IoPT (Identity Oriented Psychotrauma Theory) & infertility: How and why a greater understanding of trauma can support involuntary childless women come to terms with the perspective of a life without children

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Abstract
This dissertation addresses the questions "Can Identity Oriented Psychotrauma Theory (IoPT) support involuntary childless individuals come to terms with the perspective of a life without children?" and "if so, why and how?" While there is evidence that infertility is related to PTSD and trauma and that it has devastating consequences on the affected individual's well-being (including mental and physical health) in the long term, it is not clear what happens exactly in the psyche, why not everyone is affected in the same way, and what might help. The analysis here shows how IoPT theory and practice can help understand where infertility fits within a person's traumabiography, both as a traumatizing experience in itself and connected to previous traumas. It also demonstrates the concrete benefits of one-to-one psychotherapy sessions ("self-encounters") conducted through the "intention method" (Ruppert 2020: 162-167). The arguments are based on an empirical study that involved 6 women. The author ran 2 to 3 one-to-one self-encounters with each of them (16 in total). She also conducted individuals interviews before and after the sessions (12 in total).

Introduction

Involuntary childlessness, is a growing, yet largely unknown phenomenon. On average, one woman (over 45) in five (Beaujouan et al., 2017: 4; OECD, 2015: 5) and one man in four in the Western world (Präg et al., 2017: 8) has no children. In countries like Australia, Italy, Germany or Japan, practically every fourth woman born in the 70s will end her reproductive cycle without children.[1] It is estimated that 90% or more of all individuals without children are childless as a result of infertility rather than a deliberate choice (Keizer in NWO 2010; Ruokolainen and Notkola, in Tanturri et al. 2015: 33; Rotkirch and Miettinen 2016: 15; Beaujouan et al. 2017: 4). While not having children might be related to medical problems—rarely to outright sterility (Beaujouan et al. 2017: 4)[2]—most of the time it is a case of "social infertility" (Berrington 2016: 58) or "childlessness by circumstance": life happened to be that way due to a myriad possible reasons, like the death of one's partner, having been ill during fertile years, not being able to afford assisted reproduction to name the most common (Day 2013). Alternatively, as in the case of unmarried couples, singles, and gay and lesbian couples, one can be childless through policies that might exclude one from access to fertility treatment (Sundby 2010: 179; Ethics Committee of the American Society for Reproductive Medicine 2013).

[1] According to a report by the French Institute for Demographic Studies (INED) (Beaujouan et al. 2017: 4), up to a quarter of women born in the 1970s in Southern Europe are expected to remain childless. The proportion of women aged 45 to 49 who, in 2013, lived without children was 37.15 per cent in Germany, 23.57 per cent in Italy, and 32.33 per cent in the UK (OECD 2015: 5). In Japan, the childless rate for women born in the 1970s is 27 per cent (The Economist 2017). According to a report by the Australian Institute for Health and Welfare, based on current fertility rates, 26 per cent of Australian women are expected to remain childless by the end of their reproductive life (Ford et al. 2002: 29).

[2] According to Beaujouan and her colleagues (Beaujouan et al. 2017: 4), 2 to 4 per cent of women are sterile.

Despite the extent to which the phenomenon is affecting our societies (Kassam et al., 2015; Kotkin, 2017; Shaw, forthcoming), it is shrouded in silence and largely invisible. Infertility, in fact, contrarily to what we might think, even in democratic countries that enjoy freedom of expression, is a taboo (Pfeffer & Woollett 1983: 82; Thorn 2009: 48) and a well-documented source of stigma (Miall 1985; Whiteford and Gonzalez 1995; Remennick 2000; Riessman 2000; Donkor and Sandall 2007; Nahar and van der Geest 2014; Fu et al. 2015; Yeshua-Katz 2019).

A number of studies have established a link between "infertility," "trauma" and "PTSD" (Bartlik et al. 1997; Bradow 2012, for a couple of preliminary examples). As it will be discussed more in detail later, there is convincing evidence that infertility has devastating consequences on the affected individuals' well-being, including mental and physical health, in the long term (for a couple of examples: Schwerdtfeger and Shreffler 2009; Tsigdinos 2022). Yet, it is not clear what happens exactly in the psyche of those who are experiencing infertility, particularly why not everyone is affected in the same way, and what might help. To encourage the investigation of these aspects, there have been calls for more qualitative experience-based studies. Schwerdtfeger and Shreffler (2009: 215), for instance, point out that 'research thus far has failed to address the full extent to which a woman's life [the argument, however, could also apply to a man] is impacted when dealing with the short- and long-term consequences of the "nonevent" of involuntary childlessness.' They recommend that 'future research should involve additional self-report measures, interviews, and/or observations of trauma symptomatology' (ibid.: 224) to understand the 'unique trauma-related psychological and relational consequences of reproductive problems' (ibid.). The study I present here aims to begin addressing this gap in our knowledge of the impact of infertility.

More specifically, the argument I develop in this dissertation is that there is an urgent need to treat infertility as trauma, both conceptually and from the perspective of therapeutic practice. To make a concrete start in taking infertility-as-trauma seriously the analysis I present shows how Identity Oriented Psychotrauma Theory (IoPT) theory and practice can help understand where infertility fits within a person's traumabiography (Ruppert 2020: 168-170), both as a traumatizing experience in itself and connected to previous traumas. It also demonstrates concrete benefits of one-to-one psychotherapy sessions ("self-encounters") run through the "intention method" (Ruppert 2020 K: 162-167).

IoPT is a theory, psychotherapy practice and, more broadly, a philosophy of life developed by Franz Ruppert on the basis of his research and experience as a practitioner over the last 30 years. Without getting (yet) into the detail of the theory and to provide an introduction in lay terms, IoPT places at the centre of its theory and practice the person, whatever issue or problem one is struggling with and wishes to address, and his/her biography or life experience. The latter is, effectively what the "identity" in IoPT refers to, 'the aggregate of all [one's] life experiences' (Ruppert and Banzhaf 2018: 15). The aim of the therapy is to enable the person[3] to see—*understand* through the mind but also, most importantly, *feel* in the body—what *happened* and what consequences events, relationships, influences from one's own past, from people close to us—first and foremost our parents—but also from others, perhaps from previous generations (Schwab 2010; Wolynn 2017) are having on our present.

To reflect this perspective, I want to start by briefly sketching my own history in relation to the topic of this dissertation, in other words situating myself (Rose 1997). This is important because my experience has shaped my approach, the knowledge I bring to the subject—which is both intellectual and research-based, but also embodied and based on first-hand experience—and, ultimately, colours not only my entire study, but also its conclusions.

[3] I deliberately do not use the term "client" in this dissertation to emphasize the centrality of the *human* in the process rather than the "economic subject."

Situating myself: Where I come from and why this study

I come to researching involuntary childlessness, i.e. not having children not by choice, from having a direct experience of it. About a decade ago my husband and I were diagnosed with "unexplained infertility."[4] Although we attempted fertility treatment, this failed—it does so in practically 80 per cent of cases (Tsigdinos 2022: 454). We ended our fertility journey without a child. We are still dealing with the consequences of the turmoil it brought into our lives, our relationship, and how we relate to our future. Our experience is not at all unique.

I have written *Childlessness in the age of communication: Deconstructing silence* (Archetti 2020a) to explain the reasons behind the communication blackout around infertility—something that might even look incomprehensible in an age of hypercommunication, when we think we are connected to a constant stream of information that pervades the online and offline dimension through countless electronic devices and technological platforms. In a nutshell, I developed a new theory of silence that explains how suffering and pain felt inside the body translate into a lack of voice, social exclusion, and absence from public life—I mapped, in other words, the construction of silence "from under the skin to policy." This happens through intermediate steps that involve, among others, the role of the media in the narrative construction of the body and the self and the dynamic way in which the physical and emotional states of the body (health and well-being) are both influenced by and respond to the reality (or what we perceive this to be) around us.

I also wanted to show the devastating consequences of infertility, particularly the fact that childlessness is far more than "getting or not getting the baby" and it does not stop when one "stops trying": it affects every fiber of one's being. To start with, it affects identity (Greil 1991; Hirsch and Hirsch 1995; Thorn 2009; Leon 2010; Archetti 2020a, "Folder 3 – Identity": 138-157). To unpack this point, if to be a "successful", "happy," "real" woman, as we are repeated by countless messages in the society around us, means being a mother, can a childless individual ever be "realized"? Perhaps a woman without children cannot be a "woman" at all. Not being able to have a child also leads to grief comparable to bereavement (Thorn 2009; Volgsten, Skoog Svanberg and Olsson 2010; Rosner 2012; Day 2016, esp. ch. 4, "Working through the grief of childlessness": 79-123; Day 2018; Farncombe 2018; Hooper 2018): not only has our imagined child died—indeed at every arrival of the menstrual cycle—but also our self as a parent has died, together with our imagined future as a family, our grandchildren to come, the whole world of life-milestones everyone else is going to experience and we are going to miss out on. With the difference that this bereavement might continue indefinitely because there is no body to bury and no sense of closure. Childlessness also redefines relationships: although fighting adversity can indeed strengthen bonds between people, many couples do disintegrate as result of the life crisis brought about by infertility (Kjaer et al. 2013).[5] Further to this, when being in contact with children hurts and one by one most of our friends are lost to forming "families," most childless individuals experience, over the years, increasing isolation (Wenger et al. 2000; Dykstra 2006; Dykstra and Wagner 2007). This affects our sense of belonging (or complete lack of it) in a society that revolves around parents and their children: What happens to a society when, effectively, a quarter of its population feels alienated and so many of our politicians' speeches involve references, as in the case of Norway, where I live, to the *småbarnsfamilie*r—families with small children? Childlessness, as this last point suggests, has political consequences. The taboo around infertility, in fact, means that the needs of childless individuals are never articulated in public debate. In the UK alone

[4] Despite believing, at the time, that we had to be an extremely rare case, I later learned that 15 per cent of all couples suffer from infertility (Agarwal et al. 2015: 1). 15 per cent to 30 per cent of them are affected, precisely like us, by an unexplained form of it (Quaas and Dokras 2008: 69).

[5] The referenced study, conducted by Danish researchers, found that up to 12 years following an evaluation for fertility problems, nearly 27 per cent of the women included in the investigation (a population of 47 515 women), were no longer living with the person with whom they had lived at the time of the initial evaluation (Kjaer et al. 2014: 269). In addition to this, women with fertility problems who did not succeed in having a child after the fertility evaluation had a higher likelihood of divorce (ibid.).

there will be 2 million people over 65 without adult children by 2030 (Ageing Well Without Children 2022). Even where welfare provisions exist for the assistance to those who-have-lived-long, these de facto rely on the informal care provided by close family members. In an economic context of increased cuts in public spending, a disturbing question childless communities (Facebook group "Ageing Well Without Children (AWOC) UK" is one example) are struggling with is: Who will take care of this ageing childless population? Engaging explicitly with involuntary childlessness, for all of the reasons I have only been able to hint at because of space limitations, could not be more important for the health and well-being of those directly affected and the rest of our societies.

Writing *Childlessness in the Age of Communication* I further realized that I needed a different vocabulary and register to capture the experience of infertility. There is no lack of medical research on infertility, but its scientific, neutral, in many respects *dead* language, its many statistics, conveyed nothing about the human tragedy, the physical pain and mental suffering involved in the whole *process* of not being able to have children. That is why, in that manuscript, I deliberately combined academic prose with evocative writing. The last one also covered sharing, apart from the experiences of my interviewees, also my own (Archetti 2020a: 5):

> this book is [also] the story of how my life began to fall apart, despite having moved to Norway to get my dream job, having been promoted to professor within six months of arriving in the country, being by all accounts a "successful" academic. It fell apart, piece by piece, like fragments of the arctic pack being hacked at by the sun and gradually released into the sea. A peculiar kind of tearing apart, as if reality was imploding, progressively drained of the meanings and reference points I used to know. A crumbling so slow, yet fundamental, like a shifting of life's tectonic plates, that it escapes comprehension and makes it unfeasible to get a grip on. One can clear the rubble that follows an explosion, but what do you do when there is no more solid ground, you feel you are in a free fall, and have lost your sense of direction?

Yet, even the evocative and poetic language I used, only seemed to draw the contours of a wound that, just like in the case of all the women and men I met and who are in my same situation, was cutting through me, right to the core of my soul. How could I get *beyond* the words, diving into the depth of that wound? That is what drove an initial fascination with "trauma"—whose Greek root, not by chance, means "wound" (Maté 2019).[6] "Trauma"—which I do not define now to let the reader linger in the shadow, the images, feelings, and perhaps fears, that this very term might evoke—I felt, captured the sense of catastrophic rapture, vastness of the experience I was dealing with. An experience that was both unmistakably *present* in my everyday life, weighing like a cover of lead on it, at the same time hidden, somehow unreachable, as if haunting my every thought and my every gesture from a parallel dimension. It was like an entire universe stood behind a veiled screen I could, despite its thinness, never remove. This hidden world had the power, at points, to violently intrude, into my everyday life, destroy the little safety that was left of its routines without warning and without me being able to control it, then retreat without leaving a trace. I wanted to learn more about *this,* find a way to make sense of *it*. That is what brought me to IoPT.

Most of all, I wanted to understand what happens in the psyche and why infertility is such a profoundly shattering experience. While wanting to have children is part of being human and a "natural" instinct, there are both individuals who come to terms with childlessness and who do not *want* to have children—they latter self-define as "childfree" (The Childfree Choice

[6] Ruppert (2008: 75) renders it as "injury."

2022).[7] These people appear to be content with life, even feeling empowered by their circumstances and/or choice. It struck me that so many of the involuntary childless individuals I talked to in relation to my research and whose stories I followed online wanted to go back to "being themselves." They desperately wished to be *happy*. Instead, they (like me) were stuck in *grief*, painfully so, often many years after the end of their fertility journey. Why is it so difficult to let go of the plan of having a child? Why is it so problematic, and for some not possible at all, to return to a "normal" life?

I also noticed that writing the book, being able to talk about the topic and to share my own story, had a healing effect (Archetti 2020: 247-250). However, I was not sure exactly *why*. I had somehow "re-written" my story and I had also changed as a person. What had happened precisely, not just in my mind, but also in my body and in the spectrum of my emotions? Attending the IoPT course and undergoing my own psychotherapy as part of the training I further felt the grip of grief gradually easing. I had never directly addressed the issue of childlessness in my psychotherapy sessions, yet the grief had become somehow less "relevant," my urge to avoid children less intense. Surprisingly, the world contained fewer triggers than it did before. In addressing the traumas from my past something had happened. I realized that *understanding* the nature of trauma and its *processing* were key to the puzzle. This dissertation is a first attempt at outlining what I have learned so far.

