

THE INCEPTION OF A GROUP PSYCHOTHERAPEUTIC INTERVENTION IN INFERTILE WOMEN – DIFFICULTIES AND OBSTACLES THROUGH THE CONSTITUTION OF A GROUP SETTING IN A MATERNITY HOSPITAL

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ABSTRACT

Several cases of infertility without the presence of a known medical cause and with a spontaneous remission have been studied from the psychological point of view. A look at infertility, in a psychodynamic way, suggests that it is the result of a defensive activation, aimed at promoting emotional protection, seen in pregnant women in high-risk obstetrics, in infertile couples waiting for infertility appointments and in pregnant women waiting for amniocentesis examination outcome. Thus, a spontaneous remission may be seen as a translation that the psychological impasse would have been overcome. This article intends to present a research project that has been held at the Maternity Hospital Dr. Alfredo da Costa (MAC), in Lisbon, and which participants are women followed in the MAC infertility consultation, unable to conceive or lead to good fruition a pregnancy after at least one year of regular sexual intercourse without resorting to contraceptive methods. In this article we intend to reflect the hindrances, difficulties and obstacles felt through the inception of a group psychotherapeutic setting in a Maternity Hospital. After all the bureaucratic issues have been solved out, the psychological resistance of the participants emerged, revealing to be a pattern.

Keywords: infertility; psychological suffering; marital relationship perception; parental figures relationship perception; self-efficacy and social stigma perception; conception rate; group psychotherapy; group analysis

INTRODUCTION

The experience of infertility, the procedures of assisted reproduction technologies and the success or failure must be integrated into the patients' clinical history. This integration can occur with greater or lesser serenity, depending on psychological, sociological and religious factors (Beaurepaire, Jones, Thiering, Saunders & Tennant, 1994; Syme, 1997). The diagnosis procedures

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and the medical treatment often represent an unforeseen source of stress for most of the couples that go through this situation since they are confronted with high expenditure of time and money and with gradually invasive techniques, especially the female element (Meyers, Diamond, Kezur, Scharf, Weinshel & Rait, 1995; Brighenti et al., 1997; Fekkes, Buitendijk, Verrips, Braat, Breways, Dolfing, Kortman, Leerentveld & MAcklon, 2003). Under these circumstances, experiencing stress implies perceiving an inability to cope with the demands of the situation and, ultimately, to achieve the desired goals (Galhardo, Cunha, & Pinto-Gouveia, 2012) and persist with medical treatments or to seek for an alternative resolution to the problem different from the conception of a biological child (Cousineau, Green, Corsini, Barnard, Seibring, & Domar, 2006). Infertility and its medical treatments affect different aspects of the personal life of each member of the couple and the life of the couple together (Lemmens, Vervaeke, Enzlin, Bakelants, Vanderschueren, D’Hooghe & Demyttenaere, 2004), increasing feelings of anxiety, guilt, somatization and depression (Matsubayashi et al., 2001; Wischmann, Stammer, Scherg, Gerhard & Verres, 2001; Fassino, Pierò, Boogio, Piccioni & Garzaro, 2002) and strongly challenging beliefs about oneself and the world (Diamond, Kezur, Meyers, Scharf & Weinshel, 1999). Support, satisfaction and communication within the relationship are compromised (Andrews, Abbey & Halman, 1992; Meyers et al., 1995; Diamond et al., 1999) and major changes in sexual life occur (Leiblum, Aviv & Hamer, 1998; Tuschen-Caffier, Florin, Krause & Pook, 1999; Lee, Sun & Chao, 2001), as well as in the couple’s social network (Meyers et al., 1995; Fekkes et al., 2003).

