

Gender and Infertility: A Relational Approach to Counseling Women

Donna M. Gibson and Jane E. Myers

Much of the research on infertility reinforces differing effects for women and men, with women reporting more serious repercussions medically, psychologically, and socially. However, the unique counseling needs of infertile women have not been addressed through traditional counseling theory. The Relational Model (J. V. Jordan, 1995) of women's development is a theory that explains women's development in a context of relationships, specifically relationships that promote growth for self and others. This model is applied to counseling women who are experiencing infertility, and a case presentation is provided to illustrate the approach.

The ability to conceive children is a "universal, biopsychosocial assumption (that) goes unchallenged until a couple faces infertility" (Meyers et al., 1995, p. 219). The Centers for Disease Control and Prevention (CDC, 1998) estimated that 2.1 million married couples in the United States are currently experiencing infertility, an estimate considered conservative by many authors who suggest that 12% to 20% of couples will at some time face this life challenge (Abbey, Andrews, & Halman, 1991; Korpatnick, Daniluk, & Pattinson, 1993). The distinction between *primary infertility*, the inability to conceive a first child, and *secondary infertility*, the inability to conceive after one live birth, provides evidence that infertility affects even more couples than originally considered. In fact, an additional 10% to 12% of women experience secondary infertility, thus doubling the number of women for whom childbearing is problematic (Trantham, 1996). The fact that infertility rates increase with age is an additional consideration (Mosher & Pratt, 1990), given the trend among young couples toward delaying marriage and childbearing in favor of career pursuits (Eunpu, 1995; Matthews & Matthews, 1986; Stewart & Robinson, 1989). Among women of childbearing age, difficulties conceiving combined with an inability to carry a child to term result in 6.1 million women between the ages of 15 and 44 reporting an impaired ability to have children (CDC, 1998).

Because childbearing is a major, normative role transition for both men and women, the experience of infertility, a nonevent transition (Korpatnick et al., 1993), has been conceptualized under the rubric of "the crisis of infertility" (Atwood & Dobkin, 1992; Butler & Koraleski, 1990; Slade, Raval, Buck, & Lieberman, 1992). This crisis is complex

and is accompanied by various physical, financial, psychological, and social stressors (Domar, 1997; Shepherd, 1992; University of North Carolina Hospitals, 1998). The manner in which individuals and couples cope with infertility issues varies considerably, with gender differences noted in several studies (Connolly & Cooke, 1987; Levin, Sher, & Theodos, 1997; Ulbrich, Coyle, & Llabre, 1990). In fact, many authors suggest that women experience a more difficult adjustment to infertility than their partners, due in large part to the emphasis in our society on the role of women as mothers (Abbey et al., 1991; Keystone & Kaffko, 1992).

The process of helping infertile people has traditionally focused on the role of medical personnel whose goal is diagnosis and treatment designed to help couples conceive (Cook, 1987). The identification of psychological factors related to infertility has increasingly led to suggestions for helping interventions, most of which are based in cognitive, behavioral, and family systems theories (Butler & Koraleski, 1990; Cook, 1987; Daniluk, 1991; Myers & Wark, 1996; Williams, Bischoff, & Ludes, 1992), as well as transition theory (Korpatnick et al., 1993; Schlossberg, Waters, & Goodman, 1995). These theoretical models fail to consider the importance of gender; thus the unique needs of infertile women are often ignored or minimized in favor of interventions focused on the infertile couple (Atwood & Dobkin, 1992; Trantham, 1996). Although theoretical models emphasizing the development of women have been proposed (Gilligan, 1991; Jordan, 1995; Keystone & Kaffko, 1992), these theories have not been applied to the 20% or more of women experiencing the crisis of infertility.

In this article, infertility is examined from medical as well as psychological perspectives. Treatment options and mon-

Donna M. Gibson was a doctoral candidate in counseling and counselor education at The University of North Carolina at Greensboro and is now an assistant professor in the School Counseling Program of the Department of Education at The Citadel, Charleston, South Carolina. Jane E. Myers is a professor in the Department of Counseling and Educational Development at The University of North Carolina at Greensboro. Correspondence regarding this article should be sent to Donna M. Gibson, 3101 Highbridge Circle, Jamestown, NC 27282 (e-mail: gibmac@msn.com).

etary costs are briefly explained, to provide a context for better understanding the full impact of infertility. Gender differences in response to the "crisis of infertility" are described, which form the basis for examining differential coping processes among men and women. Developed at the Stone Center by Jordan (1995) and other researchers, the Relational Model is described as a paradigm through which the coping processes of women may be better defined (Miller & Stiver, 1997). (The Stone Center is based at Wellesley College in Massachusetts, and research at the center focuses on women.) Implications for counseling women based on this theory are discussed. Finally, we provide a case study from our clinical practice demonstrating the application of the theory with an infertile woman. In reporting this case, the American Counseling Association's (ACA, 1995) ethical guidelines were followed.

INFERTILITY FROM A MEDICAL PERSPECTIVE

From a medical perspective, *infertility* is defined as the inability to conceive after a minimum of 1 year of regular, unprotected, sexual intercourse (Cook, 1987; Meyers et al., 1995; Trantham, 1996). When couples first seek treatment, the focus is on determining which partner is infertile and the reasons underlying the problem. Treatment options are selected based on diagnosis, prognosis, and financial resources, among other factors.

Which Partner Is Infertile?

Statistics suggest that men and women are about equal as the source of a medical diagnosis that impairs fertility (Eunpu, 1995; Robinson & Stewart, 1995; Trantham, 1996). The medical reason for infertility is directly attributed to 40% of women alone and 40% of men alone. The remaining 20% of infertility problems have been related to interactions between the couple (Robinson & Stewart, 1995; Trantham, 1996). These interactions include, but are not limited to, inadequate intercourse, female production of antibodies to sperm, or undiagnosed infertility of one or both partners (Robinson & Stewart, 1995).

