STORM CLOUDS ARE COMING: WAYS TO HELP COUPLES RECONSTRUCT THE CRISIS OF INFERTILITY

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ABSTRACT: This paper examines the crisis of infertility; takes into account several theoretical considerations, exploring the socially constructed cultural-historical definitions of infertility and the definitions and meanings which flow from these constructions; the family life cycle stressors which influence the couple's psychological reaction; and the mourning and grieving process of infertility. Therapeutic interventions using a constructivist theoretical framework are presented. By assisting the couple to reconstruct the crisis of infertility, over a period of time, family therapists can help couples to visualize a future in which the fertility problem plays a minor role.

The National Center for Health Statistics (NCHS) estimates that 2.4 million married couples or 8.5 percent of all married couples in the United States are infertile. The study also reported that infertility increases with age. Infertility rates rise from 2.1% between the ages 15-19 to 13.6% between ages 30-34, to 27.2% between ages 40-44. Infertility is higher among black couples, older women, and lower educated women. Approximately 31% of infertile couples seek medical treatment for their condition. Of those couples who seek treatment, most are white, older, and better educated women (Congress, 1988). Other researchers state that the estimate of 2.4 million couples is too low, because these estimates do not account for the ex-

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istence of hidden infertility (i.e., cases of infertility in women in the lower age brackets who have never had intercourse and therefore do not know their fertility status, Greil, 1991).

When couples begin to interact with the medical system, they learn medical jargon. Medically infertility is viewed as a reproductive impairment. The standard medical definition for infertility is the inability for a couple to conceive after 12 months of intercourse without contraception (Congress, 1988). Other definitions have also been used by the medical community (Congress, 1988): (1) The inability to conceive a pregnancy after a year or more of sexual relations without contraception or the inability to carry a pregnancy to a live birth (i.e., miscarriages and stillbirths); (2) The inability of a couple to achieve a first pregnancy after engaging in sexual activity without using contraceptive methods for a period of two years or longer; (3) The inability of a couple to conceive after two years of intercourse without contraception; and (4) The inability of a male and female gametes (sperm and ova) to fertilize and appropriately implant.

Infertility is also classified into primary and secondary infertility. Primary infertility occurs when a man or a woman is unable to procreate. Secondary infertility occurs in men and women who are unable to have children after having at least one biological child (Greil, 1991).

Several factors can contribute to infertility. Sexually transmitted diseases (STDs) account for 20% of infertility cases. The three most common STDs involved in infertility are gonorrhea, chlamydial trachomatis, and mycoplasmal infection. The diseases sometimes cause infertility indirectly because they often lead to pelvic inflammatory disease (PID). PID can damage or block the fallopian tubes and/or the ovaries, which often results in infertility. In men these diseases can affect semen quality or even block sperm transport. Other factors include hormonal disturbances, endometriosis (presence of cells of the uterine lining outside the uterus), and varicocele (abnormal dilation and twisting of the veins carrying blood from the testes back to the heart). In about 3-20% of infertile couples, no clinical cause can be determined (Franklin & Brockman, 1990).

CULTURAL AND HISTORICAL DEFINITIONS OF INFERTILITY

The Bible is one of the earliest sources of cultural definitions of the meaning of infertility in that it reports stories that describe ways

of viewing fertility and infertility. The often quoted saying, "*Be fruitful and multiply*", is frequently interpreted as a commandment to be fertile and produce offspring. The four matriarchs of the bible, very important women, were infertile until God *blessed* them (Afek, 1987). Rachel addressed the psychological pain of infertility when she said to God, "Give me children or I die" (Afek, 1987, p.196). The message portrayed in the Bible is that fertility is a blessed event, without which purpose for living disappears.

Infertility before the rise of the medical model was thought to be caused by supernatural forces. Explanations included ancestors' anger at the wedding ceremony; a witch's curse on the women's ovaries or man's penis; or with loose living by the woman (Greil, 1991). Treatment was just as ritualistic and spiritual. Greil (1991) describes one tribe with a matriarchal lineage in which women live with their husband and his family after they marry. Infertility was seen as the tension between the two families of origin. Tribe leaders attempted to reduce the tension between the two families in order to cure the infertility. The constructed definition here is that infertility is a "bad thing" caused by family tension.