The impact of psychological symptoms on infertility is, however, controversial. Although it is widely accepted that infertility causes significant levels of distress (Domar, A., Broome, A. Zuttermeister, P., Seibel, M. & Friedman, R., 1992), the possibility that psychological factors may lead or contribute to infertility is still the subject of debate (Domar, Clapp, Slawsby, Dusek, Kessel & Freizinger, 2000a), being the relationship between stress and infertility quite complex. Several cases of infertility without the presence of a known medical cause and with a spontaneous remission have been studied from the psychological point of view (Justo, 2008). A look at infertility, in a psychodynamic way, suggests that it is the result of a defensive activation, aimed at promoting emotional protection (Justo, 2014), seen in pregnant women at high-risk obstetrics clinic, infertile couples waiting for infertility appointments and pregnant women waiting for the outcome of the amniocentesis examination. Thus, spontaneous remission may be seen as a translation that the psychological impasse would have been exceeded (Justo, 2008). One study pointed out that women with a clinical history of depressive symptoms were almost twice as likely when compared to women without a history of such symptoms to present a subsequent history of infertility (Lapane, Zierler, Lasatar, Stein, Barbout, & Hume, 1995).

The defence mechanisms presented by women in obstetric high-risk consultation – marked by a decrease in the use of aggressive impulse defences and excessive use of mechanisms that allow the rationalization or denial of frustrating situations – seem to be very different from those patterns of defensive organization of non-pregnant women and women with a risk-free pregnancy (Justo, 1990; Justo, Melo & Ferreira, 2010). Infertile men and women have a defensive pattern very similar to that of high-risk pregnant women (Justo, 2010). This defensive standard turned out to be designated as “*stand-by reaction*” (Justo, 2014), which means the occurrence of a transient situation where the emotional experience is discontinued. This unconscious refusal to engage in pregnancy hinder the contact between the self and its emotions, not allowing a psychological development to occur along with biological development, becoming possible to generate psychosomatic reactions (Justo, 2002).

This article intends to present a research project that has been held at the Maternity Hospital Dr.

Alfredo da Costa (MAC), in Lisbon, and whose participants are women followed in the MAC infertility consultation, unable to conceive or lead to good fruition a pregnancy after at least one year of regular sexual intercourse without resorting to contraceptive methods. In this article we intend to reflect the hindrances, difficulties and obstacles felt through the inception of a group psychotherapeutic setting in a Maternity Hospital. After all the bureaucratic issues have been solved out, the psychological resistance of the participants emerged, revealing to be a pattern.

Focusing on the methodology of this project, participants (N = 30) will be randomized into two groups: experimental group, target of analytic group psychotherapy intervention with a weekly frequency for four months (16 sessions), and control group. This research intends to evaluate the effectiveness of group psychotherapeutic intervention with infertile women, having as evaluators of their effectiveness:

i) psychological suffering, ii) marital relationship perception, iii) parental figures relationship perception, iv) self-efficacy and social stigma perception and v) conception rate.

The first stage of this research project is already overtaken. A first psychotherapeutic group is being realized with five participants. In this paper we intend to demonstrate the difficulties felt by the investigator, which is the psychotherapist as well, in the constitution and conduction of a psychotherapeutic group process. We aim to manifest the reactions – verbalized or somatized - of the participants since the moment they were proposed to participate in the group therapy until the start of group sessions. So far, the first psychotherapeutic group (constituted by five infertile women) is in the middle of the process, having already eight sessions, in a total of sixteen. Therefore, in the present article, we reflect about clinical reports, formulating relational patterns observed in the infertile women taking part in this research project.

MAIN ORIENTATIONS OF THE GROUP ANALYTIC PSYCHOTHERAPEUTIC SETTING

The psychotherapeutic intervention used in this research project is based on the group analytic theory. Group analysis is a form of psychotherapy which, through group, includes its conductor. This kind of intervention aims to reach a healthier integration of the individual in his relationships in general. Group analytic psychotherapy is based on the perspective that profound and lasting changes are possible as long as there is commitment of each individual for a period of time adequate for reflection on his life and the relationship patterns he establishes with others. In a climate of trust and confidentiality, people explore their concerns, conflicts and personal problems (Foulkes, 1948; Foulkes & Anthony, 1957), being exposed to different points of view and, thus, groups are an enriching vehicle where people learn to offer and receive feedback and support relatively to each other. In a safe environment, the possibility and the courage to see ourselves through the eyes of others emerges.