Recent reports suggest that the rate of infertility may actually be increasing more for women in the 20- to 24-year-old range than for men as a consequence of the increased incidence of sexually transmitted diseases (STDs; Trantham, 1996). STDs can result in adhesions and tubal dysfunction that inhibit successful pregnancies, the ability of the woman to carry the child to term, or both (Robinson & Stewart, 1995).

Diagnosis

The causes of infertility have traditionally been viewed as either psychological or biological, or both. Robinson and Stewart (1995) provided a brief review of research suggesting that infertility was viewed in the early part of the twentieth century as a defense against feared pregnancy or as the outcome of a conflict between motherhood and a career. This perspective provides the subtle suggestion that

the woman is the sole source of the problem, a perspective that has been found to be incorrect, as noted previously.

More recent research suggests that although intrapsychic conflict may be a factor, having children versus having a career is not the sole or even most significant issue (Stewart & Robinson, 1989). Rather, the interaction between psychological factors and infertility is what is important. For example, the biological consequences of stress may include changes in natural hormone and chemical levels that can negatively affect reproductive efforts in both men and women (Harrison, O'Moore, O'Moore, 1986; Robinson & Stewart, 1995; Stillman, Rosenberg, & Sachs, 1986). Additional biological factors that may affect fertility include "absent or infrequent vaginal intercourse; amenorrhea or impaired fecundity secondary to eating disorders; and medications that inhibit ovulation, such as major tranquilizers. It is not clear that anxiety, depression or stress causes infertility" (Robinson & Stewart, 1995, p. 285).

The biological basis for infertility is complex and varied, making the medical diagnostic process sometimes difficult and lengthy. In addition to inadequate frequency of intercourse, problems with sperm (e.g., too few, antibodies to sperm, impaired motility), problems with eggs (e.g., no ovaries, problems with ovulation), and blocked fallopian tubes have been cited (Meyers et al., 1995; Robinson & Stewart, 1995; Trantham, 1996). In women, the causes of infertility may also be related to hypothalamic dysfunction, pituitary abnormality, thyroid dysfunction, or adrenal dysfunction. Men may experience difficulties due to excessive alcohol ingestion, use of marijuana, use of tobacco or steroids, and hypothalamic or pituitary dysfunction (Trantham, 1996).

The diagnostic process begins when the individual or couple decides they are concerned and want to find out why they are experiencing difficulties in conceiving. This process may be long, typically requiring repeated visits over time and diagnostic tests for both partners. A basic evaluation including a physical examination, history, laboratory tests, and charting for two to three menstrual cycles discloses the causes of infertility for 70% to 85% of couples (Trantham, 1996). Diagnostic procedures vary for men and women, with women experiencing longer and more invasive testing procedures. The average time to arrive at a diagnosis for men is 1 month, whereas for women it is 6 months (Meyers et al., 1995).

For all couples, and especially for the 15% to 30% for whom diagnosis is most difficult and protracted, the diagnostic procedures can be both invasive and embarrassing (Cook, 1987). The financial costs can vary from a few hundred to several thousand dollars and may or may not be covered by insurance (Meyers et al., 1995). These considerations can make couples question their motives or weigh the consequences of seeking a diagnosis. Once the diagnosis has been received, the couple may decide to remain childless or to adopt, or options for treatment to enhance fertility may be considered.

Infertility Treatment

Various factors influence a couple's decision to pursue treatment for infertility. These include the financial costs of treat-

ment, options for treatment, the treatment prognosis and projected outcomes, and the psychological impact of infertility. The first three factors are considered in this section; psychological factors are considered in depth in the following section.

Financial costs of treatment. The cost of infertility treatment can be quite high, ranging from \$50 to \$12,000 per synthetic hormone-induced menstrual cycle (Domar, 1997; University of North Carolina Hospitals, 1998). Several cycles of treatment may be necessary before a couple can conceive successfully. In the United States, over a billion dollars a year is spent on infertility treatments. Insurance reimbursements vary across states and employers, and many individuals are forced to pay out-of-pocket for treatments considered "elective" by their insurance carriers (Meyers et al., 1995). Several clients in our practice have reported using second mortgages on their homes to pay for their infertility treatments.

Meyers et al. (1995) provided an extensive analysis of infertility treatments, costs, and related success rates. Noteworthy in their findings are gender differences in these factors. Only a few treatment options are available for men, with the most expensive costing approximately \$3,500. Numerous options are available for women, most costing \$7,000 to \$14,000, in 1995 medical dollars.

Options for treatment. The type of treatment recommended varies, of course, with the medical diagnosis. Men who are diagnosed with low sperm count, poor sperm motility, or poor sperm structure may be treated with antibiotics or hormones—both noninvasive treatments—or with various more invasive interventions such as varicocelectomy (a surgical procedure that ligates or binds varicose veins in or around the testicles; Meyers et al., 1995; Trantham, 1996).

Treatment options for women tend to be more varied, more invasive, and more costly than those for men. Although women may receive antibiotics and hormonal treatments, they also may take fertility drugs. Various assisted reproductive technologies (ARTs) are available for women when these treatments are ineffective, and many take drugs in addition to ARTs. These include artificial insemination, in vitro fertilization (IVF), egg donation, gamete intrafallopian transfer (GIFT), and a combination of IVF and GIFT (ZIFT; Meyers et al., 1995; Robinson & Stewart, 1995; Schwartz, 1987; Trantham, 1996). Surrogate motherhood, using a woman who is not part of the couple, is perceived by many couples as a last-resort option for women who are unable to conceive (Schwartz, 1987).