Trauma and infertility

Infertility has been connected to PTSD for at least the last 25 years. As Bartlik and others (1997) pointed out, '[w]hile commonly associated with war or natural disaster, symptoms of PTSD have been described in patients who are undergoing or who have completed infertility treatment or high-risk pregnancies' (Bradow in Rettner 2012: n.p.). Bradow has more recently also argued that the definition of PTSD, that currently requires that people have experienced or witnessed a life-threatening event, or event that could cause serious injury, should be expanded to include 'expectations of life' (Bradow in Rettner 2012: n.p.).[8] As she explains in an interview '[h]aving children, expanding your family, carrying on your genetic code—that's an instinctual drive that we have as human beings. And when that is being threatened, it's not necessarily your life being threatened, but your expectation of what your life can be or should be like' (Bradow in Rettner 2012: n.p.). As she continues: 'The general diagnosis of infertility, or not being able to have a baby, is kind of this giant earthquake that rocks your world. And then, there's all the aftershocks [of fertility testing and treatment]' (ibid.). She describes infertility treatments as most traumatizing because of their cyclic nature (Bradow 2012).

Bradow, who went through fertility treatment herself, points out that the symptoms she experienced during the procedures went beyond those of depression and grief, conditions previously linked to fertility treatment, and others she spoke with felt the same (Bradow in Rettner 2012). Corley-Newman (2017), in her PhD thesis *The Relationship between infertility, infertility treatment, psychological interventions, and Posttraumatic Stress Disorder*, further concludes that 'the stress levels in women receiving infertility treatment are equivalent to women with cancer, AIDS, and heart disease, as suggested by other researchers' (ibid.: abstract), 'all conditions that have been linked to PTSD' (ibid.: 6).

[7] From an IoPT perspective one could argue that, when not wanting children consists in extreme aversion to family and parenthood, this might also be the result of trauma.

[8] The American Psychological Association, in this respect, has a reductive definition, which relies on having been directly involved in extreme situations: 'Posttraumatic stress disorder (PTSD) may develop in some people after *extremely traumatic events*, such as combat, a terrorist attack, crime, an accident, or a natural disaster' (APA 2022a: n.p., my emphasis). "Trauma," in turn, is 'an emotional response to a *terrible event* like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea' (APA 2022b: n.p., my emphasis).

It is difficult to assess what proportion of individuals who are experiencing infertility, or more specifically undergoing fertility treatment, are affected by PTSD. Bradow (2012: 50) found that 53 per cent of the participants she surveyed (97 percent of them women, about a third trying to conceive for one to two years, about 60 percent had undergone fertility treatments for more than a year) met the criteria of the Post Traumatic Stress Disorder Checklist—Civilian version (PCL-C) based on 'symptom severity score.' Forty-six per cent of the same participants met a more stringent combination of criteria based on 'symptom severity score' and 'criterion pattern score'—the latter being a set of defining characteristics of PTSD outlined by the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV-TR) (ibid.: 50–51). A study of 172 infertile women (all undergoing fertility treatment) in Iran (Roozitalab et al. 2021) similarly found that 41.3% had symptoms of PTSD according to a questionnaire (PCL5) (ibid. 284) designed by the American Psychiatric Association (DSM5).

To get a sense of how concerned we should be about these figures we can compare them to those of a widely cited study, which investigated the mental health problems of soldiers returning from combat zones. Hoge and others (Hoge et al. 2004: 19) found that PTSD affected 18 per cent of soldiers returning from duty in Iraq and 11.5 per cent of those who had been deployed in Afghanistan (Hoge et al. 2004: 19). PTSD among women experiencing infertility, effectively, is two to four times higher than among veterans returning from war.

To further understand the extent of the devastating consequences that PTSD has on the lives of the participants, the range of symptoms Bartlik and others (1997) present by discussing in depth three case studies of patients who developed PTSD as a result of infertility ranges from not enjoying any more usual activities and deriving 'little pleasure from social contact,' 'difficulty in concentrating,' 'increased perspiration and heart rate when confronted with emotional triggers, such as seeing a baby,' experiencing flashbacks, a sense of 'estrangement' from other people, becoming 'obsessed about physical sensations,' having 'distressing dreams,' a sense that life is 'on hold, indefinitely.' These are only the ones I experienced myself and that also apply to the participants in my study.

Some studies explicitly refer to "trauma" in terms of "reproductive trauma" and this, in turn, tends to be connected to a pregnancy loss.[9] Bhat and Byatt (2016) define this as 'infertility and perinatal loss' combined. They state that '[r]eproductive trauma occurs in up to 15% of women' (Bhat and Byatt 2016: 1). They point out how they 'can change a woman's perception of herself, and be a major source of stress that often has psychological consequences': reproductive trauma can 'lead to grief, depression, anxiety and post-traumatic stress disorder (PTSD)' (Bhat and Byatt 2016: 1). Also Swift, Reis and Swanson (2022) define 'reproductive trauma' as 'pregnancy loss during the infertility experience' (Swift, Reis and Swanson 2022: 171) and underline how this is 'a significant threat to an individual's emotional and physical well-being beyond available coping resources within the context of reproduction' (Swift, Reis and Swanson 2022: 171). Schwerdtfeger and Shrefler (2009) further address the 'trauma of pregnancy loss.' Investigating the psychological reactions to pregnancy loss and infertility among mothers and involuntary childless women in the US they find that 'childless women who had experienced pregnancy loss or failure to conceive reported the lowest life satisfaction and highest levels of depression despite a considerable period of time (7 years) since the loss or first year without conception' (Schwerdtfeger and Shrefler 2009: 211). They also observe that '[c]hildless women also reported the lowest levels of happiness and the highest levels of loneliness' (Schwerdtfeger and Shrefler 2009: 218) and '[c]hildless infertile women had particularly high scores on "could not get going," and they had significantly low reports on self-esteem' (ibid.). They conclude that their study proves 'for the first time, that American women [the population being investigated in their study] with reproductive problems report significantly

[9] From a childless perspective this is both offensive and disappointing: as if society demanded the loss a fully formed body as justification for us to grieve, to have a "right," an "entitlement" to our own emotions.

worse mental health than women who do not face barriers to motherhood' (Schwerdtfeger and Shrefler 2009: 222).

Schwerdtfeger and Shrefler (2009) also point at the 'deep, lasting effect on women's well-being.' Their study shows the permanence of the effects for nearly a decade.[10] Another investigation, however, demonstrates the repercussions of failed IVF treatment as long as 20 years later (Wirtberg et al. 2007). That study involved in-depth interviews with 14 Swedish women and examined the long-term psychological effects and repercussions of not being able to conceive upon the women's relationships. The participants were selected from a larger pool of women who underwent treatment unsuccessfully: differently from the others, who acquired children through alternative means, like adoption or via a new relationship, these women had remained childless throughout their life. The experiences they shared, as the authors of the article underline, although unique in their specificity to each of them, are presented as 'typical for many people in similar circumstances' (Wirtberg et al. 2007: 599). Failed IVF, the findings show, affected all aspects of their lives, including leading to a low sense of self-esteem and a feeling of inferiority to other women. Sex was one of the worst affected areas. Not only, to show the devastating effect infertility has on relationships, half of the women who participated in the study were separated at the time of the interview, but 'in all but one [of them], sexual life was affected in negative and long-lasting ways.' As they write (Wirtberg et al. 2007: 598): 'As many as nine women [out of 14] reported that both their sexual life and their sexual desire were lost for ever. For some, this was a source of concern, but others seemed to have accepted that that part of their life was lost.'

What we know about how long the devastating effects of the experience of infertility stay with those affected is limited by the sample and the interval of time since the end of the fertility journey according to which researchers selected their participants (see also Volgsten, Skoog Svanberg and Olsson 2010 for a study conducted 3 years after IVF). Without any further research we cannot exclude that the effects do not last longer and perhaps stay with the individual as long as one lives.[11]

A further limitation to all of these studies is that they invariably regard infertility as 'a failure to conceive after regular unprotected sexual intercourse for one year' (Aiyenigba, Weeks and Rahman 2019: 76, for one example). This is the definition provided by the World Health Organization (WHO 2022). From the perspective of such specific (and very reductive) definition it is estimated that 60-80 million couples are affected by infertility worldwide (Wdowiak et al. 2016 in Roozitalab et al. 2021: 282). As I suggested earlier, however, this is only the tip of the iceberg. There are so many more cases than those captured by the statistics: because those affected by infertility never went through the medical system or attempted IVF (as one of the participants in my study), or because they did not have a partner, just to mention two of the most common scenarios.

Considering how many millions people are affected worldwide and how destructive the consequences of infertility can be on the daily well-being and ability to function of those affected, potentially for years, decades or even for their entire lives, it could not be more urgent to treat infertility with the attention, seriousness, but above all, the *care*, that it deserves.

[10] While most clinical studies, as they point out, are conducted within a year of pregnancy loss or during fertility treatment, women in their study sample 'experienced pregnancy loss or began trying to get pregnant nearly a decade before the time of the interview' (Schwerdtfeger and Shrefler 2009: 222).

[11] According to IoPT theory, as we will see, a traumatized part, unless we manage to establish contact with it, feel it and reintegrate it, will remain split off and "frozen" in the eternal present of the overwhelming circumstances that threatened one's survival—either objectively or in the perception of the person, with the resources one had at her/his disposal at that specific moment.

Trauma, infertility and IOPT theory

A psychotrauma, from an IoPT perspective, is a situation one is unable to deal with through the mental and physical capacities one has at any given time (Ruppert and Banzhaf 2018: 24).[12] It is an overwhelming experience we might undergo as a result of 'unkindness, neglect and [or] violence' (Ruppert 2021: 15). In this sense it might be something that *happens* to us (an accident, a loss), but also something that did *not happen* (a parent who did not take care of our basic needs, for instance). It might also be self-inflicted in the case when we become our own aggressors, as we will see shortly. If we are not able to respond to the overwhelming circumstances by removing ourselves from the situation—*flight*—or directly addressing the cause of the threat—*fight*—in order to survive we either *freeze* or submit (*fawn*) (IoPT course). A part of our psyche, in practice, splits off and get "buried" into our unconscious, where it will continue to live without us either realizing it is there and/or being able to reach it.

An experience is traumatizing when we feel we have no control and feel helpless, when our identity, will, our needs or our sense of integrity are threated (IoPT course, Modul 1). This can happen as a result of a sudden, unexpected and catastrophic event, like a natural disaster or a physical aggression, but can also unfold over time (see Figure 1). Infertility, in this respect, turns into a life crisis, a 'shock' as one of the participants put it and I experienced it myself, because few had ever even heard about its possibility.[13] In this respect, Liv, one of the participants in the study, describes, in her first interview, how it feels to embark on IVF without having any idea of what it will involve:

> you are letting a child out on the freeway on their own, trying to survive, you know ...because none of us has any ...knowledge or […] experiences that can prepare us for this...it's like trying to find your own way […] ...you would never let a kid out on its own...but that's how it feels.

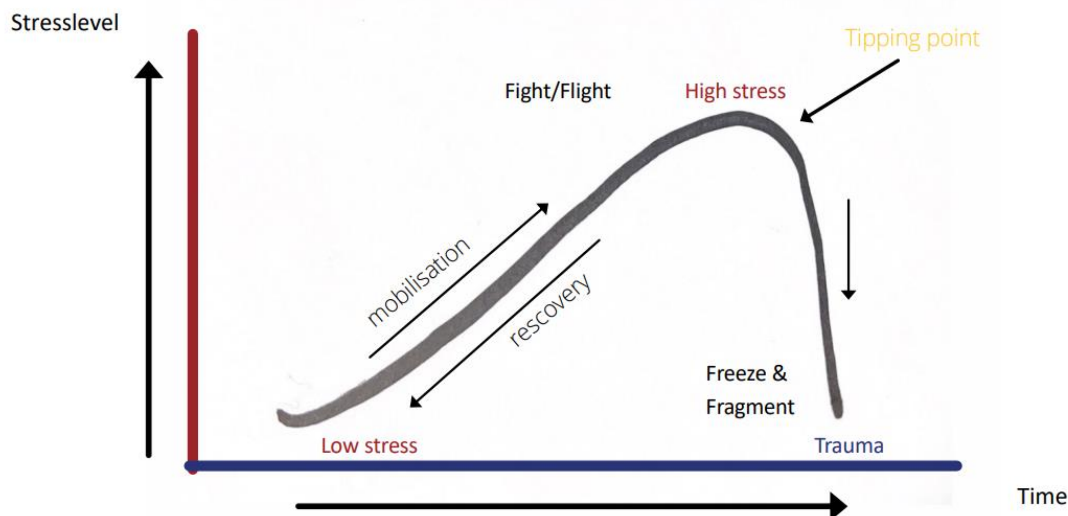

Figure 1. From high stress to trauma (Broughton 2021)

[12] A psychotrauma is, in alternative terms, a 'life experience' we have been 'unable to process' (Ruppert and Banzhaf 2018: 1).

[13] The media, when they deal with infertility, tend fall into the template of the "miracle baby" stories. The general narrative we are exposed to is that it is always possible to have a baby and, in case of any problems, then technology will solve them (De Boer, Archetti and Nyheim Solbrække 2019; Achetti 2020: 11, 29, 66, 196).

Undergoing fertility treatments that are invasive, humiliating and dehumanizing (Tsigdinos 2022) and where one has no control, neither of the procedure, nor of the result means one is stuck in a situation of extreme uncertainty, physical and mental exhaustion and, when the efforts lead to no result, desperation, often for years on end. Liv, three weeks after her last treatment failed and 4 years into assisted reproduction, provides a fresh glimpse into what this practically means:[14]

> I had the first 4 weeks in October through December [2020, the interview took place mid-June 2021]...The first 4 weeks I did not feel anything and I thought "oh, this is easy," but then the next 5 weeks, you know, developing, you know, headaches and getting moody and, you know...it was like I was in menopause...but then the last time I had all...all the side effects at the first shot because it was like ...almost like...my body just remembered...so I had a 24hour headache for 3 weeks...and it was awful...and...so you know...and all these things...and all the pains...you know...and all the bodily side effects..you know...it's *hard*....trying to function....yeah...it wasn't until March that I started feeling myself again...and have the energy to do anything in the house...you know...meeting people...I was completely isolated...and also because of the pandemic...I had to travel from [town A] to [town B, 914km away, or 1 hour and 20 min. flight] for all my appointments...so that' also an extra....in the fall there was a direct flight from [town A] to [town B] but now they are not anymore so I had to take 2 flights down and 2 flights back 24 hours later and ...yeah....so you had that side of it too....because physically that's exhausting as well...just travelling for a day and taking 4 planes, you know...so that's a lot...so it's really really hard, you know and...and...all the physical...just side effects...exhaustion, and everything, you know...it also impacts the mental side of it, you know.
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> And since, you know, because of the pandemic as well I was completely *insane* the whole fall...I got...because of my high dosages I was 13 times in [town B] over 9 weeks so I was several times there during a week ...and ...I ...I had so much at work...I was totally alone at work...I don't have any colleagues...you know...they...that's awful too. So I got...I couldn't work anymore in the fall...but my husband had to go to work and he works at a concert venue so he had a lot of people around and that I was freaking out you know home alone...freaking out that he would get Covid so my appointments got cancelled and everything...you know...and you have been there 5 weeks and you have taken...you don't want your treatment to be cancelled you know [laughs].
>
> So I was *hysterical* everyday... for the whole time I did not see my friends ...my best ...my best friend she took 3 covid tests a day so just that she could meet me because, you know [laughs], I was *completely* crazy [laughs].