With the rise of the medical profession in the 1800s, the constructed definitions around infertility moved from the supernatural to the scientific. Contemporary medical explanations include beliefs that later pregnancy, fewer children or no children, and less breast feeding increase a woman's lifetime exposure to estrogen which increases her chances of cancer. Pre-orgasmic women have been informed by doctors that once they become pregnant and have a child that they will increase their ability to have an orgasm. The message, however, was still the same: Having children is "good." Now, it is considered even beneficial to one's health.

Anthropological research indicates that other cultures have developed different definitions around infertility. In many societies, it is regarded as a women's problem and in some cultures a man is permitted to divorce his wife if she is infertile. Greil (1991) describes cultural differences regarding infertility: In Korea, an adoptive child is regarded as a biological child; in Truk culture, an infertile couple has the right to request the child of their sister or brother; and in Toradja, an infertile couple has the right to adopt from among other families. These cultures have developed alternative modes of attaining children when the typical biological route fails—modes which are institutionalized in the mores and folkways of the societies and, in this sense, have constructed different meaning systems around issues related to infertility.

Gender Definitions

There are also constructed gender definitions related to infertility. In American society, females typically are socialized to become a mother. While it is important not to overgeneralize these stereotypic roles for men and women, many husbands perceive infertility as a "bad break," whereas women report feelings of devastation. Often, during times of crisis women say that they want and need greater intimacy and emotional support than does their spouse. They say they feel more of a need for closeness and to talk to their spouses. Many men report that during this time they have difficulties knowing what there is to talk about. Some men may withdraw and internalize their feelings. This can lead to a distancer/pursuer relationship with the end result being an increase in marital tension during the infertility crisis.

Based on differential socialization, men and women then construct different realities. Routine interactions of everyday life continually reinforce the sense of failure and isolation of many infertile women. Every pregnant woman or child is a constant reminder to them. Movies such as, *Three Men and a Baby, Three Men and a Little Lady, Parenthood*, as well as television shows such as *Full House, Baby Talk*, and *Family Matters*, are constant reminders to couples even within the confines of their own home.

STORM CLOUDS ARE BUILDING

Physical Toll Of Infertility

Women seeking treatment for infertility usually are assigned by medical personnel to learn how to take their basal body temperature (BBT). The temperature chart shows a rise in the middle of menstrual cycle which is a predictor of ovulation. Early in infertility treatment, husbands may be required to masturbate into cups to test for sperm count. If BBT is unsuccessful and the sperm count is adequate, other techniques may be used, such as endometrial biopsy where tissue is scraped from the lining of the uterus to test for ovulation. In some cases, a hysterosalpingogram is performed to look for blockage in Fallopian tubes. A postcoital test is also sometimes performed to see if sperm survives in the cervix (Franklin & Brockman, 1990). Many couples report an insensitivity on the part of medical personnel toward the infertility problem. Mahlstedt and Johnson (1987) report an

incident in which one infertile patient finally became pregnant, only to miscarry in her third month. She went to her physician's office to get the result of her D&C. The physician appeared and across a room filled with pregnant women said, "Sorry, the lab report said it was a bad egg. Go home and try again" (p.67).

Such tests place enormous pressures on the couple. Sexuality, an area of their life once intimate, spontaneous, and private now becomes systematic, planned, and clinical, talked about by medical personnel as though they were discussing carrots and peas. These tests can create edginess, increased tension levels, monitoring of physical states to check if "she feels different," loss of erection in the male and/or sexual desire, and depression when the woman begins menstruating.