In the United States, 1.8 million women are currently using infertility drugs and 9 million women have used infertility services (CDC, 1998). The medical side effects of these treatments include nausea, flushing, abdominal bloating, headaches, hair loss, increased risk of ovarian cysts and ovarian cancer, and increased risk of multiple pregnancies (Robinson & Stewart, 1995). These effects may be inconvenient, painful, and disruptive of normal daily routines and functioning.

Prognosis and outcomes. The potential for or experience of side effects is one reason couples may choose to defer or

terminate fertility treatments before a successful pregnancy. Success rates for medication and ARTs vary considerably, complicating the decisions couples must make. For example, fertility medications are successful in about 40% of couples. Artificial insemination by husband or by donor (consisting of fresh or frozen semen inserted with a syringe into the woman's cervix) has a success rate of 25% during one cycle, if the woman does not have a fertility problem (Robinson & Stewart, 1995). IVF, the vaginal removal of eggs from ovulating females, followed by the combination of eggs and sperm from the male in a petri dish for fertilization, generally has a low success rate. If fertilization occurs, the fertilized eggs or embryos are inserted into the uterus or frozen for future use. For women under 40, 15% to 20% of IVFs are successful, depending on male infertility factors. For women over the age of 40, only 5% to 7% of IVFs result in a successful pregnancy. Gamete intrafallopian transfer involves the reintroduction of unfertilized gametes into a fallopian tube through an incision in the abdomen. Women under 40 years of age experience a 23% to 31% success rate with this procedure, depending again on male fertility issues, whereas those over 40 have a 12% to 13% chance of successful outcomes (Meyers et al., 1995). Difficulties in diagnosis, low probabilities for successful outcomes, and painful and expensive procedures for diagnoses and treatment contribute to the overall psychological impact of infertility for individuals and couples.

PSYCHOLOGICAL IMPACT OF INFERTILITY

A myriad of feelings, thoughts, and beliefs that couples and individuals experience contribute to the "crisis of infertility" (Cook, 1987; Leader, Taylor, & Daniluk, 1984; Menning, 1980). This crisis involves an interaction among physical conditions related to infertility, possible medical interventions to diagnose and treat infertility, social constructions about parenthood or nonparenthood, reactions of others, and individual psychological traits (Cook, 1987). In dealing with all of these factors, the couple or individual may find that they lack the resources (e.g., medical, social, or psychological resources) to provide support for themselves and their partners (Leader et al., 1984). Although both individuals in a couple may experience this "crisis," research has indicated that women are more negatively affected by infertility (Abbey et al., 1991; Daniluk, 1997; Raval, Slade, Buck, & Lieberman, 1987; Ulbrich et al., 1990; Wright, Allard, Lecours, & Sabourin, 1989). Three factors that provide a better understanding of the psychological impact of infertility for women include the social construction of infertility, emotional responses to medical diagnosis and treatment, and gender differences in emotional responses to infertility. Ethnicity may also be another factor that could provide a better understanding of the psychological impact of infertility for women. However, empirical research in this area lacks adequate minority samples to support any significant findings. Most of this research is based on Caucasian, middle-class heterosexual couples.

The Social Construction of Infertility

With a shift in research identifying stress as the pathological reason for infertility to experiencing infertility as a precursor to stress, recent research has focused on the social construction and interpersonal effects of infertility (Bresnick & Taymor, 1979; Eunpu, 1995; Frank, 1984). The social construction in American society, and many other cultures, is that men and women are meant to become parents, and women are especially socialized to become mothers (Atwood & Dobkin, 1992; Cook, 1987; Edelmann & Connolly, 1996; Matthews & Matthews, 1986; Reed, 1987). Evidence suggests that after the first year of marriage, pressure for married couples to have children increases and peaks during the third and fourth years (Porter & Christopher, 1984). Becoming a parent will often confirm feelings of self-worth and sexual identity when people have been socialized to that role (Shepherd, 1992). In many cases, it may also confirm the meaning and purposes of both the couple's marriage and existence as a couple (Matthews & Matthews, 1986).

In essence, the social construction of the roles of father and mother have become a part of the identities of men and women in our society (Matthews & Matthews, 1986). However, infertility can spoil one's sense of self-identity. Research with voluntarily childless couples suggests that these couples are viewed as unhappily married, psychologically maladjusted, career oriented, selfish, unhappy, and emotionally immature (Blake, 1979; Lampman & Dowling-Guyer, 1995; Miall, 1986; Peterson, 1983; Veevers, 1980). It is not surprising that individuals who are involuntarily childless may have difficulty resolving their own past perceptions of childless couples and thus may be unable to incorporate a positive identity of themselves as child free.

Emotional Consequences of Diagnosis and Treatment

Any discussion of the psychological consequences of infertility must include consideration of the consequences of diagnosis and treatment. The guarantee of medically treating infertility is that there are no guarantees. Recent research indicates that success rates of infertility treatment decrease with each successive 1-month cycle of treatment (Meyers et al., 1995). The cycle of treatment generally consists of a protocol of fertility medications that help to stop a woman's natural menstrual cycle and substitute an artificially produced menstrual cycle while also hyperstimulating the ovaries for egg production. It is not surprising that many of our clients undergoing infertility treatments describe their experiences as an emotional roller-coaster ride. During each cycle of treatment, their hopes for a successful pregnancy escalate. The onset of menstruation creates an immediate sense of failure and frequently depression. These reactions may be attributed only partially to hormonal changes related to drug therapy regimes (Robinson & Stewart, 1995).

