evoking a feeling of badness in the child, the relationship between parent and child is disturbed. A similar feeling may be experienced for the patient feeling despair that God’s back is turned, and perhaps, she is being sent a message that she would be a bad mother and unworthy of the experience. In reaction, some patient’s stop attending synagogue or have a hard time with their personal prayer believing it to fall on deaf ears. Others will redouble their spiritual commitment in hopes that piousness will repair whatever breach has been suffered between her and Hashem.

Religious faith may be sorely tested as the strictly observant struggle to see a purpose in Hashem’s plan and their Jonah-like suffering. Feeling out of place, depressed, and isolated in one’s religious community is not uncommon. Rites of passage—marriage, baby strollers parked outside shuls and children running through aisles, attendance of brit milah and the readings of the infertile matriarchs are all constant reminders of one’s own infertility.

I often hear cries from frum women such as Rachel. Rachel, age 44 lives in an Ultra-Orthodox community in New York City. Misdiagnosed with ovarian cancer, her physician performed a hysterectomy. Although she loves her two children dearly and recovered damages for the surgery, she had not recovered emotionally when she came for psychotherapy. She felt guilt ridden for not more vigilantly seeking a second opinion and a sense of shame that as a frum woman she has so few children. Her decision was to return to work rather than have to be close to the women in her community of her age having their sixth or seventh child. She often would avoid attending shul to escape looks, of what she construed as pity, from other women. Our work together enabled Rachel to communicate with her husband the idea of changing to another local shul where she felt the women were more accepting of difference. She felt this might reenergize her faith, desire to be observant and reduce her anxiety of appearing in public.

Another difficulty for Orthodox young women is religious infertility. Faced with either a prolonged menstrual flow or short follicular phase, these women may not be able to attend the mikvah early enough in their cycle for conception to take place (Orvieto, 2006). Not quite thirty, anxiety led Chani, to the reproductive endocrinologist due to irregular menses. She believed that IVF was worth the

price rather than go through extended less aggressive procedures which might fail. As a result, she had three children and was pregnant with her fourth when she came to me. She was worried that neither her third nor fourth child who would be one year apart would get “good enough” mothering (Winnicott, 1953). Terrified that she could not provide the continuous love and care for all four of her children, she and her husband, Dovid, a yeshiva high school teacher, came for counseling together. Through our work, they were able to realize that both grew up with inconsistent and often unavailable parents, each struggling to raise their six children. Chani and Dovid determined that with a strong support system and their belief in Hashem’s providence, they would do what they could to provide the consistent and loving parenting they had each wished for as children. They were able to communicate honestly in the safety of the office and come to terms with imperfect spacing and the emotional, financial strain the fourth child puts on the family.

Although not a national or religious duty as it is may be in some Haredi communities, having children amongst secular Jews in the United States comes with its own set of pressures. Having it all, control of timing and one’s body, looking for “Mr. or Mrs. Perfect,” intermarriage, homosexuality, and remarriage are all factors which create complications in childbearing.

Despite the complications of the 21<sup>st</sup> century world, motherhood carries the same primary motivations dating back to the matriarchs. The feminist movement’s impact on the delay of childbearing has significantly increased the number of infertile women. When a woman chooses motherhood, she may find herself in a struggle of monumental proportions with her own body and unexpected forces of nature. Premature ovarian failure, advanced reproductive age, and miscarriage are frequent physical interferences which thwart motherhood for the secular Jewish woman. Choosing to be a single parent is another option for those without a partner and watching the biological clock ticking. Childbearing is assumed to be a natural birthright and presumptive expectation. As women in the United States delay marriage and conception, intermarry or remarry, advanced reproductive age causes the Jewish birthrate to decline; so too older women in Israel lose children due to the ravages of war and terrorism, thus finding they seek to replace a lost child at an advanced reproductive age. However, a significant difference between countries is the subsidizing of fertility treatments in Israel which places the cost of IVF at about \$3,000 per private cycle versus \$14,000 in the United States. In the U.S., the financial burden can be egregious. By contrast, Israeli Health Minister Yacov Ben Yizri (Jewish Standard, 2006) stated, “If our society can help these situations by bringing a child into the world, what could be better than that?”

Secular Jewish women often spend their adult years forging a career and using elective termination or years of careful contraception to avoid derailing their planned destinies. Often I hear about the scripted life of forging career, marriage (gay or straight), home and financial security before trying to get pregnant. Infertility forces them to deal with the anger and depression evoked when these fantasies of controlling their own destinies are disturbed. Life beyond age thirty-

two, known as advanced reproductive age, forces these women to confront the shock of the body not cooperating with the plan. Andy, age 28, lives in a “Hip” young community of secular Jews across from Manhattan, the first of friends to marry and plan a family, her life was disrupted by two miscarriages. Terrified she won’t survive another loss, she deals with her fright with obsessive worry. She has a brother who is a Reform rabbi and encourages her to return to a more spiritual life. Although she feels angry with God for her two miscarriages, she is trying to regain her spiritual focus. She uses a common defensive bargaining tool, when she states, “I’ll be a good Jew if you let me have this baby”, hoping it will make the difference. Through cognitive-behavior techniques, we have made inroads in containing obsessive worry as she progresses through her pregnancy. I utilized cognitive restructuring as a tool to help Andy ask herself questions such as, “Does it make sense that I am singled out by God for punishment?” A positive self talk statement, “It was a blessing that God sent me a wonderful husband and that He has a plan that did not include those two babies and is not punishing me” reduced guilt and self-condemnation.

Lauri is a Conservative Jewish woman who married at 38. After two IVFs failed, she and her husband joined a RESOLVE sponsored educational support group I led on the topic of egg donation. Active in their synagogue, both partners needed to accept her not having a biological child of her own and decide how to move forward. They explored the “Star of David”, a Jewish adoption information and support exchange prior to choosing the egg donor route. Psychotherapy assisted them to recognize that finding a Jewish donor was imperative to them. Through the internet, they found the resource they required. Ultimately, they found a Jewish woman they determined to be of no relation and not a Kohanim, (thus minimizing the complexities of halacha) and began the cycle feeling secure in their choice. Additionally, Lauri, using her well-developed sense of humor enlisted the support of her synagogue community with whom she disclosed the process, became pregnant with fraternal twins.

Deborah is thirty-four and the last in line of Holocaust survivors. Her Judaism was important enough that although she married out of the faith, she insisted that her husband convert. Deborah was raised in a liberal, secular, highly political household where high holidays were celebrated on weekends for convenience and not according to the Jewish calendar. Although not invested in organized religion, she felt it very important to have a baby to continue the family line and raise children with Jewish identity. She presented with depression and guilt for having waited so long to try to conceive. Witnessing her own parents age and become physically unwell causes her to worry that her own narcissistic ideals interfered with seeing the bigger picture of passing down her genes to another generation of Jews. Terrified by the thought of failure, we are using mind-body techniques to quell her terror as she goes through the physical process.

In conclusion, as mind-body unity is recognized to be a critical ingredient in conception, the reproductive counselor plays an important adjunctive vital role as patients endure the lack of control of their fate and reach resolution. As the old

Yiddish proverb goes: “You can’t control the wind, but you can adjust your sails.” Whether success occurs through assisted reproductive techniques, adoption, or childfree living, Jewish patients benefit from the Jewish infertility counselor’s contribution of empathy and knowledge of the combined biopsychosocial and spiritual rigors of infertility.

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