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In this issue

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All submissions are sub-edited to newsletter standards.

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Opinions expressed in this newsletter are not necessarily those held by AAIMHI.

WHEN DOES A BABY BEGIN?
THE EXPERIENCE OF INFERTILITY AND IVF AND WHAT THIS MIGHT MEAN FOR THE PARENT/INFANT RELATIONSHIP

Karen Potter

This paper is a reflection on my experience of working in an IVF clinic using ideas from infant development, psychodynamic and attachment theories.

First, a brief explanation of how in vitro fertilisation (IVF) operates in Victoria. In order to receive IVF treatment a couple or individual woman has to be diagnosed as 'infertile' which means there has to be a medical reason. These medical reasons are: a woman being 40 years old or over; if there is any problem with either male or female reproductive systems; or if a couple have been having unprotected sex for a year or over and have not conceived (this may be reduced to six months if the woman is over 38 years). There are now also more and more couples coming to IVF in their 20s and early 30s after trying for a year or two and not conceiving. What often happens for these couples is that they eventually have tests done and discover there is some medical problem which they are told will reduce their chances of conceiving naturally and that it may take a long time or it may not ever happen. Sometimes, the couple find there are no medical problems and this is known as 'unexplained infertility'. The first consultation is with an IVF specialist who determines the diagnoses and decides on a treatment cycle. A lot of couples come to IVF because they believe it to be the answer and that it will and can 'make' them pregnant and give them the baby they want. These couples often feel shocked and disappointed when they come to understand that there are no guarantees, there are factors which are said to increase the probability of conceiving (age of the woman is the main one and/or a sperm problem) but still no one can say definitively. And, it can take a very long time. The reality is that across the board only about 25% of all couples who do IVF end up with a baby, no matter what the reason.

Working in such a highly medically advanced area around couples having babies was very interesting and rewarding as well as being ethically and personally challenging. I thought it would be a lot less distressing and disturbing for me than neonatal intensive care because these were adults making informed choices about medical intervention. And it was, to a certain degree, at least I wasn't witnessing actual miniature babies in distress. But, I found the level of medical intervention, how quickly I thought some couples were moved to IVF, the drug treatment and the use of donors, in terms of how quickly this was offered as the next step and the lack of careful thought and consideration about it, disturbing, invasive and premature. Also, the boundaries around everything constantly shifted and varied between doc-

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tors and over time in terms of what the maximum age limit was for doing IVF using your own eggs or for freezing eggs, the maximum age for a single woman using clinic-recruited donor sperm, how young or old an egg donor could be and the relationship of the donor to the recipient. Despite this, I learnt a great deal from my experience and feel very strongly about the importance of counselling in this area, so much so that I am still working in the field providing counselling for patients in NSW.

As a counsellor at an IVF clinic my role was: to see couples and individuals for new patient (NP) appointments and counselling. NP appointments involved going through consent forms and exchanging information. I explained my role and availability and they told me their story in terms of how they came to be at IVF and how they were feeling at this point. The bulk of these NP appointments were with heterosexual couples doing IVF using their own eggs and sperm. But I also saw lesbian and heterosexual couples using donor sperm and/or eggs, women wanting to freeze eggs and single women (over 40 years) wanting to use clinic-recruited donor sperm. In terms of counselling, people could come before, during and after treatment for about six months of weekly sessions then there would be either a referral (if there hadn't been one earlier) or tapering off to monthly. For those who did present for counselling, there were some main reasons they came, these were: because they were seeing one of the IVF specialists and were not conceiving naturally and wanted to discuss their situation and options; they were currently having IVF treatment and were not successful in becoming pregnant; or they were near to, or at the end of, treatment and wanting to discuss what to do next, of either continuing with IVF treatment, using a donor, adoption or just finishing treatment and remaining childless.

Very few couples accessed counselling who had become pregnant and even fewer again if there was a birth. My thoughts about why this might have been the case are that for many couples IVF was seen as a medical process of trying to achieve a pregnancy and once this occurred they didn't come back to the IVF clinic unless they wanted another pregnancy. I also think, from my experience in both IVF and neonatal intensive care, that in general, many people when actually going through a very emotional experience do not want to open up and explore their thoughts and feelings during that time. What then can happen, from what I have heard anecdotally from maternal and child health nurses is that later on, after the baby is born and goes home, what was experienced earlier arises for the mother which can often cause difficulties in her relationship with her baby, within herself and/or with her partner.