Additional psychological factors related to diagnosis and treatment include stress based on the financial costs of treatment, marital conflicts, social pressures, and the invasive-

ness of medical procedures (Trantham, 1996). This stress is also prevalent among couples who are making decisions to use donor eggs or donor sperm in their infertility treatment plan. Using donors and surrogates involves issues of confidentiality, informing the conceived child of the procedure, strained relationships among family members, and deliberating moral dilemmas (Robinson & Stewart, 1995; Schwartz, 1987). There is also the time involved in waiting to determine if the treatment has been successful and the emotional "let-down" when it has not been successful (Robinson & Stewart, 1995).

The diagnosis of infertility may stimulate feelings of loss such as loss of a life goal, loss of a pregnancy experience, loss of fertility, loss of the potential for bearing children, loss of personal identity, loss of sexual identity, loss of a sense of personal control, loss of health, loss of confidence, and loss of close relationships with a male partner, friends, or family (Leader et al., 1984; Mahlstedt, 1985; Matthews & Matthews, 1986). The feelings associated with these losses may include sadness, frustration, inferiority, loneliness, fear, surprise, moodiness, disorganization, distractibility, fatigue, helplessness, poor self-esteem, shame, betrayal, powerlessness, hostility, and unpredictability (Atwood & Dobkin, 1992; Butler & Koraleski, 1990; Daniluk, 1997; Fleming & Burry, 1987; Menning, 1980; Porter & Christopher, 1984). It is not surprising that these feelings are the same as those experienced in reaction to the process of death and dying—shock/denial, anger, guilt, anxiety, grief, and depression (Bernstein, Brill, Levin, & Seibel, 1992; Kikendall, 1994; Kubler-Ross, 1969).

Gender Differences in Emotional Responses to Infertility

Many factors affect the reactions and adjustment of the couple who is experiencing infertility, and it is not surprising that significant gender differences in coping have been found (Abbey et al., 1991; Brand, 1989; Bresnick & Taymor, 1979; Daniluk, 1997; Edelmann & Connolly, 1996; Jones & Hunter, 1996; Keystone & Kaffko, 1992; McEwan, Costello, & Taylor, 1987; Raval et al., 1987; Reed, 1987). Specifically, women have reported experiencing more marital difficulties, including sexual difficulties (Abbey et al., 1991; Daniluk, 1997; Raval et al., 1987; Wright et al., 1989). They also describe their emotional reactions as being more like a grief reaction (Jones & Hunter, 1996). Men report experiencing many of the feelings, thoughts, and beliefs that women have reported (Daniluk, 1997); however, the frequency of their reports and the intensity and duration of these feelings may be more variable for men (Berg & Wilson, 1991; Daniluk, 1997; Edelmann & Connolly, 1996; Jones & Hunter, 1996; Keystone & Kaffko, 1992). This may be because women have greater physical and emotional involvement with infertility than do men; women carry most of the burden, in terms of medical evaluation, and carry physical reminders (e.g., menstrual period) of infertility that men do not experience (Williams et al., 1992).

In a study by Abbey et al. (1991), married women also reported that they believed they had experienced more disruptions and stress in their personal, social, and sex lives compared with their husbands who reported they had experienced more home-life stress. In an attempt to gain control of their experiences, women also attributed more responsibility for the infertility to themselves (Abbey et al., 1991; Daniluk, 1997). At the same time, their husbands held them responsible for the infertility (Abbey et al., 1991). Therefore, women's feelings of guilt about the infertility were confirmed. It is interesting that both husband and wife's attribution of blame to the woman was unrelated to the actual source of the infertility, and sometimes the diagnosis was actually related to male rather than female factors.

When confronted with issues of loss, women tend to share their feelings with their partner or others as a means of coping (Keystone & Kaffko, 1992). However, the male partner may find it stressful to talk about infertility with anyone and, as a consequence, may withdraw (Williams et al., 1992). Men may listen to their partners and react internally but not share their feelings with their partners. Therefore, female partners may believe they are being pushed away, contributing to a sense of isolation. Such feelings of isolation may be more significant for women than for men, as a consequence of gender differences in relational processes.

THE RELATIONAL MODEL AND ITS APPLICATIONS IN COUNSELING

Much of the existing research indicates that women often react to infertility by telling their stories to others, including telling their partners how they feel (Keystone & Kaffko, 1992; Williams et al., 1992). This sharing of their stories through relationships with others seems to be a major resource for coping (Keystone & Kaffko, 1992; Williams et al., 1992). The Relational Model of development (Jordan, 1995) provides a useful context for understanding how and why women cope in this manner and thus can be used to facilitate women's adjustment to infertility.

Relational Model of Development

Jordan (1995) and other researchers at the Stone Center at Wellesley College have created a new model of women's development based on a relational perspective of human experience. Specifically, this model states that "women grow and/or develop in, through and toward relationship" (Jordan, 1995, p. 52). Through experiencing life as arising from a context of relationships, women are provided with a sense of connection to others (Miller, 1988). Therefore, women discover a sense of value and effectiveness in themselves (Miller, 1988). Miller (1986, 1988) proposed that women—once they feel that initial sense of connection with others—will feel an increased sense of energy, have a more accurate view of themselves and others, feel empowered to act outside of their relationships because they are active within them, feel a greater sense of worth, and desire more connection. These relationships or "sense of connection"

with others are the key to women's psychological well-being (Jordan, 1995). Relationships are "growth fostering," enhancing the psychological development of all individuals involved in mutual interactions (Miller, 1988; Miller & Stiver, 1997).