For Ruppert, as a result of trauma, our psyche presents three kinds of parts: 'traumatized,' 'survival' and 'healthy' parts (Figure 2). The 'traumatised parts' are frozen in the original trauma situation: they are locked in the unconscious and there they 'continue to live, perceive, feel, and think as they did in the original trauma situation' (Ruppert and Banzhaf 2018: 26). They also always present the same age and developmental stage as the person had at the time they split. These are the parts that might get triggered by reminders (situations, sounds, words, smells, bodily sensations…) of the original trauma (Ruppert 2012: 72-73). Going back to the possibility that the consequences of infertility might stay with the individual over the entire life course, according to IoPT theory, a traumatized part, unless we manage to establish contact with it, feel it and reintegrate it, will indeed remain in its split off state. Retraumatisation occurs when '[d]espite all the survival strategies employed, memories of the trauma are re-triggered

[14] In this excerpt I deliberately left the many repetitions of 'you know' because they powerfully convey, at a verbal/textual level, the difficulty in finding the words, confusion in even telling one's own experience, as well as the sense of "being stuck on a loop."

time and again, and the images and feelings that have been split off flood the consciousness' (Ruppert 2012: 83-84). The 'survival parts' serve the function of protecting us from any memory of the original trauma through, for instance, telling themselves that 'it wasn't so bad' (denial of trauma) distracting themselves 'with all kinds of activities, such as burying themselves in work' or undergoing 'medical treatments in the hope of having some peace within their body' (Ruppert and Banzhaf 2018: 27) among many other, and often very creative "strategies" (Ruppert 2012: 73-83). The 'healthy parts' are those that are 'still able to react adequately to reality, to process it and to comprehend it in its complexity' by acting and feeling in a way that is appropriate to the situation (Ruppert and Banzhaf 2018: 25). Differently from the traumatized parts, which experience the world from an emergency- and crisis perspective, the healthy parts engage with the world with curiosity and confidence in their own resources in meeting changing situations and potential challenges (Ruppert 2012: 70-72).

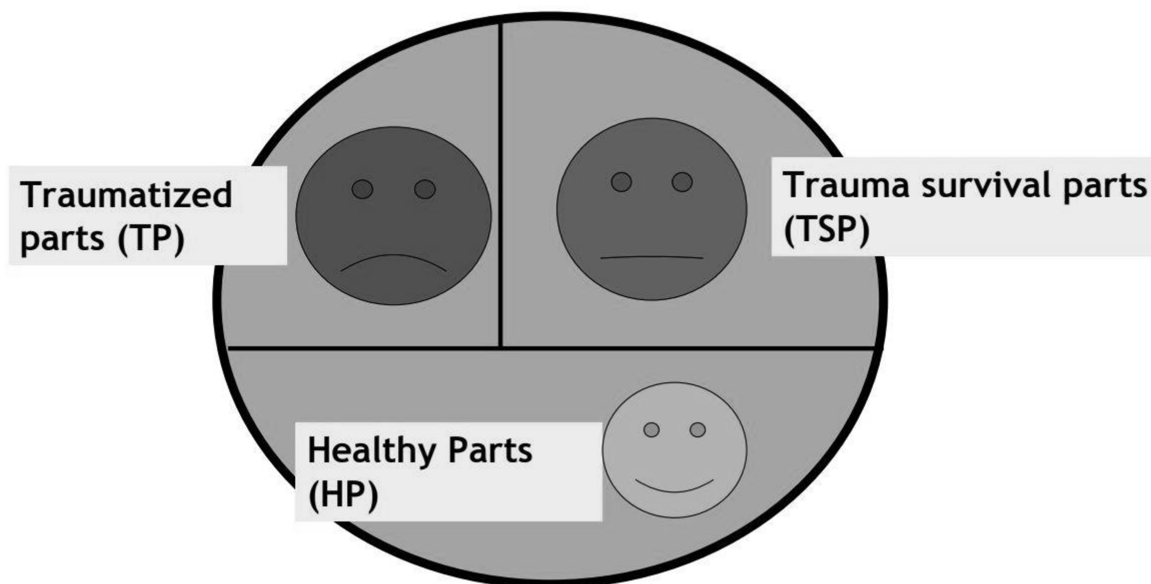

Figure 2. Splitting of the psyche after traumatization (Ruppert 2012: 69)

Although trauma can happen at any time in our life, it is far more likely to become overwhelmed when we are extremely young and completely dependent on the care (or lack of it) of our parents: from the time of conception, through our birth and in early childhood (Ruppert 2021: 141) (Figure 3).

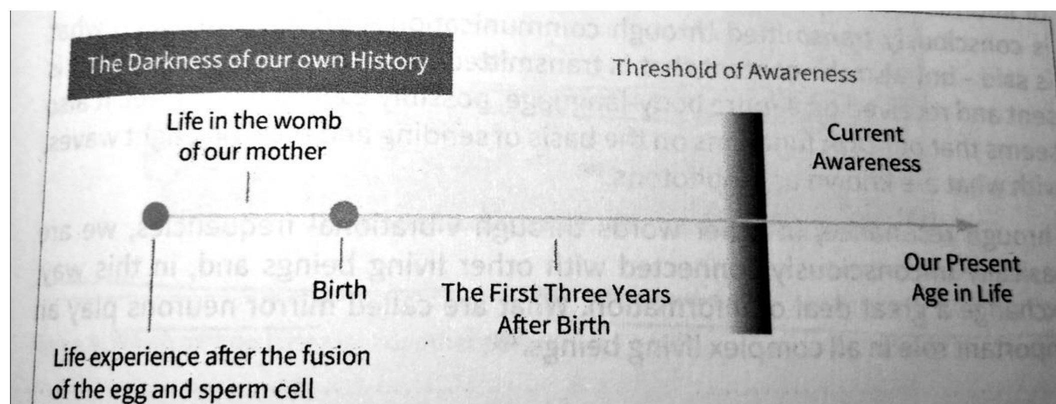

Figure 3. IoPT goes beyond the threshold of consciousness (Ruppert 2021: 141)

Ruppert further envisages, in this respect, a hierarchy of four kind of traumas, where early existential traumas become the ground for the possibility of later ones: identity, love, sexuality and self-inflicted trauma (Figure 4). ‘Identity trauma’ (not wanted) refers to the trauma experienced, still inside the womb, by a child who is not wanted by the mother (Ruppert 2020: 100-108). The “no” by the mother to the child’s existence is not necessarily the result of a deliberate rejection by the mother, although there are many children who are being born after failed abortion attempts. Rather, it can be unconscious. Perhaps the mother is not physically or psychologically ready for a pregnancy or (which in practice might lead to the same outcome) the mother is traumatized and therefore unable to be fully present (again physically and mentally) to welcome her child into the world. ‘Love trauma’ (not loved) is what a child experiences when s/he is not loved in the way s/he needed, perhaps one did not receive physical warmth or expressions of affection by the parents (Ruppert 2020: 109-114). ‘Sexuality trauma’ (not protected) relates to any form, direct or indirect, of sexual abuse (Ruppert 2020: 115-151), but also more broadly to a violation of boundaries. As Kersten writes (Kersten 2018: 305) ‘[t]here is a wide spectrum of activities and degrees of severity that violates the boundaries [of a person]. What is critical is how the person experienced the boundary violations themselves.’ In this perspective being forced to eat could be an example of a violation of physical boundaries. Being forced into roles that are not appropriate for one’s age, as in the case of a small child caring for one’s own adult parents, could also be interpreted—and experienced by those involved—as a physical and psychological violation. ‘Self-inflicted trauma’ happens when a person who has been a victim of trauma, as a survival strategy, in order not to feel the pain and unbearable emotions of the traumatized parts, turns into a perpetrator to protect her/himself from the possible shame, humiliation, terror, anger the original aggression caused (whether that was intentional or not) (IoPT course, Modul 9; Ruppert 2019, Chapter 5: 91-131). It can involve inflicting trauma on others—this is also traumatizing because there is always a healthy part inside us that knows that this is wrong: we feel shame and guilt (IoPT course, Modul 9)—but also inflicting trauma on oneself. This happens as a result of the fact that, as in the case of identity trauma, an individual might have given up one’s identity and taken on the identity of an aggressor: for instance, a child with an abusive parent will not only identify with that parent and not being able to see the abuse (as a result of survival strategies that make the child blind to them), but also turn the abuse against her/himself to “defend” the parent (and again not be able to recognize what is happening).

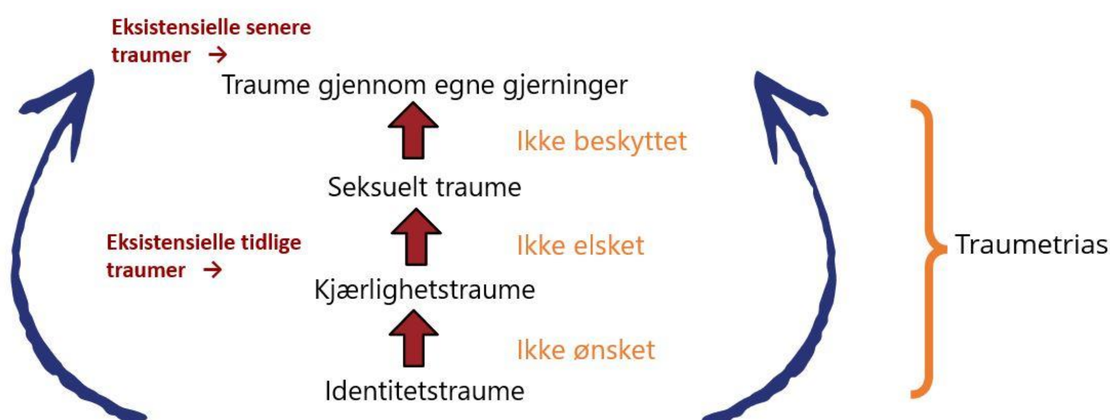

Figure 4. Possible stages in a traumabiography (Ruppert 2018: 47)

Earlier traumas, especially identity traumas, need to be addressed first in therapy for the individual to have a sufficiently healthy “I” to be able to handle and integrate later traumas (IoPT course, Modul 4). The therapist, however, cannot rush the process and can only deal

with the parts that present themselves during the therapy sessions: this is, once again, key to placing the person at the centre of the process and to allow one, contrarily to the situation that have traumatized her/him, to be in control. IoPT practice in this respect relies on the self-healing capacity of each individual and her/his inner knowledge of what s/he can deal with at any given moment.

According to Ruppert (2021: 14-15):

> a healthy psyche can distinguish between: I, you and we; Past, present and future; Perceptions and projections; Inside and outside; Realistic love and unfulfillable longings; Sensual desire and sexual greed; Realities and illusions; The possible and the unattainable; Live, survival and death.

In other words, and returning to the issue of involuntary childlessness, if having a child is not possible or the sacrifices for one's own mental or physical health, or impact on one's relationships become disproportionate in relation to the potential outcome, a healthy individual should be able to act and make choices accordingly. "Coming to terms with a life without children," in this perspective, means accepting reality for what it is. More specifically, in relation to the experiences of the participants in this study, that having a child is either not possible, or that more attempts come at a cost—and is one willing, freely and having considered all options, to pay that price?

Method and IoPT practice

The study I conducted focused on involuntarily childless women. It involved six participants. Five of them are Norwegian and one is originally from a Southern European country. Three live in the Oslo region, three reside in the North of the country. They were recruited through different channels: two joined the study via a call for participants I posted on the Facebook page of a closed group for permanently childless women I established on 1 Sept. 2019, *Den hemmelige hytta* [The secret cabin], and that has now 65 members; three were recruited through an ad published on the monthly newsletter of the organization Ønskebarn, an interest organization for the involuntary childless (about 400 members); one joined through word of mouth from the social network of a colleague from the IoPT course.

The participants were between 36 and 49 at the time of the initial interviews. Five of them underwent fertility treatment for between three and six years (four to nine cycles). Three of them ended their fertility journey through assisted reproduction between six months to one year before the time of the interview, one stopped three years ago. Although the ad specified 'I am looking for 5-6 women (any age and background) who feel they are struggling with coming to terms with life without children (women who have "stopped trying" and/or decided they are not going to pursue any more fertility treatments)' one participant had ended her last treatment three weeks before the interview and later decided to continue with more attempts. One of the participants never went through IVF and had been waiting for adoption for four years at the time of our first conversation.

I ran 2 to 3 one-to-one (Ruppert 2019: 165-167) IoPT sessions ("self-encounters") with each of them (16 self-encounters in total) at intervals of 6-8 weeks. I also conducted individuals interviews before and after the cycle of psychotherapy sessions (12 interviews in total).[15] All self-encounters and interviews took place online (Zoom) between 2 June and 25 November 2022. The therapy sessions were offered for free in exchange for participation in the study.

A "self-encounter" revolves around an "intention," a statement, a question, a collection of words (or even a drawing) of what the person undergoing therapy ("intention giver") wishes to

[15] Self-encounters lasted between 60 and 100 minutes. Interviews between 40 and 90 minutes.

investigate, explore, find clarity about. The therapist is a facilitator in this process, providing the framework where the exploration can take place safely and systematically. In the one-to-one session this happens by asking the intention giver to select a maximum of 3 words from the initial statement/question. The intention giver then "resonates" then, in turn, one by one, in the order she prefers. "Resonance" is the process through which the intention giver comes into contact with psychic structures that are not normally consciously accessible. These psychic structures might be traumatized parts, survival parts, or healthy parts. In the online setting the intention giver would write the intention and the words one wishes to resonate in the chat box. She would then resonate by either changing her name on the screen to the term to be resonated or wearing a post-it note with the word written on it, then by saying "I start resonating [term]." When the resonance is over, she changes her name back or remove the post it, then states "I stop resonating [term] and I am [own name] again." The resonance provides the opportunity to explore, through the guidance provided by the therapist, when the traumatized and survival parts formed, what happened at that point in the life of the intention giver, particularly which needs[16] were not met.