The majority of those who came voluntarily for counselling were women. Some came just to be 'fixed'; like IVF itself, they wanted the counsellor to take their feelings away or to do something to make things work out for them and so stop the waiting, uncertainty, anxiety, despair and frustrations. When they realised this wasn't going to happen sometimes they didn't come back and for some if they did it would often be only when very distressed again. One experience of this was a woman saying to me that she came in so I could stop her feeling disappointed, frustrated and anxious and to give her strategies she could do at home to stop these feelings. She then literally walked out of the counselling room after I tried to explore what was happening and explained to her what I could offer.

The question of "when does a baby begin" which I first came across in the Graduate Diploma in Infant & Parent Mental Health really came to life for me and many questions came to mind whilst I sat and listened to the stories from couples about their experiences, feelings and thoughts leading up to IVF. Some of these questions included: what type of relationship was being created between the mother and the imagined baby and would this have an impact on the actual relationship if there was a baby born? Why was this couple unable to conceive naturally, aside from the medical factors, if there were any - what might be the psychological and emotional issues that could be playing a part? What did a baby mean for this couple and what did it mean to not be able to naturally create a baby and to have to think about the possibility of it not happening? What is it that this couple is trying to conceive? What is it that's wanted? Why does it feel so crucial for many couples to have a baby? It was very interesting to think about these questions and to try and understand the baby, the relationships and the drive in the minds of a couple who had not yet been able to conceive and were coming to a clinic for help. I will offer some of my thoughts about these questions as I go along.

It might be helpful to begin by having in mind what the birth of a child can mean for a relationship. Susan Lugton (1994) states that the birth of a child is an important developmental event in a couple's relationship; it is something the couple creates together but someone separate from them who one day may find their own partner and marry. This developmental event can be a crisis in a marriage as there are feelings, ideas and beliefs that come up for both partners from their own childhood experiences with their mothers that can be difficult for the relationship to contain (Lugton, 1994). Bibring (1959) refers to this phase as a maturational crisis and that what comes up for women during this phase is a "testing ground for psychological health" comparable to the maturational crises of adolescence and menopause. Mastery of this crisis is seen as the achievement of motherhood. When we think about couples not conceiving naturally and coming to IVF, perhaps for some of them

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this developmental transition is very scary and isn't one they're ready for yet and feel very ambivalent about. Also, I found George Christie's ideas extremely helpful to keep in mind when listening to these stories as well as the findings from the work he and Anne Morgan did with couples who had unexplained or relatively unexplained infertility. George Christie (1998) talked about these particular couples as an environment that is not ready yet for a baby to come. This environment might be some intra-psychic conflict, or interpersonal or psychosocial problem that is rendering the time unsuitable for a baby to come.

One of the interesting statements heard from women in their NP appointment was, "I knew we would need IVF, I don't know why but I just knew it". Some said they felt they would need some help otherwise it wouldn't happen. Did it mean she had some idea (perhaps unconsciously) that there was something within her, her partner, their relationship or externally that was blocking or preventing a baby from coming? Did she feel that a new and separate life could not be created and developed within her, or within their relationship on their own, that they would need someone else to do something that she, he and/or they couldn't? Was this feeling or 'knowing' a message from the unconscious to let her know that there is something that needs addressing, which needs the help of someone else, outside the relationship? I thought to myself that these women know at some level that there is a problem somewhere and even though medical factors are often found and they are seen as the whole reason. I think there is more to it than that. I often thought that many of the medical factors might have some psychological origins, at least in part. A very interesting experience I had in my first weeks at the IVF clinic was when I was shown through the laboratory by an embryologist, she was telling me about a procedure called ICSI whereby the sperm is injected directly into the egg (either because of a problem with the sperm and/or the egg). The embryologist stated that sometimes the sperm looks like it is literally holding onto the walls of the syringe, not wanting to come out and it takes a lot of pressure for them to get it out and into the egg. I thought this was extremely interesting given the reason for the procedure in the first place – here is the sperm still not wanting to penetrate the egg!

At times, as some couples or women told their stories of the history leading up to IVF it appeared clear why a baby had not yet been conceived. I remember one woman who stated that just as they began trying her father died and then later her partner's father died. She told me she was very close to her father and she had been devastated and didn't think she'd grieved it properly yet. Her husband also stated that his father's death had been a huge shock. When I heard this I thought of course you haven't yet conceived there is still a lot of grief, emotions and potentially conflictual feelings tied up in these deaths that have not yet been expressed and processed. How could there be any room psychologically and emotionally for a baby to come yet? I offered counselling for the losses but unfortunately it was not taken up and I don't know if they ended up conceiving or not in my time with the clinic.