The Relational Model differs from other developmental theories that focus on the "growth fostering" of only one person in an interaction or on the nature and impact of psychological separations from others (Miller, 1988). In the context of the relational development perspective, the goal of development is for the person to build and increase their involvement in relationships, such that all individuals involved in the interactions will benefit (Miller, 1988). These relationships require both empathy and mutuality to be beneficial (Jordan, 1995; Miller, 1988; Miller & Stiver, 1997). In other words, empathy and mutuality in relationships are necessary for growth.

Empathy is a familiar concept of many counseling theories, especially in the counselor–client relationship. However, the creators of the Relational Model emphasize the use of empathy in a different manner. Empathy is modeled for clients through an examination of their relationships with others. The counselor models empathy for the client and learns self-empathy. An appreciation of ongoing interdependence of human beings is modeled in counseling and contradicts previous counseling theories that emphasize independence and self-reliance (Jordan, 1991). Furthermore, a process of mutual change and impact in the counselor and the client characterizes this counseling process. This mutual intersubjectivity means that all individuals in the counseling relationship risk something of themselves in the process and are changed and affected by each other. Therefore, they grow in and appreciate the strengths of relationships.

Empathy. Empathy is a complex, cognitive-affective process of understanding and can potentially lead to a better understanding of self, others, and relationships (Jordan, 1997). Jordan (1997) believed that empathy "relies on an ability to tolerate the tension of opening to another's experience" (p. 344). In empathizing with others, one has to be able to perceive another's affective state, psychologically identify or join with that affective state, and gain some understanding about that person's constructed reality (Jordan, 1997). Empathy is the process of moving away from the self-centeredness of being for oneself to an understanding of the growth of self and others and an awareness of relationships with others (Jordan, 1997). In counseling, empathy has usually been regarded in terms of the counselor's empathy and its impact on the client (Jordan, 1995). In relational counseling, empathy decreases and eliminates the client's sense of isolation because the client is being responded to in her attempts to relate (Jordan, 1997). This experience of being responded to will increase the client's sense of connectedness and her own sense of being able to relate; therefore, the client will develop empathy for others and self-empathy in the therapeutic relationship. Eventually, one's self-esteem increases and the client is able to accurately request the need to be understood by others and

the need to better understand others (Jordan, 1997). This leads to the client searching for relationships that offer the potential for their needs to be met, which are relationships that incorporate mutual empathy or mutuality.

Mutuality. Mutuality, or mutual empathy, can be thought of as an extension of empathy. Mutuality is reciprocal empathy where one is empathizing and is also receiving empathy (Jordan, 1997). This can happen between two or more people at the same time. In general, the individuals involved are open to this happening, are emotionally available to others, and require emotional understanding in relationships (Jordan, 1995). When this empathy is mutual and is happening within the relationship, the process affirms the self, helps the self develop, and creates a "sense of self as part of a larger relational unit" (Jordan, 1995, p. 57).

Mutuality is also a part of the relational perspective for therapeutic relationships. In the therapeutic relationship, mutuality is represented by accurate mutual empathy, mutual responsiveness, and mutual respect for one another (Jordan, 1997). Mutuality conveys to the clients that the therapeutic relationship is one that will promote their psychological well-being and encourages the clients to explore the potential of valuing others as they are exploring and learning to value themselves. Attaining mutuality within the therapeutic relationship means that the counselor adheres to appropriate roles and boundaries, and it promotes the counselor's flexibility in appropriately relating personal experience and being open to being emotionally affected by the client's experience (Jordan, 1995). Relating to a client with a presence of control, power, and emotional detachment will impede this exploration process (Jordan, 1997).

Use of the Relational Model in Counseling

The Relational Model has been applied successfully in counseling with individuals, couples, and groups (Bergman, 1991; Fedele & Harrington, 1990; Jordan, 1995; Miller & Stiver, 1997; Schiller, 1997). With individuals, issues pertaining to parenting, childhood behaviors, depression, anxiety, diversity, homosexuality, and borderline personality behaviors have been researched (Fedele & Harrington, 1990; Jordan, 1993; Miller, 1988). Couples therapy in a relational context has focused on relational awareness within the couple's system. Working toward a mutually empathic connection, obtaining mutual responsibility, and moving out of power and control struggles and mutual empowerment are components of couples' therapy using a relational approach (Bergman & Surrey, 1994). Relational approaches to group counseling are focused on providing opportunities for women to work through previous relational difficulties within a supporting relational context (Fedele & Harrington, 1990). Establishing a relational base in these groups can also provide a sense of safety and similarity (Schiller, 1997). Although the theory of relational development emerged from research on women, it has been applied to men as well (Bergman, 1991). Additional research is needed to

determine the effectiveness of using this approach with men, including men coping with infertility issues.

COUNSELING INFERTILE WOMEN USING THE RELATIONAL MODEL OF DEVELOPMENT

The psychological impact of infertility clearly creates challenges to adjustment for infertile couples, and especially for infertile women. The precepts of this model thus provide a basis for structuring helping relationships with infertile women. The model provides a context for conceptualizing women's experience of infertility, predicting difficulties in adjustment, and structuring appropriate interventions with individuals, groups, and couples to enhance the process of adjustment.

Using the Relational Model to Conceptualize Infertility Issues for Women

The experience of infertility has been shown to create feelings of loss, isolation, and self-blame among women (Atwood & Dobkin, 1992; Butler & Koraleski, 1990; Daniluk, 1997; Fleming & Burry, 1987; Menning, 1980; Porter & Christopher, 1984). The Relational Model suggests that these feelings contribute to a sense of separation or disconnection from others. When women's experiences about infertility are not heard or responded to by other people, then they detach themselves from others (Jordan, 1999). The infertile woman thus experiences a need to connect with others as an integral part of the process of coping. Failure to establish connections with others can increase feelings of loss, isolation, and self-blame, which potentially lead to a deeper depression for women. This depression can inhibit the infertile woman's action or assertiveness and enforces the loss of sense of control that she is feeling in her infertility experience. Unfortunately, depression in women that is associated with infertility is reinforced by society due to the social construction of fertility discussed earlier. Feelings of inadequacy as an infertile woman are, therefore, reaffirmed by society and not disaffirmed through her relationships with others, especially as it relates to a partner who may withdraw in response to infertility. These feelings of inadequacy and worthlessness disempower the infertile woman and immobilize her in her experience. Therefore, she may begin to believe that she should feel or deserves to feel these feelings.