Acknowledging the reality ('my mum was cold,' for instance) and the unmet needs ('I need my mum to hug me') is a first step in breaking through the 'illusion portal' created by the survival parts ('I had a very happy childhood').[17] This further leads to passing the 'threshold' of 'protection' of the trauma feelings. By engaging with, i.e. *feeling,* the emotions and pain (never as intense as they were originally felt) the intention giver found too overwhelming in the past, the self-encounter starts a process of re-integration of the traumatized part, ultimately allowing the intention giver to move towards 'freedom' (i.e. expressing one's authentic identity and will) and strengthening one's healthy parts (Figure 5).[18]

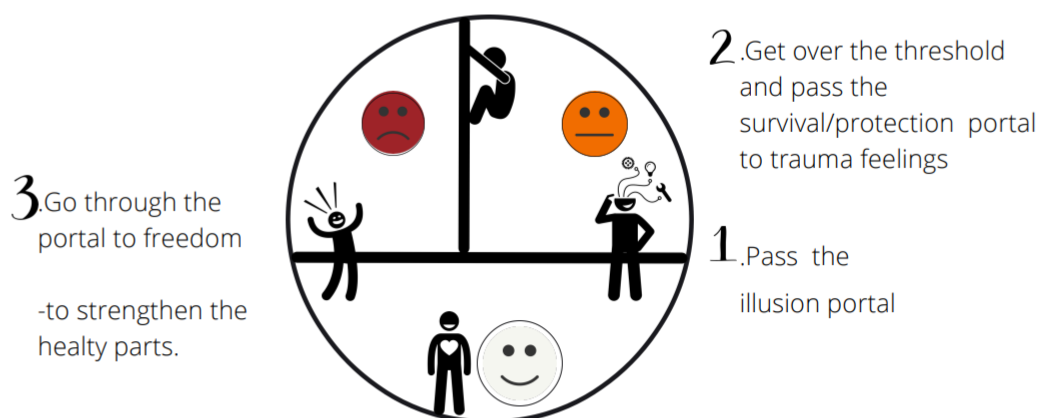

Figure 5. Integration of the splits in the psyche after a trauma experience (IoPT course, Modul 8).

In this study the self-encounters, by enabling to map the 'roots of the trauma biography' (Ruppert 2019: 168), have both a therapy and a research function. As therapy, they allow practically to reintegrate parts of the intention giver that have split off. In terms of research, they allow the therapist-researcher to identify the traumas that, within the unique life-history of

[16] Ruppert identifies both 'symbiotic' (to be fed, to be kept warm, to be seen, to be held…) (Ruppert 2021: 25) and 'autonomy' needs (to be independent, to be free, to be able to do things for ourselves…) (Ruppert 2021: 26).
[17] The quotes are from actual self-encounters in this study.
[18] For Ruppert (IoPt course), but also as I could observe in my own experience, the healing process starts when the intention begins to form in one's mind.

each of the women, are potentially behind their infertility experience and whether infertility is, in itself, a trauma—outlining a 'traumabiography' (Ruppert 2020: 168-170).

The aim of the interviews was twofold. First to get a sense of the women's personal journeys through life and where they stood in relation to the experience of infertility before the therapy. Questions during initial interviews included why they decided to take part in the study, what was their "story," what they currently struggled with in their everyday life: effectively what it meant and how it felt, concretely, for each of them, to be childless; what their expectations about the therapy were and what they were hoping to achieve through it. Second, the final interviews wanted to find evidence that might suggest that: a) a reintegration of traumatized and survival parts was taking place or had at least initiated, and b) the participant had achieved her objectives and/or benefited in other way (if so, how) by the therapy.

When it comes to the integration of the split off parts, the point of IoPT therapy is restoring the integrity of the person, her/his will, innate joy for life, autonomy, liberating her/him from the constraints of possible identifications with others' traumas and motives (parents', for instance).[19] Trauma, in this respect, does not only affect the mind, but is embodied (van der Kolk 2015; Menakem 2017; Ruppert and Banzhaf 2018). Survival strategies aimed at keeping emotions that make us uncomfortable out of reach take a huge amount of energy: we might feel drained, demotivated. We also become unable to remember things, to think straight, imaginatively and to find solutions. The final interviews thus focused on concrete examples of any changes in the women's thinking, behaviour, in their bodies, that they perceived as improving their well-being, autonomy, energy, creativity. In addition to this, I included questions about the extent to which each woman felt the original expectations were met and goals they had started with were achieved, if that was the case (if not, why not); how was the experience of the therapy sessions and how did this compare to previous therapy experiences, if any.

These qualitative measurements, again reflecting the IoPT centrality of the person and her/his experience, are not imposing externally developed and "fixed" standards of "success" or "effectiveness." Although, as in all interviews, no statement is ever purely taken at face value, the person's feelings and assessments *are* valid and a legitimate source of data. Beyond the interviewee's words, I relied on concrete examples of actions, thoughts, behaviours, accounts of bodily feelings and states before and after the therapy sessions to make my own assessment, as a therapist and as a researcher, of the extent to which the therapy had supported the participants in "coming to terms with a life without children" in the terms that meaningfully applied to each of them.

All interviews and self-encounters were audio recorded with the permission of the participants. The recordings were transcribed. The files, according to GDPR, were securely stored in the UiO cloud and only accessible by the author. They will be deleted on 31 December 2025. The quotes used in this dissertation are anonymysed and, where necessary, translated from Norwegian to English. The women's names have been changed to protect their identities.

Findings and discussion

One interesting aspects of the self-encounters is that the age of most psychic structures being resonated is roughly the same of the intention giver's: most parts are fully adult. More specifically, the traumatized and/or survival parts I observed are from the present or the time

[19] As Ruppert (2021: 15) writes, 'a healthy psyche carries the standard of truth and truthfulness within itself. It wants to be free to express its own aliveness, its own needs and its own abilities. It is ready for dialogue and open to communication. it is happy within itself and wishes other people to experience this happiness as well. It forms the basis for us to lead constructive relationships with other people.'

the participants underwent fertility treatment. This is a first confirmation that infertility is a traumatizing experience in itself.

The women in my study experienced extreme distress because of infertility, even years after stopping trying. Inger, for instance, whose fertility treatments came to a halt 3 years ago (her partner refused to travel to a clinic abroad), explicitly states in her first interview that she decided to take part in the study because 'it never ended… it is inside my head.' As she resonates "overthinking (*tankekjør*)" in the second self-encounter she adds:

> I can't get that thought of childlessness out of my head and live a normal life without the grind, grind, grind in my head all the time...it's especially when I go to bed...it's on me all the time. ...regardless of wherever I go, wherever I am, it will still be with me... [...] so getting rid of the overthinking is something that I really want to talk about .... because it takes up so much space... and hurts my heart so much here...a stab here all the time...thinking about life, how it is...how it shouldn't be...[…] ...not a day goes by without there being almost a bit of a crisis about what will come out of here....I know that it has been a long time since I finished the IVF attempt..but it is *still going on in your head* [as if talking to herself]....[sighs].

All of my participants experienced (and still experience) suffering because of the many losses they have been through, made worse by the sense of isolation at being surrounded by people who do not really understand their experience and the fear of being triggered at any time. This lengthy quote conveys the storm one is thrown into. As signalled by the interviewee laughing while telling what is, essentially, a harrowing experience, it is also a practical demonstration of the extent to which the social "dismissal" of infertility and its consequences becomes internalized, even by those who directly experience it:

> I miss in this journey...I miss...I have not found a book that told me ...that I could read ...things that I feel...what I am experiencing...that someone else has gone through the same things ...and I am not talking about the technical stuff...but the emotions and how you feel ...and how you see the world...because that has changed a lot for me...I have changed as a person through the whole thing....going through losses every month for several years...because that is what you do eventually....it is going through loss after loss after loss and people who have not tried to make a baby for longer than a year don't even know what's it like. You know, a year for somebody is a very long time, but, you know, 4 years, 10 years, it's just...because even though you know ...every time you get hope it's like...and peeing on that stick it's triggering something in me...even though I am on my period and I know that it did not stick I still get ... taking the pregnancy test even I know it has failed...it is just so weird, you know...And even the ovulation test...it never...I had 20 days in a row positive ovulation test because there is something wrong in my body ...they just don't know why...and now in March [2021] I was OK, the country opened [after Covid] and now I have a month of off time, and I said now I can get Covid because so I am over with it and then I can continue my treatment and I took so many Covid tests and they reminded me of the pregnancy test so I got really disappointed every time it was negative. It was so triggering...*completely* trigged it [laughs] and if you have not gone through those things then you never *really* understand and there are lots of people that are not listening as well, you know, if you are talking to them. They think they have the answers ...you know...if I had a penny for every time anyone said "well I know someone who, you know, got pregnant in between IVF cycles"...and now it's like...yeah...good for them...you know... "if you just relax...suddenly you get pregnant" you know...suddenly ....[laughs] (Liv, first interview).

Importantly, the 'losses' involuntary childless individuals go through are not just the actual loss of a child, through miscarriage for instance, but the loss of a child that exists, regardless of her/his physicality, in our psyche and a whole future—an entire world, in fact—as a parent.

While there is extensive documentation of the grief associated to infertility (Thorn 2009; Volgsten, Skoog Svanberg and Olsson 2010; Rosner 2012; Day 2016, esp. ch. 4, "Working through the grief of childlessness": 79-123; Day 2018; Farncombe 2018; Hooper 2018) only those who have been through it can truly understand its scope. Day (2016: 81), herself involuntary childless and founder of the association for childless women "Gateway Women," expresses the enormity of this multidimensional loss—something not even those affected by it are fully aware of, as we will see—in a way the reader can relate to it:

> What we, and others, often fail to realize is the depth and reach of our loss: that not only will we never have children, but we will never create our own family. We will never watch them grow up, never throw children birthday's parties, never take that 'first day at school' photo, never teach them to ride a bike. We'll never see them graduate, never see them possibly get married and have their own children. We'll never be grandmothers and never give the gift of grandchildren to our parents. We'll never be the mother of our partner's children and hold that precious place in their heart. We'll never stand shoulder-to-shoulder with our siblings and watch our children play together. We'll never be part of the community of mothers, never be considered a 'real' woman. And when we die, there is no one to leave our stuff to, and no one to take our lifetime's learnings into the next generation.

One of the participants not only compares experiencing complications in the adoption process to the grief at discovering that, yet again, you are nor pregnant (what she went through before deciding to adopt), but also talks about already having a relationship with the child she hopes one day will join her and her husband: 'I [was feeling grief and frustration because I] was already in love with this adopted child I have never met and…I don't know...who maybe is not even born yet' (Anna, first interview). Three of the participants in my study were never pregnant, another had positive pregnancy tests for two weeks ('that is the closest I have ever come to being […] a mother'). I was also never pregnant. And yet (in fact, also *because* of that) we all bear the consequences of trauma. In this sense current research that refers to 'trauma' only in case of a 'perinatal loss' is based on a reductive understanding of "loss." IoPT practitioners, who define as 'trauma of loss' 'the loss of, or separation from, *a person* to whom the individual has psychologically bonded' (Schulte 2016: 174, my emphasis) similarly tend to assume that the loss should involve *actual* individuals. Schulte (2016), for instance, in the context of early trauma, applies it to miscarriages and still births. This understanding, as the infertility experience demonstrates, needs to be revised and expanded.

To further get a sense of what infertility feels and means in the women's everyday life I can list the issues another participant, Nora, struggled with and initially wrote as a note for herself as possible goals for the therapy. They vividly reveal the extent to which life is no longer recognizable and one's existence has become stumped, suspended, on hold:

- Work on the identity question
- To get out of the paralysis
- To come to terms with it
- To «find myself» again, or redefine myself, and be okay with that person
- Let go of anger and bitterness
- Be able to be generous with friends who don't see or understand me, who are not able to respond to me the way I need or want them to
- Let go of jealousy and envy
- To be able to focus and concentrate again
- Find meaning, fulfilment and motivation in my work again
- To find my creativity again and be able to write and journal
- To feel meaning, light and joy in life again
- To feel whole
- To be able to make a decision

- Healing

Infertility, beyond being a trauma in itself, is also a powerful trigger on existing traumas and, along the hierarchy outlined by Ruppert—where later traumas "nest" on earlier ones—it is possible to see how deep the roots of the infertility trauma can reach into the past, often into one's early childhood. I will first present some examples of the kind of traumas I observed in the women's traumabiographies and how they all converge in explaining why it is so difficult to come to terms with a life without children.

<u>A trauma within a trauma within a trauma</u>

Identity trauma

I did not observe directly any traumas of identity, for instance by coming into contact, during the psychotherapy sessions, with a yet-unborn part. There are, however, a number of details in the participants' accounts that suggest that identity traumas might lie under other traumas that did come to the surface. Indicators of a possible identity trauma are identifications with specific roles, in my investigation that of a mother ('who am I if I cannot be a mother?') or the difficulty in recognizing the right to one's own space and needs. As Ruppert writes in presenting the perspective on the world by an individual affected by identity trauma, 'I perceive [j]ust wanting to be myself or exist as impossible and self-centred' (Ruppert 2020: 105). As he continues, underlining how identity trauma becomes the ground for love trauma and self-inflicted trauma: 'all I do is for others or for a higher purpose' (Ruppert 2020: 105) and '[t]his also blocks the love we have for ourselves, as well as the knowledge about how we can take care of ourselves' (Ruppert 2020: 105). I will return to further examples from the participants that illustrate these points shortly. For the moment I want to use briefly my own experience and the reflection I developed undergoing my own therapy—I have experienced identity trauma—to show the extent to which childlessness might deeply and seamlessly nest into one's traumabiography. In this perspective I realized that the grief I felt related to childlessness was only marginally related to my genuine desire to start a family with a man I love. The root of a pain I experienced as incapacitating and obsessively intruding into my life was rather rooted in the desperate search for belonging somewhere, especially at a time when I was disappointed with my job (I had identified with my professional position: "I am an academic") and was looking for an "escape." As a result of my identity trauma I had always and constantly longed for recognition and approval from others, not realizing that this was a quest for the love of my own parents, particularly my mother. As in the case of the participants' parents, it is not that my mum did not love me, but she did not provide love in the way I would have liked, i.e. with greater affection, physical closeness, patience and understanding (love trauma). Having a child fitted into this traumabiograpy through a reasoning that runs along the line of "if I have a child, I will fulfil my role as a good daughter and my mum will love me." I would also have liked to be that mother I had never had and fantasized about creating the "perfect family." Searching for belonging and the attempt to act in ways that would lead my parents and others to appreciate me—including being a perfectionist and being constantly busy at work to distract myself from the pain of not being loved—are all survival strategies. Trying to have a child was a survival strategy, too. Integrating my earlier identity and love traumas, thereby strengthening my healthy parts, through therapy made my survival strategies less relevant and helped me to start integrating the later trauma related to infertility.