Another woman came to see me for counselling after a few years of trying whose nephew had, around the time they began trying to conceive, disclosed horrific sexual abuse by the father. My client was very involved in the situation and very close to her sister and nephew and extremely distressed, angry and scared. She felt very afraid for her nephew and it raised in her the dangers for children in general and their vulnerability. Also, my client had always been like a parent to this sister as well as other younger siblings and this responsibility was given to her by her mother at a very early age – something she stated she felt resentful of. She elaborated further with this saying it was because of this it took her such a long time to want children of her own. Unfortunately, this woman stopped coming in to see me as well as the IVF clinic. In the few sessions we had, we did have an opportunity to explore these things a little and she was able to acknowledge that perhaps the trauma of what was happening in her life now and the issues she carried from her childhood might have been contributing to her not falling pregnant.

Some women talked of long, extensive histories of wanting, longing, fantasising and imagining their baby, of being a mother and having a family, sometimes dating back into their childhood and adolescence. In these stories there was often no stated ambivalence, no uncertainty and no anxieties about being a mother and having a baby. The want was presented as absolute. The baby seemed to have begun a long time ago and have so much invested in it; the images in mind were clear and had a lot of detail. Mostly, stories of this longing came from women, very rarely men would report these intense, long term feelings – I don't know if they generally didn't have them or did not state them. I wondered what it was that had been wanted and longed for, for so long – was it something in themselves and/or something in their relationship – some deep unmet need perhaps? Was it about a real and separate baby or was it about a fantasised idealised baby or about their own internalised infant – longing for something from her own mother, some unmet need.

It appeared for many of the women and couples I saw in counselling the relationship they had with their own mothers needed to be explored and understood. At times, initially, this relationship might be described as 'good' and 'close', but when explored in depth often uncovered deep disappointment, hostility and sadness. George Christie and others talk about this presentation in some women and state that they

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carry a deep unacknowledged ambivalence toward their mothers that often translated to the idea of a baby. George Christie and Anne Morgan stated that "ambivalence towards pregnancy is present in all of us, that is, the wish to have a baby, accompanied, at varying levels of consciousness, by a wish to prevent the baby coming, or to destroy it" (Christie & Morgan, 2003). This ambivalence is experienced not only before conception but throughout the pregnancy and after the baby is born and that in itself "does not cause infertility". Christie stated that an unconscious inhibition of fertility can often conflict with what is consciously felt and the reasons given why the couple want to conceive. Christie and Morgan (2003) state "if the hostile and fearful side of this ambivalence is disavowed, warded off from conscious awareness, and its return prevented by a defensive idealisation of the prospect of pregnancy, and an idealised image of the baby then fertility levels can fall, at least temporarily (Christie & Morgan, 2003). Other studies on infertile women with unexplained or relatively unexplained infertility frequently report on the finding that they carry "repressed hostile feelings towards their own mothers" and that this repressed hostility lead "these women to fear, subconsciously, that if they became mothers they would hate their own children and be hated by them in return" (Christie, 1998). Dinora Pines (psychoanalyst) states that most of the infertile women she had seen "have had difficult, conflicted and frustrating relationships with their mothers". She suggested that unexplained infertility for a woman means that the dual tasks of a sufficient degree of identification with her own mother's maternal function as well as a sufficient degree of separation and individuation from her had not yet been achieved. This then lead to "deep ambivalent feelings towards both her own mother and a fantasised infant" as she would be "unable to own, consciously, her underlying hostility, either towards the mother, or the fantasised infant" (Pines, in: Christie & Morgan, 2003). Pines goes on to say that these women appear to have a close relationship with their mothers in terms of frequency of contact and an intense compliance with her belief about her mother's wishes but that this is actually a defence against awareness of her hostile feelings and a genuine love for her mother.

I will give a couple of examples of this. One woman who had repeated miscarriages very early in pregnancies both naturally and with IVF, initially came in and talked of her close connection with her mother and how they talked frequently on the phone. Over time and many sessions she slowly began to say more and more about how her mother wasn't there for her, how she couldn't really talk to her and that she felt her mother wasn't really interested in what she was going through. And, later still, what began to emerge was the beginning of deep anger, frustration and disappointment from childhood toward her mother about the lack of love she felt from her and how she felt her mother was never there for her, put her down and she felt her mother was closer to her sister. A few months after our sessions ended this woman fell pregnant naturally and the last I heard she was still pregnant. I think it was her opening up, feeling understood and the exploration of her relationships with her mother and father that enabled something in her to hold the developing baby. I don't know if she went on to deliver.

Another woman had been trying to conceive for over two years and had not had a pregnancy at any point in this time. Initially, she began by talking about the closeness of her family, the love she has for her parents, how wonderful a mother she has and had as a child and how she wanted to be a mother like hers. We came to understand how difficult it is for her to know about herself and say anything negative about her family, how difficult it is for her to actually know about herself and say anything negative about anyone she is in a relationship with and how she feels very disconnected from her real feelings from the present and past. Over time what started to emerge were other scenarios from childhood, ones that she looked at and thought weren't good and where she was angry. She also just began to talk about her frustrations, disappointments and aspects about her current relationship that she felt unhappy about. Unfortunately, the therapy had to end prematurely and at that point she had not yet conceived but was feeling more relaxed about it.