Structuring appropriate interventions. As described earlier, the Relational Model provides an effective paradigm for structuring helping interventions with women. Each of the approaches arising from the model may be required, individually and in combination, to meet the varied needs of infertile women. These will include attention to empathy and mutuality in the counselor-client relationship, as well as issues specific to mutuality and empathy in individual counseling, group interventions, and couples counseling.

Empathy and mutuality. The counselor-client relationship is vitally important in helping the infertile woman find a

connection she is desperately seeking in her infertility experience. The counselor needs to immediately ameliorate any power differential that the woman may perceive in counseling. This is done by demonstrating mutual respect and openness, first through using active listening to making the client aware that the relationship between counselor and client is one designed to help her and provide her with a sense of psychological well-being. The counselor's ability to share experiences regarding infertility (e.g., knowledge of medical technology and improvements, former counseling experiences with infertile individuals and couples) and an openness to learning and being emotionally affected by this client's experience is part of the mutuality, or mutual empathy process, of the Relational Model. The experience of mutuality in counseling is important for infertile women. Women may be experiencing isolation and feelings of self-blame because of a lack of connection with others. This may be partially due to the social stigma of infertility. When infertile women experience the counselor's willingness to risk sharing the experiences of infertile women, the experience can validate women's feelings and thoughts about infertility. When the women's feelings and thoughts associated with their infertility experience are validated, they regain their sense of worthiness and control. Hence, women will be empowered to explore themselves further in their experience of infertility. In essence, infertile women lose their sense of isolation within the infertility experience as they grow in relationships that are hallmarked by an open system of feeling and learning with their counselor.

Individual counseling. The goal in individual counseling, from a relational context, is to provide an opportunity to acknowledge the client's experience as well as the counselor's experience and for the client to develop a new integration of self-other experience (Jordan, 1991). This process begins by working on the elaboration and development of empathy as a means of interacting within the counseling relationship (Jordan, 1991). With the infertile woman, the ingrained feeling of "deserving" to feel guilty, inadequate, or shameful may inhibit her ability to feel empathic with others, let alone herself. First, the counselor is to model empathy and acknowledge her feelings in an effort to normalize them. When she begins to feel "heard" and understood by the counselor, she can begin to explore more of herself in an effort for self-understanding and self-validation.

Second, the counselor needs to help the infertile woman understand that her coping through the use of relationships is not understood or adhered to by society. When this lack of understanding is coupled with the social stigma of being childless in society, then infertile women experience more conflict about their role in society and how to cope effectively with their role. Therefore, efforts are made in relational counseling to deconstruct "fertility" and what that means to infertile women. There is also a focus on recognizing the tensions that arise in women when society ridicules their efforts at incorporating emotional reactions and interpersonal sensitivity into their experiences (Jordan, 1991). Sometimes this focus in counseling takes the shape

of reviewing relationships in the client's life that represent these incongruencies. Through this review, mutual empathy and empathic response are used. Feelings, thoughts, and beliefs that the infertile woman may think she cannot verbalize are allowed and recognized. In other words, disowned aspects of the self are recognized. The counselor's job is to objectify these aspects of self and make affective connections with them (Jordan, 1991). In this process, the infertile woman begins to gain a new image of herself, others, and herself in relationships with others.

Group counseling. Group counseling with women experiencing infertility can also offer this relational movement toward awareness of self and others. However, groups also offer an extra richness in that others with similar experiences are immediate in the counseling process. The *first* consideration for the infertile woman to be involved in group counseling is whether the group is appropriate for her needs and whether she is appropriate for the group's needs. This preaffiliation stage may consist of determining if she is "emotionally ready" to connect with other women experiencing infertility. The ability to empathize with self and others needs to be generalized from individual counseling to outside of the counseling relationship.

Once the group has been formed, the *second* stage of the group is to establish a relational base to the group. Forming the relational base of the group is a time when infertile women come together to form bonds of affiliation and connection related to their infertility experiences and resultant feelings (Schiller, 1997). Counselors need to be aware of similar connections or similarities in experiences among infertile women and point these out to facilitate affiliations among group members. In addition, counselors also point out ways that group members maintain their disconnections with others. This is a paradoxical way of creating connections among group members through their maintenance of disconnections (Fedele, 1994). The counselor also needs to include herself when talking about the group, for example, using "we" instead of "you." The sense of connection in experiencing infertility is integral to establishing a sense of safety in the group, which is necessary to enable the members to deal with conflict with each other within the group and with others outside the group (Schiller, 1997).

The *third* stage of the relational group experience is mutuality. Mutuality within the group experience moves beyond the simple connections made based on similar experiences of infertility. This stage allows for empathic connection and for difference, in which trust and disclosure are paired with recognition and respect for differences (Schiller, 1997). Mutuality among group members is how group members share their experiences while providing empathic understanding for each other. This openness to understanding each other is a model of new patterns of relationships for the group members and provides a safe method of healing in the group setting (Fedele & Harrington, 1990). The counselor needs to be aware of the mutuality between her and the group members and the mutuality among group members. For the infertile woman, being understood and experiencing

understanding from others will create an environment of respect. This respect allows for recognition that others have different feelings, thoughts, and beliefs about their experiences and that there is something to learn from different experiences.