Emotional Toll Of Infertility

Each month when the woman starts menstruating the couple may experience a deep sense of loss—a loss of the fantasized pregnancy. As time goes by, this sense of loss deepens, and many couples report that their hope seems to fade. They go through life as though there is a dark cloud above their heads and experience a feeling of impending doom. When they are eventually told by medical personnel that there is a strong chance of infertility, their worst fears become realized. Many report severe physiological reactions at this time such as nausea or dry heaving, heart palpitations or tightness in the chest, feelings of faintness. Some say they wish they could cry but somehow cannot.

The major emotional toll is a deep sense of loss. This can include in some persons a loss of self-esteem (due to feelings of failure to become pregnant); sexual identity issues (in some caused by a failure to perform sexually with their partner); and feelings of loss of control over one's life and goals (feelings that unexpected events will occur for the rest of their lives), loss of privacy (due to intrusive medical procedures for both men and women), the loss of important relationships, loss of security, loss of important fantasies (raising a family), and the loss of the hope to parent a biological child (Mahlstedt & Johnson, 1987).

Other major feelings that the couple experience are those of shame, stigmatization, feelings of deviance, and fear of being labeled a failure. There can be feelings of guilt and a sense of being punished. Some couples think that God must be punishing them for something bad that they did. As a result, some couples may withdraw and expe-

rience isolation. There is a norm in our society which supports not talking about crises, so that many feelings never get expressed, and the families of these couples often "pretend" that everything is fine. Greil (1991) listed responses that were given by friends and family of infertile couples. They downplayed the importance of children. Typical responses were, "You will be happier without children," "You're young," "I know exactly how you feel," "It is the will of God," and "You shouldn't feel that way when you have so much to be grateful for," (Covington, 1987; Mahlstedt & Johnson, 1987). In many couples, there is also a sense of anger: anger at parents with dirty children or children who are not dressed nicely; anger at reports of child abuse, and anger at those women who choose abortion (Mahlstedt & Johnson, 1987).

In addition to major feelings of loss, couples may experience feelings of being overwhelmed with medical appointments, support groups, monthly disappointment, and friends calling to tell their good news (pregnancy). Greil (1991) reported that often infertile women saw infertility as being all-consuming and devastating.

MOURNING AND GRIEVING PROCESS OF INFERTILITY

At the point at which the major emotional feeling experienced by infertile couples is loss, the storm clouds are here. Couples generally follow similar patterns of mourning and grieving to those of people who lose significant persons in their life through death. The loss here though is of their unborn child. Conway and Valentine (1987) list nine losses associated with infertility: (1) lost fantasies about being a family; (2) the loss of genetic continuity; (3) the loss of one's self-image as a fertile person; (4) the loss of the successful pregnancy and birth experience; (5) the loss of the opportunity for breast-feeding; (6) the loss of the opportunity to move to the next stage in the family life cycle; (7) relationship losses; (8) the loss of the parenting experience; and (9) the loss experienced by other family members such as potential grandparents.

Afek (1987) defines eight stages of the mourning process for infertile couples. For purposes of brevity, in the present paper, these stages have been combined into four distinct stages. Because of individual differences and the gender issues involved, the partners may be at different stages of the grieving process at different times.

Stage 1. Disbelief and Denial

For the couple, learning about the infertility is a major shock and jolt to their belief system. This stage of the emotional grieving process, disbelief and denial, is mainly manifested by shock. During this shock, the couple can experience relief (that they finally know), numbness (because the feelings are too overwhelming), or panic (at the reality of the news). Relief is often felt when the infertility testing has been an extended, drawn-out process. A typical reaction to the news of infertility is fear of abandonment by the spouse who is infertile. The belief state associated with this fear is often apprehensiveness and anxiety.

These anxious feelings may be accompanied by disturbances of sleep or appetite patterns. If there are increases in food intake and decreases in number of hours spent sleeping, the person usually experiences anxiety. Decreases in food intake and increases in time spent sleeping probably are related to depression. In any case, both symptoms are indications of shock. Often, during this time individuals will report that they are unable to concentrate on work activity or carry on conversations with people. Many individuals experience feelings of numbness or the absence of feelings. Numbness is a way of muting or denying feelings which, if experienced, would be too overwhelming for the individual to handle.