Another interesting theme that came up for some women was about their focussed pursuit and determination to have a baby. With some women this appeared obsessional, where it was all that was in their minds, they were willing to do anything for it and continue trying until it happened. This could also sometimes be seen in women wanting second babies. The way the woman would talk about wanting this second baby I felt the first baby was rendered insignificant or not as important in their minds in comparison to the idea of a new baby. When reminded about the baby/child they have they would talk briefly about how wonderful he/she was but move quickly on to how much they wanted another. The reasons given were that: for some it was because the image in their minds of the family they wanted involved 2/3/4 children and so their lives felt incomplete with the child/ren they had, sometimes women stated that it was their wonderful experience with the first that made them want it again. Some couples who did not get pregnant using their own eggs and sperm would move to a donor, and then another donor and sometimes even another donor. The pursuit was relentless. Some women gave up work and devoted all their time to trying to achieve a pregnancy. This might involve: a lot of rest and relaxation (or trying to); going to different practitioners – naturopaths, Chinese medicine, massage, acupuncture; reading lots of

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books and downloading as much information as possible from the internet about ways to try and become pregnant; changing their diet and lifestyle; and wanting their partners to change theirs as well and then becoming very angry and resentful if they didn't. They would talk about it and think about it all the time. They attributed doing these things to the idea that if they did everything they could and did it 'right' and weren't 'stressed' it would happen.

Sometimes I felt overwhelmed listening to these stories. It seemed so over the top and it felt quite disturbing and scary at times as the baby seemed lost. But, it also felt very sad. These frenetic stories always left me wondering what it was really all about, what is making this woman so frenetic about a baby? What might be going on in their psychological worlds that this focussed pursuit might be covering up? Often these women appeared to struggle to really see and value what they had and to be able to sit with the possibility of having a baby with the possibility of not. Their minds seemed filled up. There seemed to be no space in mind for something new, something unknown and for something to be created or maybe for something very painful, scary or frustrating to come into it. And, even though things weren't working out the way they hoped and wanted and grief, anxiety and frustration was demonstrated, the relentlessness persisted – it couldn't seem to be let go of.

Again, George Christie (1998) offers very helpful ideas about how we might understand this. He states that an over-idealisation of pregnancy and the "frenetic need to conceive at any price" is a defence against repressed intense ambivalent feelings. Also this idealised and frenetic need to become pregnant hides a genuine "capacity to care for an infant" (Christie & Morgan, 2003). I wondered about this filling up of space in mind and whether the idea of a baby might be a way to fill this space and therefore to avoid knowing, seeing or feeling something in themselves. Maybe this intense desire and pursuit for a woman might also be about needing a baby so that she won't have to be the one feeling vulnerable, frightened, powerless, in need, uncertain and helpless. I wondered if for some of these women, wanting a baby became more about a refusal to accept and face that what they want they didn't know if they could get and that no-one knew and they could not 'do' anything to make it happen. I thought perhaps these women actually felt deeply out of control, helpless, sad and scared and that these feelings were too overwhelming, scarey or unbearable to feel, so in order to not feel them they became very focussed, controlling and wanting to believe they could do something to make it happen or that someone could. Some couples I saw talked about how in their lives they had always got what they wanted and this was the first time they had wanted something and it wasn't happening. These couples were often shocked and in disbelief that there might be something in their lives that they wanted but might not get. Usually these couples were very ordered and organised and thought they had 'done everything right' and in the 'right' way in their life. I wondered if this was a defence, a way to keep something away from the surface – something painful, shocking, messy, scarey and/or uncertain.

Some couples and women in particular (that might be because the majority of the counselling work was with women) talked about how they liked to feel in control of their lives, wanted things in order and to happen when they wanted and in the way the wanted. Trying to get pregnant and it not happening and then coming to IVF was a tremendous shock and very disappointing, despairing and frustrating. Alongside this was anxiety as things weren't happening and they didn't know if it would and they couldn't make it happen. What seemed to happen for some of these couples and/or women who came to counselling after pregnancy was that these themes of order and control continued and the anxiety that comes from this continued. It seemed very difficult for them to talk about ambivalent feelings and anxieties about being pregnant, parents and having a baby. I wondered if the unacknowledged and unspoken anxieties and ambivalence might play a part in some baby's being born prematurely – as there would be feelings that needed to be gotten rid of.