To promote a sense of mutuality, the group counselor can point out when connections have been made and the impact these have on specific women. This will affirm the infertile woman's ability to empathize and help others through her relationships with them. This is especially important because of the many different experiences among women who share the common diagnosis of infertility. The ability to accept differences in the group is important because some members may become pregnant when others do not. It is accurate to expect a variety of various emotions in response to pregnant group members. With a base of mutual understanding and connections within the group, group members are able to express their emotions in a safe and understanding environment.

The *fourth* stage of challenge and change is a stage of growth for women. In this stage, the challenge is to be able to engage in and negotiate conflict without sacrificing the bonds of empathy and connection (Schiller, 1997). In the infertility group, women have gained the tools (e.g., safety, connection, respect, empathy, recognition of difference, and mutual empathy) that are used to work through conflict. The role of the counselor is to encourage the group members to maintain their connection through their expression of feelings. In this effort, confrontation or disagreeing does not necessarily mean destroying the relationship (Schiller, 1997). Because there are a myriad of emotions that are part of the crisis of infertility, it is to be expected that some of these emotions will cause conflict within the group setting. However, tools gained in the group process can allow for confrontation of these feelings as they relate to thoughts and beliefs of women within the group.

Couples counseling. Similar to group counseling, an important first step in counseling the infertile couple is to form a relational base that helps couples stay focused on their relationship and not their individual selves as more powerful, more in control, or more to blame (Bergman & Surrey, 1994). With the infertile couple, this can be challenging if responsibility has been accepted or given to one or the other for being infertile. Usually, the woman is the "responsible" one. Therefore, the focus of the counselor is to help the couple describe themselves as a more positive "we" than when they came into therapy as a separate "he" and "she." The counselor can help this process by introducing the concepts of connection and disconnection to help the couple describe difficulties they have experienced in relating to each other during the infertility experience. The use of this language prevents the use of terms that encourage disconnection. Beginning to see themselves as "we," the infertile couple can alleviate the guilt one or both partners have felt when infertility was diagnosed.

The second step is the counselor helping the couple to move toward a mutually empathic connection with each other (Bergman & Surrey, 1994). The counselor will do this

by modeling mutual empathy during the therapy sessions. Actively encouraging the infertile woman to express her feelings, thoughts, and beliefs about her experience with infertility will allow the counselor to recognize these in counseling. As the counselor recognizes, responds with empathy, and openly exhibits respect for the woman, the counselor is modeling this process for the infertile woman's partner. In the process, the infertile woman is feeling validated for her experience and is empowered to contribute more of herself in the therapeutic relationship. She is receiving something she has not received before, and her partner is a witness to it. This process of empathy and connection is encouraged between the couple and is continually guided by the counselor.

The third step in counseling couples is to not allow the woman to be burdened by the responsibility to be empathic in the relationship (Bergman & Surrey, 1994). The infertile woman wants to connect with her partner, due to her coping style. However, she may believe that she is working alone to gain this connection. The counselor can refocus on the mutual responsibility within the couple, which relieves the woman's feelings of being burdened. By concretely focusing on the mutual responsibility of the couple, the male partner may feel as if he has been given permission to not withdraw from his feelings about infertility. He may feel as if he has been enabled to discuss them and empathize with his partner and himself.

CASE EXAMPLE: COUNSELING AN INFERTILE WOMAN USING A RELATIONAL PERSPECTIVE

Pam is a 32-year-old Caucasian woman referred to counseling by her physician. She has been married for 8 years to Bill, who is a career Army enlisted sergeant. They have been transferred three times during their marriage, preferring to live off base each time. Their current assignment resulted in a move to the local area 5 months ago. Pam has not worked during that time. Their apartment is in a community of mostly working professionals. Pam has not established friendships in the apartment complex or the broader community.

Pam first sought treatment for infertility 5 years earlier. Medical tests for Pam and Bill revealed no clear reason for the infertility. Various treatments were used during the past 5 years without a successful pregnancy. Pam took several hormones over a 2-year period to attempt to increase her chances of becoming pregnant. Her new physician suggested IVF, to which Pam and Bill agreed.

At the ART Clinic, couples seeking treatment are required to attend one session with a counselor. Pam came willingly and Bill reluctantly to this session. When asked, "How have you coped during the past 5 years with medical tests and treatments?" Bill responded, "We take care of our own problems by just doing what they (physicians) tell us to do next." He then declined to participate in counseling. Pam, on the other hand, expressed a need to continue talking with the counselor to help her cope with her feelings.

Using the Relational Model, it was apparent that Pam had become disconnected from others. Pam disclosed that she felt isolated and did not share her feelings and experiences with infertility with anyone besides her husband. Pam's husband reported that she did not need to share these feelings and experiences with anyone besides him. However, Pam reported that her husband did not respond to her in a way that made her feel like he understood what she was experiencing. He did not share his thoughts and feelings about being infertile with her. Therefore, establishing a feeling of connectedness was critical for her. The first step in intervention was to establish a relationship with her. This relationship was egalitarian and established a sense of shared power. Through the counselor's demonstrated respect and openness, Pam gained a sense of safety within the therapeutic relationship and was able to voice her feelings and concerns about infertility. The counselor reflected empathy of thoughts and feelings and shared with Pam her knowledge about infertility. The mutual empathy, or mutuality, that occurred gained Pam's trust that the relationship was one that fostered her psychological well-being.