People who have difficulty expressing their feelings and needs see in the group a safe place to share their ideas without feeling censored, having the opportunity to know themselves and to understand the relationships they establish with others in a deeper way. Therefore, the group functions as a laboratory of relationships experiences with others in which it is possible to observe movements of approach (and its difficulties), envy, jealousy, shame competition and fear among the members of the group, like a mirror. Since people do not know each other and are asked not to contact each other outside the sessions, these patterns of relationship emerge through transference movements in the group. That is, people relate themselves to what they fantasize about each other, projecting in the group matrix their internal relational matrix (Leal, 1968; 1993; 2010), formed through multiple relational experiences. The group analytic framework provides a privileged context for the staging of this matrix, activated by the regression of each of the analysands (Dinis, 1994; 2000). Thus, this

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allows that individuals may transform their internal relational matrix through the analytic relationship developed in the group matrix.

In this sense, the group analyst makes interventions and interpretations according to the context and momentum of the group and its members, which can be addressed to the group as a whole, to a part of the group or to each subject. The relational and interpretative dynamics established in the group analytic matrix (Cortês, 1989) will allow the perlaboration or *working through* of group members. It is the personal elaboration that is occurring with the group analytic work, slowly but continuously, and that acts in the dimensions of constancy and time. Interpretation is the technique that allows us to translate into new and more differentiated forms of communication and psychological organization what is communicated in the group in its different aspects (Cortês, 1989).

Although it is an unstructured type of intervention, three phases of the group process can be emphasized. In an initial phase, in which people do not know each other, there is a greater intervention from the group analyst in order to facilitate the contact between people and to inform about the working rules of the group. At this stage, people are organizing communication within the group, trying to anticipate the reactions of others. Subsequently, in a second phase, with a stimulating interaction between group members, dialogue becomes a powerful resource of getting to know themselves, and once the group matrix is established, the fears that inhibit each person from talking about their problems quickly disappear in an intense environment of support and trust. Through the relationships established in the group, it is possible to clearly observe how the patterns of past relationships are reverberated in the present, blocking growth and creativity. The analysis of the same patterns opens a path for change and for the personal development of each element. Lastly, the final stage is the closeness of the end of the therapy, in which people reflect on the impact this process had on their lives and evaluate the results and personal satisfaction of this experience.

REACTIONS TO THE GROUP PROPOSAL AND INITIAL RESISTANCES – BEFORE THE START OF THE GROUP PSYCHOTHERAPY SESSIONS

Before the start of the psychotherapeutic group, women followed in the MAC's infertility consultation were randomized into two groups: an experimental group, target of the psychotherapeutic group sessions, and a control group. In this section we intend to describe the reactions of the women when proposed to participate in the psychotherapeutic group. This first contact with the participants occurred after their infertility consultations with health professionals, such as doctors and nurses. Women tended to show up really irritated and feeling misunderstood. That happens because they think the scheduling of the next medical consultation is very spaced and because they don't feel pleased with the way doctors treat them, alleging they do not clearly explain to them their medical conditions, nor do they really care about them, feeling like numbers to the system. Most of them appeared to be really angry and peevish, although stating they can't show their anger to the health professionals.

They seemed to be really avoidant and showed huge commitment issues. They weren't really into confronting their feelings, referring they tend to deny their suffering.

When asked about being part of a psychotherapeutic group with other infertile women they felt frightened about the idea of sharing their personal issues with "strangers", asking if they couldn't choose an individual psychotherapy. They appeared to be quite ambivalent, asking a lot of questions about the group setting. One of them, which was really terrified but very curious about the group experience as well, even asked if she could bring a friend with her to the group sessions.

THE CONSTITUTION OF THE GROUP – RELATIONAL PATTERNS OBSERVED

This section will focus on eight group psychotherapy sessions that has already happened in the maternity hospital. In a total of twelve participants who showed interest in participating in the group psychotherapy, only five kept present until now. The group started with six women, but one of them only attended one session.

These numbers may be a reflection of the ambivalence about the group intervention. Just right in the first session, many “accidents” occurred to women, hindering them from being present. In the day of the first session one woman had a panic attack – something that had never happened to her - during the afternoon, right before the meeting. Another woman had a car accident while she was driving to the maternity. Another woman got the flu on the eve of the session and another one had a severe migraine.

This ambivalence prevailed. Some women never came even to one session, but sent a text message justifying their absence in all first four sessions, seeming to be a way to remain in the relationship with the psychotherapist, although they never attended the group therapy.