To give an example of this – one couple were considering using an egg donor – the woman stated she didn't care where the egg came from, the man stated he could not see anything emotional in what they were doing and why they had to see a counsellor. If a child was born they did not want he/she to know about how it was conceived, they would never reveal it. They wanted a donor who wasn't around and who wouldn't want contact. When asked about feelings about any of this, from both the reply was there weren't any and they looked at me with bewilderment. They seemed annoyed that they had to see a counsellor and talk. They answered the questions that were asked in a very matter-of-fact and disconnected manner and didn't elaborate. I felt bewildered, astonished and angry – what was going on here? What was this about? They wouldn't let me in at all, and I felt what I was offering was being devalued, unneeded and unwanted. They appeared not to want to connect with me or their feelings. Maybe then, I thought, they couldn't really let in a baby either, a baby full of emotions and needs. Maybe they were actually very afraid of knowing their own feelings, to feel their own needs and emotions and be aware of their mixed feelings of hostility, distress and fear.

Another couple who were also considering using an egg donor – the man talked about how he would not let any child know if there was one born, about its origins, because he believed a child

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born through this means was 'damaged' and 'dysfunctional' and would need a lot of therapy to get over it. He would not let any of his family know because he believed the child would be considered 'second class' and looked down upon. I wondered why this couple were even considering a donor, it appeared to be driven by the woman. But, when I tried to explore what was being said and further counselling offered, both minimized the comments and tried to reassure me that they did both want a baby and just wanted to get the 'paperwork' done. I didn't have enough time to explore all that was said. But, I was left feeling very concerned about this couple. Again, they were pursuing having a baby and using all means available but for both these couples their quest appeared disconnected from emotions around it, except frustration at the processes involved.

George Christie, a Melbourne-based psychoanalyst (now deceased) and Anne Morgan (a Melbourne-based psychoanalytic psychotherapist) worked with a lot of couples with unexplained or relatively unexplained infertility. They often saw the woman first for individual psychotherapy and the couple together from time to time; the male partner might then be referred to the other therapist for individual work. At a later stage some of these couples entered a therapeutic group, facilitated by George and Anne, who offered a 'sound co-therapy relationship' (Christie & Morgan, 2003). The success of these groups in terms of pregnancies for couples who attended the group was extraordinary. At the end of one group 4 out of 5 couples became pregnant – either from trying IVF for the first time or from going back to it after ceasing treatment and beginning therapeutic work. In another group they ran with four couples, three of the women conceived naturally during the life of the group and one baby was born, the other two pregnancies miscarried. The fourth woman decided against parenthood and resumed taking the pill (Christie & Morgan, 2003).

They suggested that for couples with unexplained or relatively unexplained infertility a level of maturation had not yet been reached. This maturation level involves "the capacity to take responsibility for our own lives through separating, individuating and acquiring a sound sense of self, but also an emerging ability to lose ourselves in a meeting of bodies and minds with another person" whereby "the wish to allow a baby to come becomes predominant" (Christie & Morgan, 2003). Another component of maturation in the women is the emergence of the "trigenerational object structure" which is "her internalised concepts of her own mother, of herself as a child of that mother, and of the foetus as her child" (Christie & Morgan, 2003). "If a woman isn't ready to face the maturational crisis of pregnancy, and the uncovering of deeply ambivalent feelings, her creative urges may be blocked, at least temporarily" (Christie, 1998). George and Anne suggest three things for couples with unexplained or relatively unexplained infertility that can "influence an outcome favourably" – one, is "a developing need in the individual or couple to explore their feelings and the human story that may lie behind their situation – two, is the presence of an individual therapist or co-therapy couple able to provide space and time for an analytically informed listening to the emerging material – and three, is a mutually respectful relationship and communication between the gynaecologist, his or her team and the psychotherapist or co-therapy couple" (Christie, 1998).

George Christie also talked about the socio-cultural and interpersonal aspects that might lead the 'environment' to be not ready yet for a baby to come. Interestingly, in his article he talks about studies that have shown that a population of people grows faster when the supply of food and other resources is good and that when war, poverty and other negative social factors are present population growth is slower and there are more cases of abortion, infanticide and sexual deviance (Christie, 1994). What is happening in the relationship, where both partners are at in terms of wanting to be parents and in terms of their commitment to the relationship and how they feel toward each other are all important factors to consider in understanding why a couple are not falling pregnant, and/or falling pregnant and miscarrying time and time again. I remember seeing a couple very early on when I started at the IVF clinic, they were hostile to each other in the session, and the husband clearly stated that he did not want children and did not want to do IVF and the only reason was because she wanted it. She was dismissive of him and saying she was not going to wait any longer, that she wanted a baby now and that that was it – I thought, yes, the environment is not ready yet for a baby to come!