Trauma of love

Most women in the study, as children, longed to be loved differently than their parents did. In her first self-encounter Anna states that she was never loved by her father ('I am not sure he even knows what love is') and on two occasions tells of how he cried when she was born at discovering that she was not a boy. In her second self-encounter, although she underlined that her mother did everything she could in a situation of poverty ('she gave 200%'), she also acknowledged 'I would have probably been happier if I had had more love from her.' In her

third self-encounter she wanted to understand why she feels intense, physical pain, which often lingers for many days, in hearing stories of child abuse or children suffering. In working with the intention "How a child's pain can hurt me so much? [sic]" it emerged that the pain she feels is, in reality, the pain she herself experienced as a child for not being cared for by her mother in the way she would have liked to.

Another participant, Berit, grew up in a 'silent house' where she felt she was invisible and even now she feels mad at her partner when he does not talk to her. While working on the intention "Why do I get desperate inside myself when it gets silent?" it emerges that the sense of desperation, rage and irritation she feels is related to her childlhood: when her mother and brother were too silent she felt like she wanted 'to be somehere else', she wanted 'to disappear.' As she further words her emotions: 'I feel I am wrong,' 'I disappear, go away, I am not important, not interesting enough to talk with.' While the situation suggests a trauma of love—a child who would have liked her parents to be 'more emotionally involved'—feeling like one does not exist unless somebody else provides acknowledgment and recognition also points at a trauma of identity.

Marianne is angry at and hurt by comments by relatives and acquaintances who do not understand that she wants to "stop trying." While working on the intention "I feel angry when I am sad" (third self-encounter) she realizes that her emotions are related to a fear that she will not be liked and even abandoned by those she loves. That is also why she does not establish boundaries:

> I don't want my surroundings to be uncomfortable […] I am afraid that they will ...change their perception of me and how they feel about me...[…]...I am afraid that they are going to leave me, abandon me and...yeah...that is the first thing that comes to mind...maybe they don't want to be my friend any more, they don't want to spend time with me anymore.

She began doing this, applying this survival strategy, when she was '4 or 5,' a time when she was afraid of losing the love of her mother:

> I think I was very very young...before I lost my father when I was 6 ...and we did not talk about it...after his funeral...but even years before that I...I cared more about my surroundings...I did not want to...I liked to be as *invisible* as possible, if you understand what I mean […] I don't like to ...*take* any place.

In particular, she was concerned that her mother, who had divorced her father (she 'vocally expressed how much she hated that person') 'would only see the father in me.' As the exchange in the self-encounter went ("T" from now on stands for "therapist"):

> T: Are you afraid that your mum will not love you?
>
> [tense sigh] yeah [said with deep sadness]...I think that is more accurate, yeah...it's so cliché...and so shameful, yeah...[voice breaking]

Trauma of sexuality (lack of protection)

I did not observe any trauma of an explicitly sexual nature. However, I identified violations of the physical and psychological boundaries in the traumabiographies of several of the participants, especially when they were children. More specifically, material circumstances and the lack of protection by the parents, often because the latter struggled with their own traumas, meant that some of the women were forced into situations, roles and responsibilities that were too heavy to bear for them as small children. While I am presenting the following examples as evidence of "lack of protection" from a conceptual perspective, it is difficult to separate them from traumas of love and identity.

Since Anna was a small child, she felt she needed to take care of her mother and her brothers and protect them from a father who was an alcoholic. She is currently a fervent Christian who is dedicated to helping others: 'because in the Catholic faith you learn to accept your cross and move on and move others in a way […] you can help the others ....and I believe that when you focus on the others you heal faster.' When Anna discovered that the husband could not have children she decided they would adopt. Adopting has become part of her life-long mission to help others, especially children, as the many activities she runs with and for children show. This includes hosting two children once a month as part of a home visiting (*besøkshjem*) programme.

Marianne, whom we already mentioned in relation to a trauma of love, recounts sitting in the first row at the funeral of her dad when she was 6, surrounded by relatives, but not her own mother. She felt completely alone in her grief, while her mother, who had divorced Marianne's father when she was 3, started the relationship with another man and gave birth to a stepbrother 6 months after the funeral. Trying to regain some form of 'control' Marianne stopped eating and began suffering from anorexia at the age of 9. For Ruppert (2016: 253) anorexia, denying oneself food, is 'in terms of a love trauma, an attempt to disappear physically because, as children, they were not wanted' (or that was their perception, one might add).

Liv was bullied when she was in 3rd grade and those events, even if they might appear remote and totally unrelated to infertility, still weigh heavily on her present. She started her first self-encounter with the intention "Exploring my self worth within myself. Realize my purpose of living [sic]." She is concerned that, if having a child does not work out, she will not know what to do:

> What I realize, the most important thing...I can never be prepared...and know how I would react if this doesn't work out, but it might be good to start working on myself, preparing for a failure, or an outcome that is not what I wish for... [sighs] because that's what scares me the most...if this doesn't work out what the *hell* do I do then? And how...I know it will *break* me [half laughs]...but I will always *survive* but...but...I am just so scared of all the emotions and all...how I will be able to go further in my life...because this has been...it's become and obsession, there is just no...and especially living where I live now, not working...[…] what is my life worth? I have not accomplished anything. That's what it's feel like. And it's not true, but that's how it feels like now...it's just…yeah...if I die, whoever cares... that's what it feels like.

While resonating "self-worth (*selvverdi*)" it emerges that these feelings are, deep down, related to her school experience. At that time her grandmother, who lived with her family and whom she saw as a 'third parent,' further contributed to her insecurity. Although Liv expected her grandmother to support her 'unconditionally,' she felt that the woman broke her trust. On the ground that 'they had done nothing to her' she invited the classmates who bullied Liv around her place. Not only felt Liv unsafe in her own house ('the bully was in the home'). She also did not feel like she could live up to the standards of other people, whom her grandmother tended to praise ('what did others have that made them so good'?). This has not only affected her sense of self-worth, but has also meant she constantly has tried to adapt herself to others. She recalls how she would try out different behaviours to see if that would appease the bullies. As she describes her attitude later in life (last interview): 'one of my weakest personality traits is that I have always been giving and giving and giving and giving and never receiving anything...I have been like a dog ...that runs around and want everyone to love you ...[laughs] ...that is how I have been...that's not healthy.' She explains that she is no longer like that: 'IVF has made it impossible to be like that' by imposing constraints on her time. As she puts it: 'I have been working very hard to set boundaries for myself...' In examining self-inflicted trauma,

however, I will return to her traumabiography: often we can keep ourelves safe from others, but what if we become our own aggressors?
Self-inflicted trauma
Several of the women I talked to, not differently from what I or others I have encountered have previously experienced in undergoing fertility treatment, were not in control of the process and had lost sight of why they were doing it: the IVF attempts had somehow become an absorbing goal in themselves, even leading to a sense of 'dread' in at least two of the women upon merely imagining the treatments would actually lead to a pregnancy; one felt she was not able to 'draw a line under it' even if the attempts had ended years earlier; another stated that the "end line" would be 'when the money finished' not her deliberate choice. Relentlessly pursuing fertility treatment despite the enormous impact and objective damage on one's life ('I felt I was dying,' 'it was terrible' repeated over and over again) is, in this perspective, not only traumatizing, but a way to inflict trauma on oneself: punishing oneself for not being 'good enough,' for not achieving what one 'should,' often for the sake of others (one's own parents or one's husband, for example), not for oneself. Not being able to take decisions to take care of one's self and dedicating all one's efforts to others—including the perspective, yet-unborn child—are possible manifestations of traumas of identity.

Further to this point Marianne (who, we have seen, used to suffer from anorexia) referred to repeatedly having 'crossed so many boundaries' with her own body: 'I feel like I have lost myself so many times trying to please others' (third self-encounter). She has done so for her husband—'I went through more than I would have done because he really wanted it [a child]' (first self-encounter)—something she now resents him for. Adapting oneself to the needs of others is, effectively, the same survival strategy she first started pursuing to deal, as a child, with her mother. In the same self-encounter it also emerges Marianne's difficulty in recognizing her own needs. Here is a telling exchange that also shows the extent to which we might be able to see, to be aware of what we do on the surface, but the nature of trauma—emotions and experiences locked away from our consciousness—prevents us from fully connecting the dots of the motives behind our actions:

> T: Would it help to vocalize the need of this part [Marianne is resonating "angry" while working on the intention "I feel angry when I am sad"] ...like "I need to be seen, I need to be accepted, I need my choices to be accepted and respected"?
>
> For me it is very difficult to express my needs and to ...set boundaries for myself...for others or for my surroundings. I hear what you are saying and I agree, but saying it out *loud*...comes very very unnatural to me ...without knowing *why*...

The reason is the trauma of love (and possibly also of identity) we have already discussed. One of its further repercussions is Marianne's inability to be loving towards herself, which also explains why it becomes so "easy" to engage in behaviour that might lead to self-harm without recognizing what is happening:

> T: If you could talk with this part of yourself [the little girl who is afraid of not being loved by her mother] as the adult woman you are, what could you tell to this part?
>
> The first thing that comes to mind is that maybe you don't have to look for love in your closest surroundings, in your closest circle, you can find love...in other places...[long pause]…love will eventually come your way....and you can give love to others and make others feel love...
>
> T: Can you love yourself as well?
>
> [silence]

T: [After having acknowledged the reality, in IoPT practice the therapist suggests a sentence to strengthen the healthy parts] "I am worthy of love"

I am worthy of love [does not sound convinced]. No, I don't…Something I have talked about before...because I have so much resentment towards myself...I have had many many years [she says these words while sighing] with anorexia... I feel more comfortable providing love than receiving it.

Liv also talks about the process of undergoing IVF as almost betraying oneself (first interview):

What's hard in going through this is also that you meet yourself *everyday* in the mirror. Every thing you said you would not do you are doing, you know, and everything you said you would do you are not doing. In the beginning that was the hardest part...actually accepting myself in this...because I have been *so* vocal about what I meant, about infertility ...I would never judge anyone else who got through IVF...I was just *so* decided on what I would do [laughs] meeting myself was probably harder than everyone telling me that I should relax and then it would happen...because I had to accept myself ...in going against everything I believed in [laughs].

This even leads her (second self-encounter) to want to numb herself in order to make it through the treatments and to confuse—this is again an illusion created by the survival parts—denying her own emotions, her pain and experience (a form of aggression towards oneself) with self-care:

T: You say "I" is trying to take care of yourself, to think about yourself. What does that mean?

Doing things that I need or make me happy...or sometimes I just need to do things that make me feel nothing...I just need to feel nothing […] Not thinking or feeling so much about the things I am going through. Being worryless and don't think about or feel anything...being numb…that can also be very satisfying sometimes.

This last point raises the question of whether the boundaries she has managed to establish to protect herself from others, also apply to protecting her from herself.

Survival strategies and why it is so hard to let go

Longing for a child might well be natural. However, that longing might be entangled with and even be fueled by a thirst for love that we had as small children. As in my case, trying to have a child became a survival strategy.[20] What I could observe in the self-encounters, more specifically, was that some of the women would have liked to have a child to give her/him the love they did not themselves receive. This shows how powerfully the past affects both the present and our imagined future and how important it is to be able to trace the origin of the longing for a child. It explains why it feels so difficult to let go of the dream of the child: because our own survival depends from the love of our parents. The child we are not having is in fact us being deprived of the love we so desperately need. Without that love, as small children, we would have died. That is why we feel that, without the child, we cannot even imagine going on living. One could argue that, without addressing the trauma, even having that child would still not address the longing that is the root of our pain.
As Marianne puts it in a reflection following the third self-encounter:

[20] This, by the way, also affects parents. Many have children for other (or additional) reasons than wanting a child for whom s/he really is. Sometimes the child is a trophy to show to someone one wants to impress (usually one's own parents or the rest of society), an excuse for not knowing what to do with one's life, or to save a relationship. Not having problems in conceiving, however, means most parents never get to reflect on and question their hidden motives.

> Going back to me as a little child [during the self-encounter] I feel very sorry for her ...I feel sad for her and for myself today, also because I don't get to see that future little girl that I was supposed to... take care of and love in a different way that I experienced myself...that is what everybody thinks they are going to do, right?...when I get my own children I am not going to do what my own parents did...

Anna, resonating "child" during her first self-encounter, explicitly relates becoming a parent to giving herself what she did not have, in a situation where she did not receive full emotional support by her parents and the family lived in poor conditions:

> A person I can protect and love and give my strength to...another thing I can thank my childhood and my family for is my strength ... I had it difficult…but learnt how to stand up […] This [to adopt] can be a shortcut to having a very difficult life but I am willing to sacrifice and help another person to have what I did not have.

Anna is also concerned about whether her father will like the child she might acquire through adoption. In exploring the intention "How my father will/would react when I appear with my adopted child or realise [sic] I won't have any child? [sic]" it becomes clear that the child is a projection of herself and an opportunity for her father (who, as already mentioned, cried when she was born because she was not a boy) finally loving her. As she reflects after the end of the self-encounter: 'Maybe unconsciously I want [him] to love the child...as a way to love me ...if he loved the child I would feel more loved.'

Nora's words underline how the child is a survival strategy and, ultimately, a substitute to "be" someone. Although during the self-encounters very little emerged of Nora's childhood, all of this suggests a love and/or an identity trauma:

> what you long for, when I long for a baby, a child, is to be important to someone, really being needed and shift the focus from myself and my own issues and worries and everything and shift the focus to this little human who is totally dependent on you. And that would maybe create some sense of belonging and then having a place in the world (Nora, second self-encounter).

A similar point can be made about Liv (first self-encounter), whose words also suggest both a trauma of identity and one of love:

> Wanting a child, it sits in my whole body...it penetrates my nervous system...it's like everything...I feel...a physical feeling...and there are lots of aspects to it but it's having that little bundle *needing* you in some way, I have a purpose doing that for them, taking care of them...you know, it's...obviously it's not everything to the wish of becoming a parent, but I think that...that's one of the big parts of it...having someone to take care of...that gives you love back and that...will just stick with you forever [laughs].

