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# Mother-Embryo-Dialogue in medically assisted reproduction

Self-preservation by means of reproduction is an imperative deeply anchored in the genetic substance of all living beings, as our cultural inheritance from earliest times demonstrates in imagery and mythological traditions. If undesired infertility becomes a couple's fate, it may give rise to great distress and deep pain of failure. If the desired child remains a phantom this may create an all-consuming 'phantom pain', together with that triad of deep soul sorrow, physical pain, and the mental awareness surrounding the desired but absent child. This pain applies to both to the women and to the man.

Birth is the junction point of life and death, both for the child as well as for its mother. Every being-born event constitutes an intense physical shock experience, threatened by the possibility of death. British psychotherapist, David WASDELL (1993) describes the process as follows,

"Growth comes to a halt and the previously nourishing and protective environment increasingly transforms into a location of deprivation and persecution, accompanied by a decline in the physical and emotional wellbeing of the foetus. This is why the child is actually badly equipped for the titanic birthing-battle of life and death" (page 16).

More and more couples are undergoing medically assisted fertilization, a procedure that contradicts our inherent genetic preconceptions of reproduction by means of the sexual act. Thus the very public and technological primal scene in a laboratory may considerably interfere with the natural female ability to conceive. The frozen desire, the denied sexual act of procreation, and the painful instruments prevent any erotic procreative or bonding urges exacerbating the mental trauma often present in the female IVF recipients.

When a prenatal girl, as an adult, is preparing for pregnancy, and even more so when she is pregnant, unconscious body-memories from her own pre-birth time and of her own birth are reactivated and then influence her attitude toward her child to be.

My thirty years of psychotherapeutic experiences with involuntarily childless women have given me multi-faceted insights into the psychogenesis of so-called female sterility.

Through my work at a fertility clinic I have experienced the helplessness, suffering, frustration, failures, and fears, but also the tenaciousness of those couples who tried to conceive a child there; often over a period of several years. I also felt sadness for the loss of the many embryos; those potential children who were unable to enter life according to their biological promise, but simply died.

The affect that stands out in some of the women, who undergo medically assisted fertilization, is the high degree of fear. I described a group of them, in whom this fear arose only during the period when the desire for a child came up, and which we were then able to understand in connection with their own threatening prenatal or perinatal phase (AUHAGEN-STEPHANOS 2012). Traumatic near-death experiences or

prenatal life-threatening experiences, which have become stored in the physical body, will form both the conscious and the unconscious attitude towards children. They may even lead to infertility or miscarriages. Thus a pregnancy will represent for such women the danger of death or extinction. Such feelings block the inner sense of security needed to allow one's own child to grow within one's body.

EMERSON (2011) calls this reactivation of traumatic memories stored in the body Recapitulation. In this recapitulation the woman identifies with the aggressor, her own once pregnant mother and that traumatic event, the life-threatening situation in her mother's body, and through which this woman then reactivates a combined perpetrator and victim role. This means, she will carry both the inner representation of the threatened child as well as the destroying mother within herself. In order to survive, and in an unconscious repetition compulsion, they will have to let their embryos and foetuses die.

We know that the soul may say 'No' to a pregnancy, even though a child is consciously wanted, if a woman is afraid of endangering herself, or if she unconsciously fears not being ready for a child. Fear works like a contraceptive pill. In some women the desire for a child is ambiguous, so that the conscious wish for a child and the unconscious fear of the child are kept in balance. The psychic disturbances which I have experienced with IVF-women (In-Vitro-Fertilisation) may be categorised into three groups, namely intrapersonal and biographical factors, trans-generational factors as well as relationship conflicts.

Building on the bonding analysis therapy methods of the Hungarian psychoanalysts Hidas and Raffai (Hidas and Raffai, 2006), I have developed the Mother-Embryo-Dialogue and introduced it into the field of reproductive medicine. I integrate this as a parameter according to Eissler (Eissler, 1953date, p.n more as a guided affective imagery into an ongoing psychoanalysis/ psychotherapy at the time of assisted fertilization. The Mother-Embryo-Dialogue is, so to speak, a mental 'sensing' of the body, a 'return' to the uterus and all its capabilities. It reveals the insufficiencies of the woman's own pre- and perinatal experiences, and her resulting concept of motherhood. The transference created through the Dialogue enables the mother-to-be to re-experience her own earliest body memories mentally and emotionally, even before an actual conception occurs.

By using the human instruments of speech and language, we are able to transform the work of the medical instruments into a communication of the soul.

According to Lévinas is the nature of language friendship and hospitality. And according to Freud language means consciousness.

The transitional space created by the Mother-Embryo-Dialogue can biologically increase the chances of pregnancy and establish primary maternal preoccupation.