For some women who were seen in counselling, once they did become pregnant the other side of the wanting and longing emerged – the not wanting, uncertainty and anxiety about pregnancy, being a mother and having a baby. Some talked of disliking the pregnancy, their growing and changing bodies, sleeplessness, nausea etc. and felt anxious and worried about how they would be as parents when they didn't feel they received all they needed and wanted as children by their own mothers. Some were also concerned about the impact on their individual and couple life. I thought perhaps now they were actually pregnant some women felt able to allow these thoughts and feelings into their conscious minds and to feel able to talk to someone about them. I wondered whether women who do IVF find it particularly difficult to express these feelings if they do become conscious because they feel they "should be happy now", as they have been wanting and trying for so long. For

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example, with one woman I was seeing for counselling who became pregnant she stated that she felt "bad" and "ungrateful" for feeling frustrated and disliking the pregnancy, she found it difficult even in the counselling to fully express her anxieties and concerns because she had always maintained a very strong want, desire and ability to be a mother and had gone to such lengths in order to have a baby. She began to open up about the frustrating aspects of being pregnant and her anxieties about being a mother and knowing what her baby needed and being able to respond. She didn't enjoy the early stages of pregnancy, the nausea and her swelling stomach. She was anxious about her ability and capacity to be a mother given her own experience of being mothered and the disappointment, frustration and anger she felt toward her parents for what she felt they didn't do and didn't provide. It was interesting because when I initially saw her for counselling, long before she became pregnant, she was very worried and concerned about her husband's ability to be a father, a provider and supporter of her when she did have a baby, given 'his' childhood experiences and anxieties, but was not anxious or concerned about herself – perhaps unconsciously she was actually talking about herself but unable at that time to consciously know it.

When I reflect back over all the couples and individuals I saw for ongoing counselling (as opposed to NP appointments) most of them subsequently became pregnant. I believe it was the opportunity and space to talk about their frustrations, anger, resentments, disappointment, anxiety and grief within a safe, supportive and containing environment that contributed to these couples becoming pregnant. Two women I worked with for quite some time that became pregnant wanted to show me their babies. They both felt I had helped them get to this point. George Christie talked about his clinical experience with patients and how often conception followed an "increasing capacity to retrieve negative feelings and achieve a more balanced awareness of having strong feelings both for and against allowing a baby to come" (Christie, 1998). Christie stated it very nicely when he said the counsellor/ psychotherapist "must be able to provide a setting in which the individual or couple can explore, in an unhurried way, the hidden and sometimes moving conflicts that may lie behind such an unconscious holding back from successful conception" (Christie, 1998).

Consider the different styles of attachment – secure, insecure-avoidant, insecure-ambivalent and disorganised – when it comes to a mother and her baby. Can we see these styles of attachment beginning, from the idea of the baby and the experience of trying to conceive and it not happening? Attachment is looked at in terms of separation and reunion with the attachment figure – the coming together and moving away from. In healthy, secure attachment, the feeling of security remains stable whether there is physical contact or not. I would say from this that many women who come to IVF after a long period of trying naturally have an insecure attachment with the idea of baby. Some appear cut off emotionally from their experience and resistant to letting someone in. Some focus so frenetically on it happening and don't want to think about the possibility of it not. Some shift between all positive and all negative thoughts about it and when experiencing one side the other side doesn't get in. Women who display a frenetic desire for a baby seem to be defensive which may indicate repressed hostility and anxieties. I wondered with women who had long histories of wanting a baby and had detailed fantasies and images of a baby and themselves as mothers that if a 'real' baby was born would the baby feel overwhelmed by these desires/fantasies of who they should be and would there be any room for the baby to be its own person, separate and free to explore and develop in its own unique way. Some women moved between frustration, anger and resentment to anxiety, grief and distress and back again. Some women avoided their real feelings of anxiety and ambivalence about a baby and the mother/infant relationship.

From my experience with many women and couples I did think that if they were repressing their ambivalence or were overly anxious, frustrated, disappointed and/or depressed that this might mean that they would struggle, if a baby was born, with the actual relationship with a real baby. But the research so far doesn't seem to support this. From the research that I have looked at there doesn't seem to be any indication that attachment between mothers and babies in the early stages after birth is any different for IVF families than for other families. Brazelton and Als (1979) conducted a study on primiparous women through their antenatal and postnatal experiences and found that although several women had "almost pathological proportions" of anxiety through the antenatal period later on as mothers with their babies these women did very well. They suggested that the anxiety and "distorted unconscious material had clearly become a force for reorganisation and readjustment" (Brazelton & Als, 1979). In George Christie's 1998 article he documents that others have shown how "these qualities also facilitate the emergence of a healthy relationship between mother and baby". I think further research from a psychoanalytic perspective on couples who go through IVF and the later infant/parent attachment is much needed, particularly with women who have a frenetic wish for a baby and who don't present any anxiety and ambivalence around this wish. I also think research on the use of donors would be very interesting and very informative.