<u>Benefits of IoPT</u>

When discussing the extent to which the therapy has supported the participants in coming to terms with the perspective of a life without children three caveats are in order. First, when it comes to the "evidence" that the self-encounters are "working," I can establish connections within the material the participants provide—especially by comparing statements in the interviews before and after the psychotherapy sessions—however, I have to rely, in the first place, on what the participants report themselves. It is possible that changes happen in their lives, but they are not aware of them. Or that they have become aware of something that was already happening. It is also possible that more or different changes will materialize at a later stage. In relation to this last point, self-encounters are the beginning of a process of integration

of the parts that “showed up” in the self-encounters. To an extent, in IoPT’s systemic view of our psyche as a multi-layered collection of interrelated parts that are constantly evolving, one could even envisage each self-encounter as starting a process similar to a small big-bang—whose effects will keep on expanding and reverberating on our experience, like circles on water that travel further and further. Second, the therapy is one component of a flow of many events that are happening in the participants’ lives. Marianne, for example, moved from the far North of Norway to the South of the country, something she had planned before the therapy and that marked a “new beginning.” Berit, who works in healthcare, is joining a new team of colleagues in a different part of town. On the other hand, some of the changes were perhaps facilitated by the therapy. Nora, as she tells me in the final interview, ‘is expecting a puppy’ and is letting herself ‘fall in love with this little dog.’ Although getting a dog was the plan all along, this had not been possible before because the family wanted a hunter dog, a breed that was not easily available. While Nora was taking part in the study, she and her husband settled, instead, for a shepherd dog. When I point out the inspiring symbolism in the change of preferences, her reaction suggests an interweaving of both changing circumstances and a new opening in her way of relating to her surroundings:

> Yeah, I mean that's actually very...it is a nice symbolism because I have been hunting for so long [chuckles] this...[sighs] dream [sighs] of having a baby...and I have been ...I have probably said that at an earlier point that the plan had always been to get a dog but of course we wanted to wait until after we had a baby...and I have been afraid of ...like getting a dog now in this process of grieving because ...I have been afraid that it would be difficult for me not to see the dog as a replacement for the baby and I have been afraid that I would resent the dog because it is not my baby [chuckles] ...something that probably would sound strange to anyone who has not experienced this but…I guess after this new news of the pregnant stepdaughter of my husband [an announcement that she found extremely triggering and she lived as a crisis] it suddenly felt like we needed some thing [big sigh], a dog into the family who could give us all some positive feeling and positive focus and actually gather us…[to] gather around this dog...suddenly felt very important and right timewise…so that was suddenly what made the decision quite quick… when my husband found this breed and [found out that it] expected puppies ...so it was a short process and decision making...now I feel very ready...even though I feel… I can feel this caring instinct with this dog, I am able to separate it from what I think I would feel about having a baby and I feel like I am able to see them as totally separate things...yeah.

Third, there was no expectation that the therapy, especially only 2 or 3 sessions, would lead to any dramatic change in any of the women’s lives. This is precisely the nature of integrating trauma: it is an invisible process and it manifests, as Berit put it, through ‘small steps,’ ‘small milestones’ and ‘work in progress’ (last interview).

Having said that, all women experienced positive changes, including the participant who decided to continue with fertility treatment. She stopped the therapy after the second self-encounter. While initially stating, in the last interview, that she did so because of the method (‘I did not feel comfortable’), her inability to commit to the therapy ‘at this particular time,’ and because she did not feel she was gaining ‘anything’ out it, later in the conversation it emerged that her initial goals had changed. While when she joined the study she wanted to prepare herself for the possibility of not succeeding in her attempts to get pregnant, she ‘decided that it is too early to start thinking about *that’:* ‘we had an *amazing* egg retrieval in October [2022] so now we have 7 embryos in the freezer, so there is a chance that it can work out...so it is too early to start thinking “what if”.’ She also admitted that through the first self-encounter (where she set an intention about self-worth) she understood the extent of her grandmother’s influence on her life in the present:

> I got the realization that ...oh my God ...*she* is the reason for so many bad things in my life ... you know...it's when you do those discoveries on another level than just thinking about things...reaching another level you were unaware of ... and making me want to change that in my life...not letting her...she died five years ago...she can't control who I am today any more... yeah...it's just...it's completely uncomfortable discovering those things... but there are things that are not really present ...you have to tap into the unconsciousness to realize that and I would not have done that without that session...so that was very helpful.

The changes the women reported are small, however, as the examples I am going to present next reveal, they could lead to substantial changes in the women's lives. They involve, as I will illustrate, a different, more caring, relationship with themselves, the ability to see new opportunities—from realizing one can "say no" to developing a different mindset to find a new job—and experiencing "more" both physically and emotionally. These aspects point at a receding of the survival and traumatized parts and to a strengthening of the women's healthy parts.

Taking care of oneself to a greater extent than before
As Inger states in her final interview: 'It might sound selfish, but I've been thinking a little more about myself...actually...since I've talked to you...I've been thinking that when I have bad days I listen more to my body.' For instance, she talks about having been invited to a "double birthday celebration" that took place in a hotel over a weekend. She knew the gathering of family members and friends would be triggering—there, she would be confronted, as she phrased it, with 'all the others who have the *perfect family*.' She realized one choice she had was to 'actually' say "no." While she still decided to attend, she took steps to take care of herself: she went earlier on Friday to have the time to 'breathe,' prepare herself by dealing with her feelings; and she left early on Sunday before everyone else got up. This is the same woman who, years ago, as it emerged in her third self-encounter, drove for many hours, all the way from the North of Norway to Stockholm, while she was affected by extreme pain ('the worst I have experienced') because she had just had miscarriage, yet 'put on a mask,' pretended she was 'not in pain,' did not say anything, not even to her partner, because that weekend was supposed to be 'nice and everything,' 'they had bought a new car and booked a hotel' in the Swedish capital.

Seeing new possibilities
Berit talks about having become better, after our meetings (2 therapy sessions and one conversation), at 'protecting herself' from situations that involve children and babies: 'at least I can have the thought "maybe you don't have to do it," you know ...normally [I would think]…"I just have to go," "I have to be a part of it" ...but maybe *nej*, I don't need to do it' (last interview). She underlines that she is still 'vulnerable': from 'being able to protect myself ...to not being able to do [it] is quite [a] small [step].' She talks, for example, about an uncomfortable conversation she had with a friend who is also a mother of two. As Berit explains the situation, she wanted to tell her friend about the health benefits of fasting during the day, after she herself had had a positive experience with this practice. When her friend coldly replied 'ah, ja but...you know, with children and kindergarten…I just need to eat...you cannot do that, you know, when you have children,' Berit felt like a 'stupid teenager,' 'just talking qvatsch': 'I don't have anything...so I can just do my stupid things…but she does not have the time because she has *all* those things in the morning.' However, while thinking back about this episode, she also realizes that she is not as fragile as she would have been before—she recognizes that her friends has been abrupt: as she adds, 'maybe she also is stupid.'

Berit also expresses her wish to stand up for the rights of the childless. In this respect she explains how attending a presentation about protecting people who wear a hearing device from discrimination made her reflect about the rights of people without children:

> it is not allowed to discriminate people on the workplace because of different issues...like disability ...or colour and race and all those things...and they also have *pregnancy* ...that it is not allowed to discriminate [against] *pregnant women*...and I was also thinking ahhhh, a lot of people who feel that...I need to be a part of this "don't discriminate me" thing ...I was thinking ahhhhh you should also have *childless* in that law.

As she adds: 'I kind of feel more powerful around it...since they cannot discriminate people with *hearing devices*, then ...yeah...it just made me even more...don't *fuck* with my no-children life.'

She is, at the time of the final interview, looking for a 'new flame' in her work: she has come to realize that she has been locked in a job position that made her feel 'less than other people,' but she now realizes that there are many ways in which she can use her skills. As she reflects on it:

> …it is a good thing for me to see that there are many ways to work as a healthcare nurse...I don't need to sit in my office with families from half past eight until 2 o'clock…every half an hour or every hour and run family visits for new babies and tch tch tch [sound of "getting things done"]…run many families through the day…and my heart shrinks because [sound of choking] ...did I say something wrong?...Does the baby die if I don't feed the baby enough? [again sound of choking] tut tut tut [sound of doing things mechanically]...but as I see the work where I am now…they have a completely different way to work....and not so many conversations through the day...I get a bit stressed because I really need to work for my money ...but there are many ways to work for money...I don't need to have my heart up here [in my throat] every day....so...maybe that can be something ...a new way…I have been there since 2009 and really loved my work and my clients...I have never been jealous of them for having babies...because that is work in a way ...and I was able to separate it, I wanted to do a good work for them ...now I lost it...but yeah....I have always, always, always since 2008 and even when I was a student in my nurse study…I always felt less because I don't have a child...so that is quite many years where I worked in a feeling where I feel less than other people, my colleagues and my clients...I kind of coped with it ...but I am not able to cope with it [read also as: I am not willing to put up with it] any more ...and now I am trying to find a new platform to stand on.

Berit, as also Nora, signed up for grief groups organized by Ønskebarn in the attempt to come into contact with others in the same situation. These are important steps towards accepting the perspective of a life without children. Especially for Nora this very notion was initially petrifying. Consider this excerpt from her resonance of "let go," while she worked on the intention "I would like to start to let go of my anger, bitterness and jealousy towards other people who get pregnant, have babies and toddlers" during her first self-encounter:

> I want to let go of all these [voice breaks]…sad feelings [cries]…I want to be free of them …I feel trapped, stuck [sighs]…I want to be free from them [sighs, cries] […] in order to be able to do other things in life that bring me joy and laughter and pleasure...I really want to let go [voice breaking] of bitterness and these sad feelings...but also letting go feels scary because ...it feels like I have to accept that I will never be a mum… and that it's over and that the opportunity will be gone...even if I know that there is something that we can choose ...it is not my choice... but I still feel that if I accept it and let go of the sad and bitter feelings of sorrow it's my fault ...that I give up...so […] I feel paralyzed.

Feeling more

Most participants talked about physically feeling different. Marianne starts her final interview, for example, by saying that 'it's good to finally say when people ask me "how are you?"… I

can actually say "fine" and "good".' Nora describes the 'good feelings' she is experiencing in relation to her new puppy, within a greater awareness of bodily sensations:

> I think that the exercise that I did…describing where I felt it [emotions resonated in the self-encounters] in my body and you talking about these things [feeling the emotions] has made me more aware, not that I was not aware of bodily feelings, but I have become ...what is...it has become more normal for me ...how it feels in the body...I notice feelings in the body ...where they sit in the body ...sort of...but it is actually a little bit funny to reflect on this...[chuckles] these good feelings with the dog ....it sorts of feels like little bubbles in the stomach…and that is very like located in the stomach ...where these painful feelings that I described... from the stomach and up to the throat ...that felt like they could paralyze my whole body and affect the core of me […] these good feelings [are now] located in the same area [chuckles].

Inger and Anna report actively trying to "go inside themselves" to *feel*, as they did during the therapy sessions. They have, in other words, become less afraid of their own emotions. For Anna, this means having learned to feel *all* of her emotions, not just the negative ones: 'when I feel sadness I should let it go...feel it…how it feels and try to understand why, where it comes from ...and I do the same now with happiness.' When I ask Anna whether she still feel as much physical pain as before when she hears stories about children suffering (an issue she worked on in her third self-encounter) she explains that being 'more aware of her feelings' gives her more 'control' on them and makes her able to remain present to face problems and situations. As she elaborates on this:

> I think I get less pain...of course I have not come across so many cases of heavy stories...but also now with these kids in the catechism [Sunday religious school], when I see that they [children] have problems I react in a more rational way than I did before...When I thought about them I thought I could help them and give them more attention ...but in a more practical way…perhaps I can sit with them ....so it is mostly here [head] and not so much here [heart] in the sense that […] I can also help more...I still think a lot when I see...I remember I had this catechism this weekend and I was particularly thinking about 2 or 3 of these children at the beginning of the week... what I think is good is that it is 80 kids and of course I do not know every single one of them...but it is important for me that I try to help, but at the same time not being so involved with my heart.

As she further phrases it: 'I still feel it [the pain], but not like this hole, the hole […] I go *inside* [a hole I get sucked in], […] it [feeling my emotions] allows me to go *out* ... and try to see a solution.' It is interesting to notice how feeling more, makes her, counterintuitively, more 'rational,' as she remarks. This, in IoPT perspective, is a positive development: a psychologically healthy individual uses one's mind, senses, emotions—the whole organism—to perceive and make sense of reality.

Why and how IoPT made a difference

The therapy made a difference first and foremost by providing a safe place, not only for taking in what had happened to the women—placing the infertility experience in a longer perspective—and how they felt about it, but also for pausing and actually embracing those feelings. While this is essential for all kind of traumas, I can't underline enough how important this is when it comes to infertility. Because not having children is a source of stigma, the deafening silence around it means that the broader society hardly hears anything about this subject. In fact, involuntary childlessness is not expected to exist at all: technology and a fertility industry that is very skilled at advertising its successes—often through misleading advertising (Tsigdinos 2022)—are believed to always be able to "fix" the "problem." Involuntary

childlessness is thus regarded as a temporary stage until one “gets the baby” (Archetti 2020b). The childless experience is thus thoroughly dismissed and denied.

In this context it made a tremendous difference to all participants to be met with acknowledgment, understanding, validation. As Marianne replied to me having just shared how ‘devastating’ I had found IVF and how it amounted to ‘one of the worst experiences in my life’ during her first interview:

> I have not heard anybody say that before. Yeah...everybody...even the doctors in the hospital...yeah, just one round...that does not even *count*...I am like, what? No, we have to try several times...you know, we don't know, we have to try different things...and even your friends and family who do not know how this works...it's a pressure...you have to try one more time, two times, three times...and I have been saying to my husband...I am proud of myself that I have done 4 rounds...one was more than enough...I was constantly in flight mode...I did not go into fight mode […] I just counted the hours and the days before it would be *over*...I didn't have any hope, any joy, anything...it was just about surviving...I felt like I have been permanently ill and I had to do *this*...yeah.

For Berit the benefits of the therapy consisted in “unpacking” the ‘big bag’ of all the things infertility is. As she phrased it in her final interview: ‘saying it aloud, having this room with you being so interested in it ...and having been through it yourself.’ Nora (also in her final interview) similarly stated:

> these sessions, I think, have been difficult because it is always hard to get into the raw feelings of everything and really be ... putting, like, honest words to them and being honest with myself about having such feelings that I don't really find to be nice [bitterness, jealousy towards other women]...yeah...as we talked about last time...[feelings that were] making me feel like a bad person ...but I think it is important…and also the recognition that I get from you about these feelings being justified and normal.