In the initial stages of the infertility grieving process, denial may occur. This may be beneficial in that it keeps the person from experiencing intense emotional feelings for which he or she is generally unprepared. This denial is usually temporary. At this time it is important for the couple to communicate and express feelings to each other.

Stage 2. Anxiety, Anger, and Feelings of Loss of Control

At this stage, individuals may experience sudden outbursts of tears or anger. Some persons report that they often lose control of their anger and, for what later seems to them to be an insignificant reason, explode into sudden flashes of rage. This is a response to the helplessness and loss of control felt by both the husband and wife. Here the partners experience intense emotional swings. They feel as if they are on an emotional roller coaster, alternating between calm acceptance of emotions and emotional discharge. The only thing that is predictable in this stage is the unpredictability of feelings.

Feelings of disorganization may occur. One day there may be a sense that the entire world has turned upside down; the next day persons may feel perfectly comfortable with the possibility of their new found freedom. Volatile, explosive emotions may surface unexpectedly. Individuals in this stage typically feel like they may fall apart at any time.

Feelings of guilt and anger become strong. Often these strong feelings are directed toward the spouse. Persons may feel enraged at their spouse and then, a few hours later, feel ashamed and guilty about their angry feelings. They may experience periods of anger at themselves and their spouse for having failed at conceiving. Along with these feelings they may also ponder if they should stay with their spouse. At times there may be feelings of regret for having married in the first place. Such feelings usually come in waves and may catch the person off-guard. This stage is typified by conflicting emotions: At any given time the individual cannot predict which feelings he or she will be experiencing.

Also during this second stage of the infertility grieving process, the individuals may do scanning. They reminisce about how hard they tried to become pregnant, who was to blame, what their own role was in the failure, how they handled it. If the person has at any time had an abortion or taken birth control pills, the anger that they experience may be intensified in that they may feel that perhaps there was a chance at one time to have a child. It also means that they are reliving the best times in the marriage and the worst in mourning the loss of the possibility for a child. This review process may continue for months and be a major contributing factor to the mood swings the grieving person experiences. Each memory, each hope, and each new disappointment causes the person to feel different emotions. This process, although emotionally uncomfortable, enables individuals to release their pent-up feelings which might otherwise cause them much distress at later points in their lives.

During this stage of emotional upheaval, the sense of loss may deepen and loneliness at the possibility of never having a child may develop. The loneliness manifests itself in many ways. Some individuals may sit in front of the television set for hours. Gradually, they may withdraw from social contacts. Others may experience a more active type of loneliness. Instead of sitting at home, they may frequent parks where there are a lot of children, look in the children's departments of stores, watch children playing, look at pregnant women, watch parents with their children. Some persons will do volunteer

work with children at hospitals or orphanages. Others will work in day care centers or nursery schools. Still others will go back to school for a teaching certificate so that they could work in the schools.

Although individuals at this point typically experience strong emotional swings, at times they may experience periods of calm. Some couples report that at this stage there are times when they feel a sense of relief, increased personal freedom, newly gained competence, and a reinvestment of emotional energy in the marriage. These positive feelings tend to appear suddenly and for no apparent reason, causing the person to feel "on top of the world" or at least "normal" again. These happy feelings may last for days or weeks. The danger during this phase is that the person may think that the worst is over, only to suddenly plunge into the depths of depression. In sum, for most people this stage represents an emotional see-saw, characterized mainly by psychological unpredictability.

Stage 3. Isolation, Alienation, Guilt, Low Self-Esteem, Grief, and Depression

Stage 3 involves changes in the couple's identity. In many ways this is the most psychologically stressful aspect of the grieving process. Being a mother or a father is a primary source of self-identity. The two individuals involved construct identities about who they are and where and how they fit into the world and construct social definitions consonant with the social definition of marriage and family. They also construct anticipatory identities—how they will be as a mother, a father. When they learn they will not have a biological child, they may feel confused and fearful, as though they no longer have a script telling them how to behave. Their constructions have been pulled out from under them.