The current social situation means that

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When does a baby begin? (cont.)

more and more people want things immediately and when they can't get it immediately they see that as a 'problem' that needs to be 'fixed'. A lot of people, myself included, struggle with waiting in uncertainty and don't want to. IVF is on the increase and more and more couples, single women over 40 years (at the moment but that age criteria may decrease) and lesbian couples are turning to IVF as the way to have a baby. As such, I think, it is really important to keep in mind what Petersen and Teichmann (1984) stated, that there is "a deeper level involved in the creation of a human being" and I think therefore a deeper level involved when it does not happen. There is still a lot to understand about the psychological and emotional aspects to infertility. Perhaps if we do think about it as potentially being a psychosomatic avenue for the expression of some intrapsychic, interpersonal and/or external issue as well as medical it might really help us when working in counselling with these couples to think more deeply and laterally about what is happening and why.

Counselling in IVF clinics, at the moment, is mandatory and unfortunately it is not often seen as a key component for people who choose this path. Hopefully over time counselling in IVF clinics will become much more integrated and valued in the service as a whole and seen as something important for all who choose to take this path to have a baby, through the process itself and when the use of donors is raised.

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NATIONAL NEWS

There are a couple of important conferences coming up. One is the world conference in Yokahama in August. You can register from www.waimh.org. There is a discount for members of the World Association for Infant Mental Health.

Closer to home is our own conference, 5-8 November 2008, in Adelaide. Again we will be combining with Aboriginal perinatal and infant mental health. We think this will be a really good conference for clinicians, not only because we have very exciting presenters but because we have structured the program a bit differently. Most of the invited speakers will be giving half-day workshops instead of short keynote presentations to give participants a chance to really learn from them. The theme of the conference comes from Alicia Lieberman's concept of "angels in the nursery" or benign parental influences – the emphasis is on the positive – what we can do to support the benign parental influences. (There is a link to her paper in the conference registration brochure and it is well worth reading). We will be having some submitted papers but a much bigger emphasis on poster presentations in order to give more people a chance to explore the different presentations. So encourage your colleagues including Aboriginal colleagues to submit their abstracts. And to come to the conference of course. There is a link to the conference registration brochure, including abstracts from the keynote speakers, on www.aaimhi.org

The National committee has also put in a submission to the Inquiry into paid parental leave.

And lastly, keep an eye on the website. Soon, possibly by the time you get this newsletter, there will be a new members' database on the site. This is mainly due to the vision and hard work of Victor Evatt from the NSW branch, and is finally about to appear after a very long gestation. We are very grateful to Victor as it should make life much easier for membership secretaries especially.

Pam Linke AM
National President

STATE REPORTS

Queensland

AAIMHI Qld held its second clinical seminar of the year on 22 April. Janet Rhind (psychiatrist and psychotherapist) and Robyn Purvis (social worker in private practice) facilitated a discussion around the Michael Trout DVD, "Breaking Peaces: Babies Have Their Say About Domestic Violence". (The video/DVD can be found at http://healthy-family.net/transition4.html).

This DVD provides the neonate's and infant's perspective on domestic violence. A young child narrates where appropriate and at other times printed words fill the space over still images in a harrowing portrayal of the impact of domestic violence in the earliest years and its later implications. The seminar was held in a very darkened and smallish conference room beside the hustle and bustle of labour wards at the Mater Mothers' Hospital in Brisbane – an appropriate venue in many respects.

This evening seminar was very well attended and supported. Fruitful discussion around the challenges of sitting with infant emotional pain and discussion about community responses to this pain followed the film. The work of James and Joyce Robertson in the UK in the 1950s and 1960s was raised and viewings and discussion around selected Robertson films might be offered via a series of clinical seminars later in this year.

AAIMHI National Conference 2008

5 – 8 November 2008

Hilton Hotel, Adelaide

Programme and registration now available, see

www.sapmea.asn.au/aaimh08

Victoria

This year has seen the introduction for Vic AAIMH of new directions and thinking around scientific meetings with a move to holding four half-day seminars throughout the year. The first two sessions have proved very successful, attracting increased numbers of members to the meetings and also appealed to the wider non-AAIMH therapeutic community and thereby hopefully promoting a greater understanding of the importance of the concept of infant mental health.