This last point, particularly ‘not being judged,’ was important for her to be able deal with all the ‘layers of shame’ that infertility involves.

Understanding the place of infertility into the women’s life-course enabled them to *own* the emotions associated with it and to appreciate its *reality*, away from rose-tinted glasses and well-meaning attempts at positive framing by medical staff, family and friends. As again Marianne talks about going through the therapy in her final interview:

> I have been thinking *a lot* about these sessions that I have had with you...and I think that's been the first time in these years trying to conceive that I have had someone to talk to...[about anything] other than the medical issues...yeah...and not just...someone ...how to put it...someone I can...I can reflect with, I can come to terms with what happened...this *happened* to me ...yeah...it's started a lot of reflections and we got to talk about my childhood and my relationship with my *mother*...and that is not something that I have addressed before to *anyone*... what I have become...in the sense of my life, my childhood and everything that's happened throughout the last couple of years...[…] reflections but also some understanding and acceptance of who I am ... it's been very useful and interesting, but first and foremost I would say that...you are the first person that I have ever spoken to about the childlessness…who did not have a medical perspective or judgment or advice...and stories about who they know that [got pregnant]...you know that...that I just can speak about it *as it is* ...just exactly where *I am ...in my body and my soul*.

Allowing oneself to feel, in a context where even the medical establishment encourages becoming numb and dissociated, was another key component of the process of coming to terms with the reality of infertility. As Marianne further explains:

> I feel it has been very, very helpful...it made some things come up to the surface just by *saying* it, and *feeling* it, being able to...letting myself *feel*...those feelings...that I have repressed since I was a child…it's been very useful...just by *allowing* myself to do it, feel that, feel the feelings...yeah.

Society dismisses the infertility experience to such an extent that even those directly affected by it end up dismissing it. Inger, in her final interview, points out how, through the therapy, she realized how significant infertility has been in her life:

> I think it's has been difficult in a way to find a way forward when you've had this problem, because [my situation was] I haven't gotten over it yet, I haven't been able to say, "OK, that's life, just go on, do the best out of it"...I work all the time to achieve a good everyday life …I think it's really strange that the body wouldn't just put a line under it…that I have to work the whole time, every day….so when I've talked to you, I've sort of realized "oh! it means *so much* to me," it means so much when we talk about that feeling…the sense of being an outsider, the loneliness, for feeling like one who is not good enough…and when I start to go into it then...I think it has been very special, really very nice…so effective.

Sharing one's story in a safe setting is healing because acknowledging one's reality and feelings as valid is the initial step to going through the first wall built by our survival parts not to come into contact with the unbearable emotions of the traumatized parts—the wall of illusion (see Figure 5). As a result, we believe that there is "nothing" to see in the first place. In the case of involuntary childlessness, this is a particularly thick wall, reinforced by such lack of recognition from the society around us—in the childless community this is often referred to as 'disenfranchised grief' (Day 2021)—that we do not take it seriously ourselves.

Could not the validation, one could argue, have been achieved by attending a group of like-minded people, without the help of trauma therapy? Yes, that is possible and it could be a good *beginning* of the process that leads to reintegration, but it is not sufficient for two reasons. First the point of systematic therapy is outlining the intention giver's traumabiography. This is a process similar to drawing a map: the intention giver can clearly see how things connect over one's own life experience. This long and deep view on one's past gives a sense of perspective, ownership of one's experience, but also, exactly like a map, constitutes a starting point for navigating forward. This statement by Marianne in her last interview eloquently underlines this point:

> I have been reflecting a lot about what you said [in the conversation following the resonance] about my relationship with my mother and that has been very, very helpful...in a good way…I would never ever, ever, ever forget that you said that "you are trying to impress your mother...you are trying to...yeah...make your mother proud"...that was a *life changing* moment in some way...it makes so much sense […]...I had never ever thought about it that way.

Second, it is through the resonance that one can go through the wall of the unconscious, safely accessing the second wall: the portal to the trauma feelings that were once experienced as unbearable (see Figure 5). This requires trauma-specific handling. Inger explains more in detail why the self-encounters were 'effective' and how they were different from attending, as she did in the past, both a grief group and a psychologist not specialized in trauma:

> How shall I explain it? The other therapy sessions or conversations were totally different ...in the conversation with you I am *Inger*...I am myself and I go into that...I thought it was really nice ....because I have not done this with the grief group....which was nice and we could exchange experiences ...[name of facilitator] is good in leading that [the group] but she is not a therapist ...she has just her experiences she has gone through herself ...she is good at talking to people...she definitely is...it is just a matter of beginning and asking some question and it becomes, in a way, a conversation with all who are there ...and we exchange experiences ...someone who has had endometriosis, or has had an operation....[but this, IoPT therapy] is completely different... completely different…When I went to the psychologist it was difficult to pick out just "childlessness" as far as I am concerned because there has been so much chaos in my life with [name of the partner] and his children ...so it became actually more a conversation about his [partner's] situation…then it became a conversation about what happened ...but I did not think that was *therapy,* it was more like we sat and talked ...it did not *help* me just to tell everything again, because it is so much, isn't it? It was not *good enough* therapy for me ...but what you have done now ...it was been effective [*virkningsfull*], as I said, completely different because here I am *Inger*, I go into myself, and I am allowed, in this space, to breathe, *feel* the feelings [*kjenne på følelsene*] *before* I start talking. That moves something inside me ...and I begin to become very emotional now as I talk about this [voice slightly breaking] because it is a tough subject and it happens rarely that I have somebody I can talk about *that…*and this is addition to feeling the feelings...it has been very effective for me.

Marianne also underlines the difference of the IoPT sessions from "ordinary" therapy, especially the possibility, through the resonance, to reach deeper than what we are aware of:

> this was more than talk about what happened...yeah...I have talked to other people who have been to therapy and they said it is just..."tell me what's going on" and you have to talk...this was a different experience... by using the tools that you gave me during the sessions...that I had to bring in sentences [intentions] and resonate on words...I don't think I would have been able to resonate or reflect on my own just by asking questions...yeah...many things that I have said to you I have not said to *anyone* before... and did not realize [I was thinking them] myself.

Conclusions

As I wrote in my book 'Why has this [the relationship between infertility and PTSD] been known for at least 20 years [now 25], yet I have never heard about it? Why is nobody talking about it in the open?' (Archetti 2020a: 207). The answer lies at the convergence of, on the one hand, the stigma and silence that surrounds infertility, and on the other hand a multibillion, and ever developing, fertility industry. As Tsigdinos (2022: 443) eloquently puts it, the ART (assisted reproductive technology) industry has been able to 'expand with impunity for decades by downplaying and silencing patient-consumers' damaged corporealities and trauma. Moreover, stigma and suffering associated with failed procedures stopped most former patient-consumers from organizing for greater consumer protections and industry reforms.'

This study wanted to be a first step in taking the trauma of infertility seriously. I have shown, more specifically, that IoPT theory can help explain how infertility fits into one's traumabiography. This provides answers to: why for many individuals infertility is a trauma in the first place; why the experience of infertility and what revolves around it, including fertility treatments, might be triggering of earlier traumas; why its grief is "complicated" and why it is so difficult, in the words of many of the individuals affects, to let go of the "dream" of having a child.

From a therapeutic perspective even 2 to 3 IoPT one-to-one sessions did bring positive changes in the lives of the participants. While there were early identity traumas whose consequences could be observed, the limited context of intervention offered by such few sessions did not allow addressing them directly. There could be, in other words, more processing to do. Work in the longer-term, in this respect, would enable deeper and longer lasting changes.[21] This is something I will focus on in my future practice, together with the possibility of running group sessions to amplify the sense of validation one can get from sharing one's feeling and experiences with others who are in the same circumstances.

While I have not systematically compared IoPT with other approaches, my argument is that if an experience is a trauma, it needs to be conceptualized and treated like a trauma. This is why any "treatment" that involves mere affirmations or "rewriting" of one's story—any approach that mostly revolves around the cognitive level (for one example: Aiyenigba, Weeks and Rahman 2019)—is likely to have limited effects. It is crucial to address the roots of trauma by investigating one's traumabiography. Where infertility turns into a self-inflicted trauma—for example by continuously subjecting oneself to invasive fertility treatments—or a re-traumatization, it is not sufficient to deal with infertility only (an example of infertility-focused treatment is offered by Jaffe 2017), rather it is necessary to go back, often far back, into the individual's past.

Often even therapists that talk about "trauma" in relation to infertility do not really treat is as trauma. Reading the book "Infertility and PTSD" (Flemons 2018), a chapter entitled "Trauma 101" ends with the following advice: 'It may seem impossible, but you still need to find areas to exercise healthy control. You need to make as many daily life decisions as you can on your own terms […] *You need that place or experience where you can just hit the "pause" button. And receive*' (Flemons 2018: 30-31, emphasis in the original text). The very notion of "hitting the pause button" or "receiving" feels almost triggering to me. I am not doubting this could work in the absence of trauma. But in my case, or in that of most of the women who took part in this study—individuals who have experienced identity trauma—it is completely inappropriate.

During the self-encounters many of the parts that were resonated had difficulties even admitting to having needs at all. In fact, not only do such recommendations reiterate the idea that one "just" needs to relax—one of the well-meaning arguments of the many people who have little understanding of what infertility means and feels like and want to give us suggestions on how to deal with it—it is also impossible to implement: for an individual with an identity trauma, there is no "pause" button. The world one lives in is a dangerous place where one's very existence is constantly threatened. In that world, where one also has to struggle to be loved and feel wanted (identity trauma is normally the ground for love trauma), there is no straightforward "receiving," let alone from oneself! As children we are unable to explain why our unconditional love for our parents is not returned. We believe that it is because of us: we are wrong, we are not "good enough," in other words it is "our fault." The recommendation that we "just" have to find more control in our life—a control we can never find because we live in a constant state of emergency—is practically setting us up for failure: when we will not be able to achieve it, we will fall back onto the well-stablished line of explanation: it is our fault.

Effectively, trying to change the story so that it is "empowering" and oriented towards "positive thinking" without a change in one's psychic structures—especially a strengthening of the healthy parts—consists in yet another dismissal of the reality of infertility and the emotions that revolve around it. Corley-Newman (2016: 101) in a study on the relationship between infertility, infertility treatment, psychological interventions, and posttraumatic stress disorder

[21] An image Marta Torsheim uses in teaching IoPT theory at the Institute for Traumearbeid in Oslo is that of "layers of trauma" that are progressively addressed, self-encounter after self-encounter.

very interestingly finds that women ‘who received no psychological treatment had significantly lower PTSD scores than those who received psychological treatment once or throughout their treatment.’ She is unable to explain why. Roozitalab and others (2021: 286), picking up on that result, hypothesize that it ‘can be due to the fact that individuals with higher stress are more interested in receiving psychological interventions.’ That might of course be the case (the intervention still does not appear to work, though, which begs the further question of why). But my point is, the researchers do not specify what kind of psychological interventions the women received. Although I have no evidence about that specific study, what if those women felt worse because, in the treatment, they were encouraged to do exactly the opposite of what would actually help them?

I realized that in the process of writing my book I did re-write my story, but this was not purely a cognitive exercise. It was the reflection of the fact that, in the process, I had also changed my identity: by attempting to develop a language of “feeling in the body,” as I called it (Archetti 2020a: 16, 97), to enable to reader to access my experience I came into contact with what had happened to me and the emotions of my traumatized parts. I had started integrating them. Those emotions were raw and I almost forced myself to experience them for the sake of my writing. This caused me a great deal of suffering and, possibly, re-traumatization. Looking back at it as a training practitioner, it is something that, if I had been more aware of the nature of trauma, I could have achieved less painfully, more safely and systematically through the help of a trauma-specialized practitioner.

Finally, infertility is a taboo topic also for professional therapists. As one of the participants in the study (Inger, in her last interview) explained to me why previous therapy she had been through (contrarily to IoPT) had not worked for her, she said that conversations ‘ground to halt’ because ‘the therapist […] did not dare to go into a topic he experienced as taboo.’ It is crucial that the therapist is trained not only in trauma, but also to stand in one’s healthy parts to provide a safe space and be able to tread into the zone of what is, by all practical means, an extremely uncomfortable subject for all.

The therapist should have undergone one’s own therapy and, in the specific case of involuntary childlessness, ideally, I would add, be childless her/himself. Being surrounded by so much lack of understanding, it is difficult, especially for those who struggle the most, to even ask for help. Knowing that the therapist has been through the same experience, as I observed first-hand, makes all the difference in feeling listened to, safe and, ultimately, in enabling one to begin the journey back to oneself.

References

Ageing Well Without Children (2022) Homepage. https://www.awwoc.org/

Ageing Well Without Children (AWOC) UK (2022) Homepage [Facebook group]. https://www.facebook.com/groups/1476937045912974

Aiyenigba, Abiola O., Andrew D. Weeks and Atif Rahman (2019) Managing Psychological Trauma of Infertility. *African Journal of Reproductive Health* 23 (2): 76-91.

Archetti, Cristina (2020a) *Childlessness in the age of communication: Deconstructing silence.* London: Routledge.

Archetti, Cristina (2020b) Childlessness: Our very existence is being denied. *Aftenposten*, 27 June. https://www.aftenposten.no/meninger/kronikk/i/qLGvGz/childlessness-our-very-existence-is-being-denied-cristina-archetti

Agarwal, Ashok, Aditi Mulgund, Alaa Hamada, and Michelle Renee Chyatte (2015) A unique view on male infertility around the globe. *Reproductive Biology and Endocrinology* 13:37. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4424520/pdf/12958_2015_Article_32.pdf

American Psychiatric Association (APA) (2022a) "Posttraumatic stress disorder" definition. https://www.apa.org/topics/ptsd

American Psychiatric Association (APA) (2022b) "Trauma" definition. https://www.apa.org/topics/trauma

Bartlik B., K. Greene, M. Graf, G. Sharma and H. Melnick (1997). Examining PTSD as a complication of infertility. *Medscape Womens Health* 2(3): n.p.

Beaujouan, Éva, Tomáš Sobotka, Zusanna Brzozowska, and Kryštof Zeman (2017). Has childlessness peaked in Europe? *Population and Societies* 540 (January): 1–4.

Berrington, Ann (2016) Childlessness in the UK. In Kreyenfeld, Michaela and Dirk Konietzka (eds) *Childlessness in Europe: Contexts, causes, and consequences.* Cham: Springer Open, pp. 57–76. https://link.springer.com/chapter/10.1007%2F978-3- 319-44667-7_3

Bhat, Amritha and Nancy Byatt (2016) Infertility and perinatal loss: When the bough breaks. *Current Psychiatry Report* 18: 31.