Often during this period they may try on different identities, attempting to find one that is comfortable for them. At this time the grieving couple face a major change in self-perception. Instead of being a father, a man may find himself visualizing a future without a family. Instead of being a mother, a woman may find herself feeling alone, not knowing how to plan her life as a wife.

The emotional task for the person at this stage involves making the psychological transition from expecting to be a parent to the realization and acceptance of the fact that they will never be a biological parent. This constitutes a deconstruction of the anticipatory role of biological parent and the construction of a new identity consonant

with the infertility information which for many is psychologically the most difficult and stressful undertaking of the grieving process.

In this stage, the partners actually mourn the loss—the loss of their dreams, the loss of their child, the loss of being genetic parents, the loss of nurturing the child. Here, they reevaluate their goals and their need for parenthood. Often during this stage the marriage is reevaluated. However, it is usually not simply a reevaluation. It is a reevaluation that is laden with conflict. At one moment the couple can accept the infertility, and then one of the partners may see a child and decide to leave the marriage to seek out another relationship where pregnancy may be a possibility. It is at this stage that the couple is faced with probably the most crucial decision in the process—are they going ahead as a couple or are they going to go their separate ways? Until the decision is made, the partners cannot enter the final stage of the grieving process. It is at this point that the couple will most likely seek counseling to resolve this issue.

Stage 4. Resolution

Finally, (usually after several months, years), the person enters Stage 4. In this stage individuals typically feel a sense of relief and acceptance about their situation. If the partners have decided to remain together, they eventually start to experience a new sense of strength and accomplishment. For the most part in this stage they feel quite content with their lifestyle and no longer dwell on the fertility problem. They now have constructed a new sense of awareness and knowledge of their own needs. Many have recommitted to the marital relationship.

The most painful aspects of the grieving process peak within the first several months of knowing about the infertility and then tend to level off by the end of the first year. This, of course, varies among couples and in some cases, depending in particular on the medical testing outcomes, can last much longer. The emotional resolution of the grieving process generally occurs when the partners are no longer influenced significantly by the previously described reactions. Based on the author's clinical experience, this usually takes between two and four years.

If the partners remain a couple, they enter into the final stage of the infertility grieving process—acceptance. Acceptance can be defined in many ways. They could decide to accept the fact that they are infertile and seek to adopt a child. They could seek surrogate parent-

ing, artificial insemination, in vitro fertilization, or decide to remain childless. At this point, the partners understand the meaning of their negative experience and have a sense that this experience can lead to a sense of mastery in other areas of their lives. If they have successfully worked through the earlier stages, they will have a feeling of having done the best they could do. The crisis is over, the storm has passed, and they once again see alternatives and options for their life.

CREATING A NEW REALITY AROUND THE INFERTILITY

Constructed Perceptions

The term self-narratives has been used to describe the social psychological process whereby people tell stories about themselves to themselves and others and establish coherent connections among life events (Gergen & Gergen, 1985). By using schema in an attempt to understand life events as meaningful and systematically related, individuals render events understandable and intelligible because they are located in a sequence or as part of an unfolding process. It is this process that enables individuals to make "sense out of nonsense" and to interpret events in a coherent, consistent manner.

These narratives or belief systems are originally created by and maintained by interactions with significant others. The process begins at birth and continues until death. If a person holds a particular belief system, he or she then will seek out events and persons that are consistent with that belief system. These belief systems in turn lead to belief states, the emotional reaction to the belief system, and belief behaviors, the behaviors that are consistent with the belief system. Therefore, each person brings forth a different reality. For example, if a person has developed a belief system centered around traditional, conservative gender roles, more than likely he or she will marry someone with a similar belief system because his or her belief state will be uncomfortable with the more liberal roles. His or her belief behaviors will be manifested as the wife not working while rearing children, and so on. As long as both marital partners define the situation similarly, few problems will arise.