In the first sessions the main theme was the medical treatments they had already been through, the failed pregnancy attempts, the private clinics they had already resorted, the names of doctors and nurses of the maternity and the diagnosis they had. Thereby, therapy was seen by them as classes – a place where they would learn school subjects. The posture they assumed was like they were assisting a classroom, giving many advices to each other. The younger ones got a little worried about the clinical courses the others had already been through. Later, they started finding common points. All of them felt that the health professionals addressed them in a cold manner – feeling that they were treated not as human beings but as statistics – and reported their difficulties going to the maternity because it made them remember hard moments.

These women appear to be childish, having real difficulties in dealing with adversities. Everything is dramatic and unresolvable when it comes to them. On the other side, they spend a lot of time looking after others’ problems, frequently assuming the role of caregivers.

They present difficulty in fantasizing. They are discredited women, without dreams and expectations. Some of them have already done four failed In Vitro Fertilizations and are desolate.

Especially in the first sessions they assumed a rigid and tough posture. They would not allow themselves to cry anywhere and they exposed to the group how difficult it was for them to let other people know what they feel and think – a situation that keeps them really frustrated.

The dependence on their husbands emerged very early in the group. All of them said they wanted their husbands to be present at the meetings, often complaining about it in the first sessions. When the marital relationship was explored, a controller pattern was clear. These women are very bossy in their marriages and assume their husbands can’t do their own tasks without them, choosing even the clothes their husbands will wear the next day on a daily bases. Sexual intimacy, which appeared to be an uncomfortable topic for some of them, is seen as a task rather than as a pleasurable thing. They have indications by the nurses about the best days to have sex, which turns it into something scheduled and not spontaneous.

Another fundamental common point concerns the relational difficulties these women have with their mothers. They feel deferred towards their siblings and being difficult to “compete” with them because they are perfect in the eyes of their mothers. They perceive that their mothers take sides of their brothers and sisters, always defending them. At least these in their fantasies, these are mothers who have been or are negligent and incompetent. In these first sessions a window has been opened for the hypothesis that these mothers do not want their daughters to become pregnant. They were not present when their daughters lost their babies, neither accompanied them in the process,

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not even wanting to know how their infertility treatments were going. Despite this, these women are very dependent on their parents.

Perhaps as a reflection of the relationship with the maternal figure, these women report having difficulty dealing with female authority and power figures, such as doctors and bosses. The same thing happened in the sessions, since the analyst is a figure of authority in the group. One of the ladies could not look at the analyst in the eyes; when this woman was talking, she blocked their thoughts when she looked at the analyst. However, at the beginning of the process they spoke almost exclusively to the analyst and not to the group as a whole - there was also a great reliance on the analyst. They did not want to share the analyst with the other sisters. Now they talk more to each other.

They do not feel “normal” in the society. They feel that family, friends and work colleagues reject them for not having children. They feel excluded and that people treat them differently, afraid to hurt them, not inviting them to social events involving children. They feel misunderstood by others, saying they blame them for not being able to have children, for thinking too much and not letting things happen naturally.

They themselves are very ambivalent about what they fantasize to be the role of a mother. They live in an impasse, between wanting to have children and not wanting to give up on the pleasures of life - especially freedom of time and lack of responsibility. One of them also added she was afraid that the child would like more her husband than hers, which can be a repercussion of her rejection feelings.

Throughout the sessions, escapes and avoidance begin to emerge. The defence mechanisms of rationalization and denial begin to be called into question and the sense of losing control increases, leading to an internal conflict. From the fifth session there were the first absences, which can be also a reflection of commitment difficulties and fear of dependence on the group, once it is becoming clear that the process is already halfway. It should be noted that there was never just one absence in any session; absences are always collective, with at least three women missing a session, presenting psychosomatic manifestations (flu, diarrhea, indisposition).

FUTURE PERSPECTIVES

This article presents a reflection, not intended to be definitive, of the participant’s relational patterns observed in this initial phase of the research project.

For future work, we have, in the short term, the goal of giving continuity to the current psychotherapeutic group, which will be facing more eight sessions. Subsequently, a second round of sample collection will be held for the beginning of a new psychotherapeutic group to obtain a total of 15 participants in the experimental group and afterwards generate new reflections.

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