Speak to it, - to the unborn being! That is the challenge of creating a bonding analysis between the mother and the unborn child, as developed by Hidas and Raffai. Speak to the unconceived one! became my extended starting point, one which I placed even earlier in the sequence and which I introduced into the fertility clinic scenario – the place where the goal is to make a pregnancy possible, to make the female body ready for conception and to give the embryo a chance of life through its lodging in the uterus. Using the dialogue right from the beginning, even before conception, we are able to extend the boundaries of reproductive medicine through this mental and spiritual aspect, to give the embryo a greater chance of life, and to guide the hopeful mother-to-be to loving motherliness. This early accompaniment of the future child deepens the bond and helps to compensate for the difficulties encountered in technological fertilization.

This dialogue is a high emotionally verbal communication between the woman who wants to get pregnant and her womb, later on also with her embryo shortly before or after conception. Often I have to support the dialogue myself speaking instead of the mother-to-be, showing her how to communicate with her sexual organs and her later child with respect and love. Through that she can identify herself with my motherly care and attitude for her womb and her future baby.
A number of women who had previously suffered unsuccessful IVF treatments or miscarriages were able to rediscover trust in their own bodies and to become pregnant after learning the Mother-Embryo-Dialogue. The future mother's unconscious bodily processes and reactions may endanger the child by reducing the blood supply to the uterus, or creating states of excitation and stress. Her mental experiences during a pregnancy, whether positive or negative, are transformed into the biological events of the pregnancy and cannot be separated from the further development of the unborn child. If possible, I begin the treatment with a course of psychotherapy/psychoanalysis where I can accompany the woman (or the couple) and we can begin to deal with fear of failure, sorrow, pain and feelings of guilt. In this framework we can lay the foundations for trust and opening-up, for deeper understanding and insights, and for considering possible feelings of ambivalence towards having a child.
This dialogue is divided into two steps. The first step makes provision for the container of the embryo, the uterus. Only in the second step does the mother-to-be address her embryo as her future child. By preparing herself for becoming a mother she is also preparing the embryo to become a child of its mother and to accept and acknowledge this individual mother. According to D.W. Winnicott is a baby without a mother unthinkable (D. W. Winnicott 1965).
A woman has to learn that the doctors of reproductive medicine cannot create her offspring by themselves. They may help, with their instruments and medications, to form an embryo and to prepare the woman hormonally for a pregnancy. But the future mother must not be viewed as another instrument among other technological instruments. It is her task alone to give the child a spirit and a soul, through love and desire.
We like to use the metaphor of hospitality for the Mother-Embryo-Dialogue . The maternal body is the house, the woman is the landlady, (or perhaps the house mother) while the womb is the guest-room and the embryo the guest. With the help of language, the potential mother is able to transform the work of the medical instruments into soul communication. The purpose of the Mother-Embryo-Dialogue is thus to create the status of an independent subject for both the mother and the unborn child. What I found surprising, to begin with, was that the first perceptible result of the Mother-Embryo Dialogue for these women was the disappearance of their menstrual problems.

I often use the narrative. For this, I utilize the insights, which I gained during the foregoing psychotherapy sessions regarding life-historically important events, about the physical status or about unconscious feelings of the patient. Out of these I construct a story, which I tell to the uterus of the woman – and naturally therewith to her – in the meditative, body-referred context of the Mother-Embryo Dialogue and in the form of simple, understandable and bias-free words. During this process, the main issue is her own time spent in her mother's womb and her experiences with her own belly. Through tuning in to this, I make myself into a witness of that which the woman experienced. Through expressing verbally what is happening, or what

happened, I bear witness to her objective and subjective experiences, which are impairing her life and her ability to conceive children. Once the woman has become conscious of her painful feelings, she has the option to let go of them and thereby to enhance the chance of life for the next generation.

RAFFAI (2006) referred to the uterus as a ‘multi-generational inner space’. In some of the cases I was able to clearly sense this in my counter-transference. At the moment when I departed from my seated psychotherapeutic setting, and the patient wordlessly lay down on the couch in order to engage with the Mother-Embryo-Dialogue I suddenly experienced a tormenting deathly fear in myself. I was only able to gain control again with difficulty through intensely concentrating on my medical task. In my counter-transference I had to bear the reactivated foetal, fear-ridden and aggressive feelings of my patient and contain them within myself. In a symbolic pregnancy with my patient I offer her a safe, detoxifying uterus, which is meant that her future child come into life more easily. In this way she is able to deposit her terrible unconscious feelings in me and create some relief for herself. Thus the Mother-Embryo Dialogue offers a possible way to reactivate and to live through pre- and perinatal body-experiences through transference and counter-transference processes. Ursula VOLZ describes similar experiences of the emerging of prenatal issues with her own patients within psychoanalytical treatments.