Individual Counseling

The first step in working with Pam was to foster the development of her ability to empathize with herself. Through Pam's reports, it was evident that she empathized with her husband by attempting to understand his experiences as a man with no children. Although he did not verbally share his experience, Pam was possibly attempting to understand his experiences with infertility. Furthermore, she seemed to adopt her husband's behavior in not recognizing her emotions and thoughts in connection with her infertility experience. With this focus, Pam was encouraged to relay her experiences with infertility (e.g., thoughts, feelings, and beliefs). As previously mentioned, Pam may have believed that she deserved to feel guilty, inadequate, and depressed about her infertility status. Once these feelings were verbalized, the counselor recognized them through responsiveness and empathy. This process of recognition validated Pam's infertility experience. The counselor also conveyed a willingness to share the experiences of other clients with infertility, and Pam became aware that she was attempting to communicate her understanding of the counselor's experiences as they related to her own. In this effort, she began to understand more about herself and her need to relate to others about her experience.

The counselor also helped Pam deconstruct what society and possibly her husband have thought about women's efforts to react emotionally to infertility. Furthermore, the active deconstruction of "infertility" and how it related to Pam's identity was required. Pam recognized the pressure she had felt—to be a mother and to not hold a career outside of the home—from her family of origin, society, and her husband. She verbalized her anger and her fear about being childless in her relationships with others. The counselor validated this anger and fear, and Pam expressed a desire

to learn about how others cope with these same feelings and circumstances. She reported that she felt compelled to become more active in her learning process. Therefore, after 3 months of individual counseling, Pam was ready to join an infertility women's group using the Relational Model.

Group Counseling

The ART clinic formed a group for women experiencing infertility using the Relational Model. This group ran for an undetermined amount of time, meeting twice a month. Pam was encouraged to attend the group by her individual counselor. During the first meeting, everyone introduced themselves and gave a short history of their infertility experience. The group counselor encouraged the women to discuss their feelings about their infertility. Pam immediately recognized several similarities in the individuals who had experienced her same infertility scenario. The group counselor also recognized these similarities. Pam felt very connected to another woman who had not had a career outside of the home since her marriage due to her husband's frequent transfers within his company. Pam briefly introduced herself to this woman at the end of the meeting, and they agreed to see each other at the next meeting. Consequently, Pam and this woman developed a friendship.

During subsequent meetings, Pam recognized that she was able to trust the group enough to talk about deeper feelings concerning her experiences with infertility and with her husband. Many of the group members recognized her feelings and responded with similar feelings and experiences, which Pam recognized in return. At times, the group counselor remarked upon the mutuality of the group and the positive impact they were having on each other. Pam began to recognize that everyone in the group did not share her same feelings about infertility, but respected the feelings that they shared. At one point, Pam's close friend in the group announced that she was pregnant. Pam instantly felt disappointment for herself, but she also felt very happy for her friend because she was able to empathize with her friend about her feelings of joy and happiness.

Pam began to feel that she was truly learning more about herself and others in the group process. She had mentally tossed around the idea of attending a couple of classes at the local community college in the area of graphic design. When she proposed this to her friend in the group, she was overwhelmed with the positive response she received. However, she had her doubts about how her husband would feel about the idea.

Couples Counseling

Although we believed that couples counseling would be a necessary component for Pam's growth in her relationship with her husband, Pam's husband continued to refuse to attend couples counseling. Therefore, the following is a recommendation for counseling an infertile couple using the Relational Model. For the purpose of continuity, we use Bill and Pam's names to illustrate various points.

Based on Bill's former responses about his and Pam's experience with infertility, it would be necessary to determine if he saw infertility as "their" experience and not just "Pam's" experience. Through modeling empathy and mutuality, Bill and Pam would be encouraged to positively define the "we" in their relationship. If Bill recognized the experience as both his and Pam's experience, then Pam could be relieved of some of the guilt she was feeling about the infertility and showing any emotions related to her experience.

Bill and Pam would also be encouraged to be empathic with each other and encourage this with each other. The counselor could model this in their counseling sessions, especially as it relates to coping style differences. Bill might need "permission" from the counselor to relay his experiences, with recognition from the counselor that this is more difficult for men to do because society typically does not encourage men to express their vulnerability.

The counselor would also have to continually remind Bill and Pam about the joint responsibility of their sharing their experiences and their coping. This could be a metaphor for the joint responsibility of being a parent and the reason they are going through the in vitro fertilization process.

Counseling Outcomes

Through individual and group counseling experiences, Pam gained a better understanding of herself in her infertility experiences and other aspects of life. She felt empowered to express her feelings and share with others who were in similar situations. Pam also felt the desire to attend to and help others who were experiencing infertility. She continued to attend group sessions through the ART clinic and also attended community college courses in graphic design. Eventually, she became employed on a part-time basis through an advertising agency.

During her third cycle of in vitro fertilization, Pam (and Bill) became pregnant. This pregnancy did not carry to term. They attempted in vitro again and became pregnant during their first cycle. This pregnancy was successful, and Bill and Pam delivered a healthy 8-pound daughter. Pam and Bill separated when their daughter was 8 months old, in part, due to disagreements over Pam's career aspirations. Pam lives approximately two blocks from Bill and reconciliation is being attempted.

CONCLUSION

The Relational Model of development offers infertile women an avenue to regain a sense of control, a sense of self-worth, and a new and better way of understanding self and others. In learning the basic tenets of the model—empathy and mutuality—infertile women can validate their thoughts, feelings, and beliefs in the experience of infertility. Furthermore, they can learn to validate others with similar experiences. Essentially, the Model provides a better understanding for infertile women and teaches them a way of coping through their relationships and connections with

others. Further research is needed to determine the effectiveness of this model with various individuals and couples, including ethnic minorities for many of which collectivist orientations may already include some of the precepts of the model.

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