Dissonance occurs when inconsistency is introduced into any one of these junctures (Festinger, 1957). For example, if the wife in the situation described above decided to have unprotected sexual intercourse in order to become pregnant (belief behavior), was pleased

with the decision (belief state), and after a few months had not become pregnant, inconsistency or new information would have been introduced via her belief system and dissonance would then exist. If the partners are not able to "take in" this new information, decide to go for therapy and learn, after many months of arguing about this issue, that there are times when they both actually like the freedom of not having children, inconsistency is thus introduced, and the possibility for change in their belief system occurs.

The view presented here is based on a social constructivist framework. Constructivists believe that how we know what we know is not through an exact pictorial duplication of the world, "the map is not the territory." Rather, reality is seen experientially, in terms of how we subjectively interpret the constructions (von Glaserfeld, 1979). In this sense we are responsible for what we believe, feel, and do. What this means is that our story of the world and how it works is not the world, although we behave as though it is. Our experiencing of the world is limited to our description of it. Using language is action, and it is through "languaging" in therapy that persons define and experience reality. It is therefore through languaging in therapy that an environment conducive to change is created.

It is helpful for the family therapist to view the crisis from a constructivist framework in order to understand what the partners are experiencing and to co-create with them the possibility for a new view. When the couple come for therapy they will already have constructed their own reality about the problem, on a couple level and on an individual level. The goal of therapy, therefore, is to help couples, separately and as a couple to deconstruct the fertility crisis, to move to the acceptance stage, and then, through languaging with the couple, to help them to construct a new reality around their marriage and children.

Acknowledge the Crisis of Infertility

Therapists can help couples deal with several main constructions that they typically bring to the session. They can communicate their understanding of the importance of the couple's feelings of loss of control over their life goals, and they can explore with the couple their reasons as to why they perceive they have no control over other aspects of their life. Therapists can be aware of the client's belief state. They can help the client to express anger, sadness, and helplessness. The therapist, in collaboration with the couple, can assess which

stage(s) they are at in the mourning/grieving process. The therapist can ask the couple about their support structure and help them to mobilize their network of friends and relatives in assisting them to seek out resources. The therapist can also look for coping strategies that the couples currently employ. They can notice when clients have *too* much support. If couples become too dependent, they may compromise their own ability to grow and survive on their own. Here the therapist can assist the couple by teaching assertiveness, coping, and communication skills.

Assist The Couple With Communication Skills

Couples who come to therapy in times of crisis may have difficulties communicating their feelings to each other. For example, (1) Therapists can help couples use "I" statements. "You" statements are usually followed by criticism or blame. Instead of saying, "You don't care about our problem," help the client to say, "I felt hurt when you canceled the doctor's appointment for the sperm analysis. I felt like it was unimportant to you;" (2) Provide information to couples around the use of mirroring or reflective techniques. Assist the couple in listening to their partner and reflecting or mirroring back what s/he said. This avoids problematic communications such as talking simultaneously or not listening and instead planning a rejoiner. Mirroring and reflecting helps the sender to feel heard and validated; (3) Encourage couples to assert their needs to their friends and families. Help the couple to express their feelings to each other and help them role play expressing their feelings to significant others. For example, while they may like to be invited to niece's and nephew's birthday parties and baby showers, they may need help verbalizing that there may be times when they feel too uncomfortable to attend and may have to cancel at the last minute (the woman may have just been through a strenuous medical procedure or she may begin her menstrual cycle which confirms her infertility).

Provide Couples With Psychoeducation

We believe that the therapist can help the couple change their construction of the crisis of infertility by giving them factual information to displace myths that influence their belief systems. Information about specific medical procedures, the likelihood of becoming pregnant during these procedures, what questions to ask the medical doc-

tors, and a list of referrals to medical personnel or clinics that have high success rates can be useful. For example, RESOLVE is an international organization that helps couples change their meaning systems around infertility by giving information about the latest advances in the medical field, talking to other infertile couples who are all experiencing the same agony and tension, thereby lessening the isolation felt by these couples. These all help the couples be prepared for their ordeal as well as teach them coping skills. It also helps the couple to seek information and support networks. Finally, information assists the couple in formulating a plan of action.