The first seminar –"Exploring the Territory" – dealt with the topic of inter-country adoption acknowledging that this is now the most common form of adoption in Australia, involving some 300-400 children per year. Presenters included Paul Robertson who discussed his experience of assessing and treating adopted children; Sarah Armstrong (author of *The Colour of Difference: Journeys in Trans-racial Adoption*) related the reflective experiences of young people and adults who were adopted as infants; and Barbara Mushin, Social Worker, formerly with the Intercountry Adoption Service with DHS.

Vic AAIMH members Julie Stone and Sarah Jones rounded out our morning with some examples of clinical work with children and couples. This half-day promoted our understanding of the adopted child's experience of settling with racially different adopting parents and the complexity involved for the adopting family yet also allowed thoughtful discussion regarding the experiences of any child who endures separation from a biological parent or the disruption of repeated placement and removal with foster families, as well as the importance of place and culture in the developing infant's world.

The second half-day scientific meeting – "Domestic Violence and The Infant" – was conducted as a workshop with short presentations from both researchers and clinicians, layering our understanding of the needs of babies exposed to domestic violence. Presenters included: Jeanette Webb - High Risk Infant Unit Manager DHS Child Protection Services; Sylvia Azzopardi, Senior Clinician Berry Street, Take Two; Wendy Bunston, RCH Mental Health Service - "The Peek a Boo Club: Infant/mother group work and family violence"; and again beautifully rounded out by clinical presentations from Jenny Re and Dimitra Bekos, Child Psychotherapists, Gatehouse, RCH, detailing work with a mother, her infant and her toddler as they moved on from the traumatic experience of domestic violence.

Two further seminars are planned for the ***23 August (*** Autism/Autistic Defences) *and* ***29 November (*** Where do babies come from/go to?) . Stay tuned for date, topic and venue clarification!

Advanced Course for Developmental Professionals Working in Newborn Care Units

OCCP 5070: Selected Topic, offered in Semester 2, 2008 - 6 credits
Taught by: Assoc Prof Elsie Vergara, Fulbright Senior Specialist
4 to 8 August 2008

Suited to occupational therapists, physiotherapists, and other health care professionals who work with premature infants and their families.

This course is geared toward practitioners and post graduate students seeking to gain expertise for working in neonatal care units (NCUs), particularly with prematurely-born infants. Content focuses on developmentally sensitive intervention strategies supported by scientific evidence as being effective for promoting the development of the immature brain. After examining the basic premises of developmentally- supportive, family centred neonatal care, students will learn to recognise individualised physiological and behavioural self-regulation and stress signals, as well as to respond adequately to such signals to decrease the infants' stress and optimize their self regulation and well being. Specific areas of intervention, namely environmental modulation, positioning, oral feeding, social interaction, and family support will be thoroughly explored through a variety of vignettes. Elements of effective developmental follow up programmes will be discussed. As the final course activity, students will develop intervention plans for a series of assigned case studies. Opportunities for video-based observations will be provided to practice essential observational skills such as physiological and behavioural monitoring and to help students integrate content. Assessment will be by case study.

Fulbright Award for Senior Specialist A/Prof Elsie Vergara

Elsie Vergara is Associate Professor of Occupational Therapy at Boston University and the foremost expert in Occupational Therapy and Physiotherapy practice in special care nurseries, will join the University of Sydney and Children's Hospital Westmead, for 6 weeks in Semester 2, 2008 as a Senior Specialist jointly supported by the US-based Fulbright Senior Scholars Program and the University of Sydney.

A/Prof Vergara's primary roles will be: (a) to train and mentor practitioners to provide 'best practice' in hospital special care nurseries and (b) to develop sustainable curricula to prepare University of Sydney undergraduate and postgraduate students for practice in this area. Dr. Elsie Vergara has a Bachelor of Science degree in Occupational Therapy and Physiotherapy and a master's degree in Public Health from the University of Puerto Rico. She obtained a Doctor of Science degree in Therapeutic Studies from Boston University. For her doctoral research Dr Vergara examined the effects of environmental stimuli on the physiologic and behavioural responses of preterm infants. As part of her doctoral education, she received training from neonatal scholars such as Kevin Nugent and Heidelise Als. Dr Vergara.has over 30 years experience teaching occupational and physical therapy, particularly in the area of paediatrics. She has authored a wide variety of educational materials (e.g., books, curricula, self-guided training resources, journal articles) and conducted numerous training programs in the United States and abroad for health-care personnel seeking to become neonatal interventionists.

The University of Sydney

Faculty of Health Sciences

Occupational Therapy

Cumberland Campus C42

East Street Lidcombe

ALL Enquiries: fhspginfo@usyd.edu.au. number with enquiry.

Closing date for enrolments in award courses 30th June.

Closing date for non-award single units of study will be extended to 23 July.