Bradow, Allyson (2012) *Primary and secondary infertility and post traumatic stress disorder: Experiential differences between type of infertility and symptom characteristics*. Ph.D. Thesis. Spalding University, Louisville, KY.

Brotughton, Vivian (2021) *Trauma and Identity: Identity Oriented Psychotrauma Therapy: Theory and Practice*. Steyning: Green Balloon Publishing.

Corley-Newman, Antoinette (2017) *The relationship between infertility, infertility treatment, psychological interventions, and posttraumatic stress disorder*. Ph.D. Thesis. Walden University, Minneapolis, MN. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=3908&context=dissertations

Day, Jody (2013) 50 ways not to be a mother … Gateway Women, 6 September. http://gateway-women.com/50-ways-not-to-be-a-mother-with-apologies-to-paul-simon/

Day, Jody (2016) *Living the life unexpected: 12 weeks to your plan B for a meaningful and fulfilling future without children*. London: Bluebird.

Day, Jody (2018) MTL Webinar – Jody Day – The Grief of Childlessness [YouTube video]. Fertility Network UK, 8 July. www.youtube.com/watch?v=6M4EE7UIBfQ&feature=youtu.be&t=25m7s

Day, Jody (2021) The disenfranchised grief of involuntary childlessness: A living loss that society dismisses [Youtube video]. Talk for «Grief: A Study of Human Emotional Experience». York, University of York, 5 March. https://www.youtube.com/watch?v=y15Z8NE6lo8

de Boer, Marjolein, Cristina Archetti, and Kari Nyheim Solbrække (2019) In/fertile monsters: The emancipatory significance of representations of women on fertility reality TV. *Journal of Medical Humanities* 43: 11-26. https://doi.org/10.1007/ s10912-019-09555-z.

Donkor, Ernestina S. and Jane Sandall (2007) The impact of perceived stigma and mediating social factors on infertility-related stress among women seeking infertility treatment in Southern Ghana. *Social Science and Medicine* 65(8): 1683–1694. https://doi.org/10.1016/j.socscimed.2007.06.003

Dykstra, Pearl A. (2006) Off the beaten track: Childlessness and social integration in late life. *Research on Aging* 28(6): 749–767. https://doi.org/10.1177/0164027506291745

Dykstra, Pearl A. and Michael Wagner (2007) Pathways to childlessness and late-life outcomes. Journal of Family Issues, 28(11): 1487–1517. https://doi.org/10.1177/0192513x07303879

Ethics Committee of the American Society for Reproductive Medicine (2013) Access to fertility treatment by gays, lesbians, and unmarried persons: A committee opinion. Fertility & Sterility, 100(6): 1524-1527.

Farncombe, Vicky (2018) Fifty and childless: Finding a way forward. *BBC 5 Live*, 13 January. www.bbc.com/news/education-42647471.

Flemons, Joanna (2018) *Infertility and PTSD: The uncharted storm*. CreateSpace Independent Publishing Platform.

Ford, Jane, Natasha Nassar, Elizabeth Sullivan, Georgina Chambers, and Paul Lancaster (2002) Reproductive health indicators, Australia, 2002. Sidney: AIHW National Perinatal Statistics Unit. www.aihw.gov.au/getmedia/50ee0a89-d057-4698-abb3-771991b9cf01/8471.pdf.aspx?inline=true

Greil, Arthur (1991) *Not yet pregnant: Infertile couples in contemporary America*. New Brunswick, NJ: Rutgers University Press.

Hirsch, Anne M. and Stephen M. Hirsch (1995) The long-term psychosocial effects of infertility. *Journal of Obstetric, Gynecologic and Neonatal Nursing* 24(6): 517–522. https://doi.org/10.1111/j.1552-6909.1995.tb02389.x

Hoge, Charles W., Carl A. Castro, Stephen C. Messner, Denis McGurk, Dave Cotting, and Robert L. Koffman (2004) Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *The New England Journal of Medicine* 351(1): 13–22. http://doi.org/10.1056/NEJMoa040603

Hooper, Ryan (2018) 'Intense grief' after failure of fertility treatment is comparable to bereavement – new research. *Independent.ie*, 30 October. www.independent.ie/life/family/fertility-and-you/intense-grief-after-failure-of-fertility-treatment-is-comparable-to-bereavement-new-research-37473334.html

Jaffe, Janet (2017) Reproductive trauma: Psychotherapy for pregnancy loss and infertility clients from a reproductive story perspective. *Psychotherapy* 54(4): 380-385.

NWO (2010) Kinderloosheid is zelden een keuze [Childlessness is rarely a choice]. NWO, 5 February. https://web.archive.org/web/20160816043652/www.nwo.nl/actueel/nieuws/2010/Kinderloosheid+is+zelden+een+keuze.html

Kassam, Ashifa, Scammell, Rose, Connolly, Kate, Orange, Richard, Willsher, Kim, and Ratcliffe, Rebecca (2015) Europe needs many more babies to avert a population disaster. *The Guardian*, 23 August. https://www.theguardian.com/world/2015/aug/23/baby-crisis-europe-brink-depopulation-disaster

Kotkin, Joel (2017). Death spiral demographics: The countries shrinking the fastest. *Forbes*, 1 February. https://www.forbes.com/sites/joelkotkin/2017/02/01/death-spiral-demographicsthe-countries-shrinking-the-fastest/#445392afb83c

Kersten, Ellen (2018) Who am I in my body and my sexuality as a woman? In Ruppert, F. and H. Banzhaf (eds) *My body, my trauma, my I: Setting up intentions, exiting our traumabiography*. Steyning: Green Balloon Publishing, pp. 303-316.

Kjaer, Trille, Vanna Albieri, Allan Jensen, Susanne K. Kjaer, Christoffer Johansen & Susanne O. Dalton (2014) Divorce or end of cohabitation among Danish women evaluated for fertility problems. *Acta Obstetricia and Gynecologica Scandinavica* 93: 269–276.

Leon, Irving G. (2010) Understanding and treating infertility: Psychoanalytic considerations. *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* 38(1): 47–75. https://doi.org/10.1521/jaap. 2010.38.1.47

Maté, Gabor (2019) *When the body says no: The cost of hidden stress*. London: Penguin Random House.

Menakem, Resmaa (2017) *My grandmother's hands: Racialized trauma and the pathway to mending our hearts and bodies*. Las Vegas: CRP.

Miall, Charlene E. (1985) Perceptions of informal sanctioning and the stigma of involun tary childlessness. *Deviant Behavior* 6(4): 383–403. https://doi.org/10.1080/01639625.1985.9967686.

Nahar, Papreen and Sjaak van der Geest (2014) How women in Bangladesh confront the stigma of childlessness: Agency, resilience, and resistance. *Medical Anthropology Quarterly* 28(3): 381–398. https://doi.org/10.1111/maq.12094

OECD (Organisation for Economic Co-operation and Development) (2015) Childlessness. OECD Family Database. www.oecd.org/els/family/SF_2-5-Childlessness.pdf

Pfeffer, Naomi and Anne Woollett (1983) *The experience of infertility*. London: Virago

Präg, Patrick, Tomáš Sobotka, Eevi Lappalainen, Anneli Miettinen, Anna Rotkirch, Judit Takács, Annalisa Donno, Maria Letizia Tanturri, and Melinda Mills (2017) Childlessness and assisted reproduction in Europe. Summary report of key findings for WP4. Families and Societies Working Paper 69: 1–32. https://doi.org/10.31235/osf.io/sxgu4

Quaas, Alexander and Anuja Dokras (2008) Diagnosis and treatment of unexplained infertility. *Reviews in Obstetrics & Gynecology* 1(2): 69-76.

Remennick, Larissa (2000) Childless in the land of imperative motherhood: Stigma and coping among infertile Israeli women. *Sex Roles* 43(11/12): 821–841.

Rettner, Rachael (2012) Fertility treatments may put women at risk for PTSD symptoms, study suggests. *NBC News*, 8 August. https://www.nbcnews.com/health/health-news/fertility-treatments-may-put-women-risk-ptsd-symptoms-study-suggests-flna931257

Riessman, Catherine Kohler (2000) Stigma and everyday resistance practices: Childless women in South India. *Gender and Society* 14(1): 111–135. https://doi.org/10.1177/089124300014001007

Roozitalab, Sahar, Mitra Rahimzadeh, Seyed Roghieh Mirmajidi, Mina Ataee, Sara Esmaelzadeh Saeieh (2021) The relationship between infertility, stress, and quality of life with posttraumatic stress disorder in infertile women. *Journal of Reproduction & Infertility* 22(4): 282-288.

Rose, Gillian (1997) Situating knowledges: Positionality, reflexivities and other tactics. *Progress in Human Geography* 21(3): 305–320. https://doi.org/10.1191/030913297673302122.

Rosner, Marni (2012) *Recovery from traumatic loss: A study of women living without children after infertility*. Ph.D. Thesis. University of Pennsylvania, Philadelphia.

Rotkirch, Anna and Anneli Miettinen (2016) Childlessness in Finland. In Kreyenfeld, Michaela and Dirk Konietzka (eds) *Childlessness in Europe: Contexts, causes, and consequences*. Cham: Springer Open, pp. 139–158. https://doi.org/10.1007/978-3- 319-44667-7_7.

Ruppert, Franz (2008) *Trauma, bonding & family constellations: Understanding and healing injuries of the soul*. Steyning: Green Balloon Publishing.

Ruppert, Franz (2012) *Symbiosis and autonomy: Symbiotic trauma and love beyond entanglements*. Steyning: Green Balloon Publishing.

Ruppert, Franz (ed.) (2016) *Early trauma: Pregnancy, birth and first years of life*. Steyning: Green Balloon Publishing.

Ruppert, Franz and Harald Banzhaf (2018) (eds) *My body, my trauma, my I: Setting up intentions, exiting our traumabiography*. Steyning: Green Balloon Publishing.

Ruppert, Franz (2019) *Hvem er jeg i et traumatisert og traumatiserende samfunn? Hvordan styrer offer-overgriper-dynamikk livet vårt, og hvordan kan vi bryte ut av den?* [Who am I in a traumatized and traumatizing society? How the victim-aggressor-dynamic drives our life and how can we break its cycle?] Oslo: IoPT Norge – Institutt for Traumearbeid.

Ruppert, Franz (2020) *Kjærlighet, lyst og traume: På vei mot en sunn seksuell identitet* [Love, desire and trauma: On the way to a healthy sexual identity]. Oslo: IoPT Norge – Institutt for Traumearbeid

Ruppert, Franz (2021) *I want to live, love & be loved: A plea for all of us to find true joy in life and real human connection in peace and freedom*. Hamburg: Tredition.

Schulte, Cordula (2016) Misacrriages and stillbirths as trauma. In Ruppert, Franz (ed.) *Early trauma: Pregnancy, birth and first years of life*. Steyning: Green Balloon Publishing.

Schwab, Gabriele (2010) *Haunting legacies: Violent histories and transgenerational trauma*. New York: Columbia University Press.

Schwerdtfeger, Kami L. & Karina M. Shreffler (2009) Trauma of pregnancy loss and infertility among mothers and involuntarily childless women in the United States. *Journal of Loss and Trauma* (14)3: 211-227. DOI: 10.1080/15325020802537468

Shaw, Stephen (forthcoming) Birthgap [documentary] https://www.birthgap.com/

Sundby, Johanne (2010) Infertility in public health: The case of Norway. *Facts, Views & Vision in Obstetrics and Gynecology* 2:3, pp.177-181.

Swift, Alison, Pamela Reis & Melvin Swanson (2022) Infertility-related stress and quality of life in women experiencing concurrent reproductive trauma. *Journal of Psychosomatic Obstetrics & Gynecology* 43(2): 171-176. DOI: 10.1080/0167482X.2021.2008901

Tanturri, Maria Letizia, Melinda Mills, Anna Rotkirch, Tomáš Sobotka, Judit Takács, Anneli Miettinen, Critina Faludi, Venetia Kantsa, and Despina Nasiri (2015) State-of-the-art report. Childlessness in Europe. Families and Societies Working Paper Series, No. 32. www.familiesandsocieties.eu/wp-content/uploads/2015/03/WP32TanturriEtAl2015.pdf

The Childfree Choice (2022) Homepage [Facebook group]. https://www.facebook.com/thechildfreechoice

The Economist (2017) The rise of childlessness. *The Economist*, 27 July. www.economist.com/international/2017/07/27/the-rise-of-childlessness

Thorn, Petra (2009) Understanding infertility: Psychological and social considerations from a counselling perspective. *International Journal of Fertility and Sterility* 3(2): 48–51.

Tsigdinos, Pamela Mahoney (2022) An IVF survivor unravels 'fertility' industry narratives. *Journal of Marketing Management* 38(5-6): 443-459. DOI: 10.1080/0267257X.2021.2003847

Van der Kolk, Bessel (2015) *The body keeps the score: Mind, brain and body in the transformation of trauma*. London: Penguin Books.

Volgsten, Helena, Agneta Skoog Svanberg, and Pia Olsson (2010) Unresolved grief in women and men in Sweden three years after undergoing unsuccessful in vitro fertilization treatment. *Acta Obstetricia et Gynecologica* 89(10): 1290–1297. https://doi.org/10.3109/00016349.2010.512063

Wenger, G. Clare, Anne Scott, and Nerys Patterson (2000) How important is parenthood? Childlessness and support in old age in England. *Ageing and Society* 20(2): 161–182. https://doi.org/10.1017/s0144686x99007631.

WHO (World Health Organization) (2022) "Infertility" definition. https://www.who.int/health-topics/infertility#tab=tab_1

Wirtberg, Ingegerd, Anders Möller, Lars Hogström, Svein-Erik Tronstad, and Ann Lalos (2007) Life 20 years after unsuccessful infertility treatment. *Human Reproduction* 22(2): 598–604. https://doi.org/10.1093/humrep/del401.

Whiteford, Linda M. and Lois Gonzalez (1995) Stigma: The hidden burden of infertility. *Social Science and Medicine* 40(1): 27–36. https://doi.org/10.1016/0277-9536(94)00124-c

Wolynn, Mark (2017) *It Didn't Start with You: How Inherited Family Trauma Shapes Who We Are and How to End the Cycle.* New York: Penguin Books.

Yeshua-Katz, Daphna (2019) Blame or shame: The search for online support and stigma origin among Israeli childless women. *Mass Communication and Society* 152: 1–22. https://doi.org/10.1080/15205436.2018.1469152