Use Metaphors To Describe The Crisis

Our concepts of reality are influenced by our language, and our language is grounded in metaphor. A metaphor can also be seen as a model for changing the way we see the world (for a description of therapeutic metaphors, see Atwood & Levine, 1990; Atwood & Levine, 1991). Using a metaphor for infertility can be instructive for couples in viewing their problem. For example, a storm metaphor can be used. At first glance, the home (marital couple) appears intact, similar to many other homes (marriages) in the neighborhood. Homes in general have many expected tasks that occur over time (horizontal life cycle events) such as painting, common repairs, and adding extensions (children). Minor storms may strike the home, but usually any damage caused is easily repaired (minor marital arguments). Infertility, on the other hand, is similar to an approaching hurricane. The couple sense that there is a danger nearby (they have been unable to conceive for months). They feel an impending sense of doom as the storm clouds hang over their heads. They do not want to look up—to see the clouds. They try to pretend the sun is still out. Finally, the full force of the storm hits; the couple have been told by the doctor that they are infertile. If the home has been properly reinforced (good coping and communication skills), it (marriage) can survive and adapt to the storm. If, however, the home does not have a good foundation, it can experience extensive irreparable damage.

Infertility can threaten the very structure of the home. When a house (marital unit) is shaken, the first step is to put up support beams so that the house (marital unit) does not collapse. Effective communication techniques are support beams that help the couple begin to put their home (marital unit) back together. Couples usually seek out therapy in the midst of the storm (crisis). In therapy, the

therapist and the couple can assess the underlying structure of the home (diagnosis and assessment of the marital couple) and co-create ways for it to be strengthened (the couple survive the infertility crisis). If the home can be strengthened and reinforced, then the couple relationship will survive.

Using this metaphor, the family therapist is similar to a general contractor. He or she cannot rebuild the home; only the couple can do that. What the family therapist can do is help the couple reinforce their home (coping skills, communication skills) to get through the storm, and eventually help them to reconstruct a new home (reality). If successful, this home (marital unit) will be significantly stronger than it was prior to the storm. Through questioning and the use of the storm metaphor, the therapist can help the couple re-construct their belief system. Some relevant questions are: "How can you shrink the storm clouds, make them less important? What reinforcements can you use to strengthen your home? How can each of you strengthen the structure? If you weathered the storm, what would your relationship look like?"

Help The Couple Explore The Effects Of The Problem

It is useful for the couple to focus on the effects of the problem rather than specifically focusing on the content of the problem (Durrant, 1991). As this is done, the problem begins to be located external to the couple. They begin to see themselves not as "having" infertility; but rather, as the problem having negative effects for the marriage. Questions such as, "How has this problem influenced your relationship? How has it influenced your relationship with your friends? Family? What was your relationship like before the problem was there? How was your relationship different? What was different about your relationship when the problem was not there?" are useful.

Help Couples To Externalize The Problem

The idea of "externalizing the problem" (White, 1985, 1989) provides a form of metaphor that may offer an alternate frame to that held by the couples. In contrast to the couple's view of the infertility as part of them, an externalized description would propose it as something separate from them. Beginning with the couple's meaning system and their definition of themselves as infertile, the therapy gradually moves to the definition of them as a couple with a fertility

problem. Use the client's own language in creating the foundation for the externalization of the problem—and what is most important in this process that seeks to build an externalized description is that the language must fit both the therapist's style and the couple's experience.

Once the couple's infertility becomes a fertility problem, the new frame generally unsettles their previous, all encompassing way of seeing their situation and may open the possibility for them to feel as if they have some control over their lives. At this point, the partners usually accept the externalization of the problem and begin to join with the therapist in a different construction of the problem. The new information that they are not dominated by the infertility problem challenges their belief system and introduces the possibility of behaving differently. Once the therapist has helped the couple change their self-definition from an infertile couple to a couple who have a fertility problem, the problem has been externalized. By externalizing the problem, neither partner is viewed as responsible for the infertility. In addition, the therapist can help the couple to see differences between what they can control and cannot control, can assist them in seeing exceptions where they do have control over events in their lives, help them not to overvalue uncontrollable life events, help them to increase attainable goals, and assist them in talking about "the fertility problem" with friends and relatives where appropriate. This will give them a sense that the problem is not within them but something external that has its own identity.

Help The Couple See Exceptions Or Alternative Rewards

Change of belief systems requires a two-sided perspective, and a therapist may seek to construct a relational definition by developing two (or complementary) descriptions of the problem. White's (1985) notion of exceptions was originally based on Bateson's ideas of restraint—those ideas, events, experiences that are less likely to be noticed by persons because they are dissonant with individuals' description of the problem. "Exceptions are those bits of experiences, behavior, interaction, or self-perception which serve to challenge the dominant description" (Durrant, 1991, p.6). White (1985) believes that as a couple's definition of reality is challenged through questioning about these exceptions, that couples ultimately come to recognize other aspects of their reality that do not involve the problem. In so doing they create another story about their lives, a second story, that

does not include the problem. In the uncertainty that now exists between the two descriptions or frames, information has been introduced that suggests different roles for the couple. "Is it true that you *always* think about the infertility? "Is there *never* a time when infertility is not in control? Was the infertility *ever* under control? How often was infertility under control?" When individuals become aware of occasions when the problem does not have control over them, they then demonstrate some influence over the problem.

With couples who are experiencing a fertility problem, it is generally helpful for the therapist to help the couple look for alternative rewards. This can include the benefits of childlessness, travel, adoption, artificial insemination by husband (AIH), or artificial insemination by a donor (AID), In Vitro Fertilization (IVF), concentrating on careers, having a close marriage, helping other infertile couples in their crisis, working or doing volunteer activities with children.

Help The Couple Amplify A New Reality

The amplification of the exception is essential. "When you are not thinking about the fertility problem, how is your relationship? If you were to enjoy your relationship more frequently, the way you used to before the problem, how would you notice? How else would you notice?" Anderson and Gollishian (1988) see therapy as a process of expanding and saying the unsaid and the development of dialogue or language through new themes, narratives, and finally a new history. The goal of such therapy is to assist the couple in deconstructing the crisis of infertility by assisting the couple to not see it as an all encompassing, devastating problem. At the same time, ther therapist helps the couple to construct a view of their life in which the "problem" plays a minimal part.

Prigogine and Stengers (1984) describe the building of a termite nest in which a small fluctuation (slightly more hormone) caused more termites to drop their pieces of dirt on the hormone, eventually resulting in the building of the pillar. This can be applied here to show how a small exception (fluctuation) can create an alternative definition about the potential of the relationship.

The Future: New Possibilities And Fresh Starts

Future focus enables the couple to focus on a future where the problem plays a much smaller part in their lives. It helps the couple

to visualize a more positive relationship once again. "If the both of you projected yourselves three years into the future and the fertility problem now played a minor part in your lives, what would your lives be like? How would your relationship be different? How would your relationship with friends, families be different?" At the end of the therapy, a ritual for a "fresh start" may be suggested. At this time, the couple can choose a date when they begin their lives with the problem much smaller than it was when they entered therapy. They can write out what kind of a relationship they would like to have. They can talk about creating a new marriage. They can redo their commitment to each other. They can create their own new story about their future.

SUMMARY

This paper explored the crisis of infertility, taking into account constructed cultural and historical definitions from which flow definitions and meanings of infertility. The family life cycle point of view was also explored, illustrating the pressures experienced by these couples. The couple's actual experience of the infertility crisis was presented, focusing on the stages of the infertility grieving process. Therapeutic interventions grounded in a constructivist framework were then presented in which the goal was to assist the couple in visualizing a future in which the "problem" had minimal effects on their relationship.

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