

Coping with infertility: a body–mind group intervention programme for infertile couples

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BACKGROUND: The recognition of the distressing character of infertility diagnosis and treatment has led to the development of several psychosocial interventions for infertile couples. At the Leuven University Fertility Centre, a body–mind marital group intervention was developed to help infertile couples cope with the distress related to infertility. **METHODS AND RESULTS:** This treatment programme was originally adapted from a mind–body approach, but integrated concepts and techniques from body-oriented therapy, art therapy and multi-family group therapy. In this paper, the therapeutic foundations, treatment goals and practical implications of the mind–body marital group intervention are outlined. Further, the treatment procedure is explained in detail and illustrated by clinical vignettes. **CONCLUSIONS:** Although the first clinical impressions about the usefulness of the body–mind group programme in fertility clinics seem promising, further research is needed to assess its effectiveness.

Key words: art therapy/body–mind/infertility/marital group/psychosocial intervention

Introduction

For many couples, infertility is undeniably a major life crisis and psychologically stressful (Leiblum and Greenfeld, 1997; Brkovich and Fisher, 1998; Burns and Covington, 1999; Wischmann *et al.*, 2001). The distress of infertility and its medical treatment is reported to affect different aspects of each partner's personal and the couple's life. First, the experience of infertility often leads to important boundary ambiguity within the relationship and family structure (Burns, 1987) and increases feelings of anxiety, guilt, somatization and depression (Domar *et al.*, 1992a; Greil, 1997; Brkovich and Fisher, 1998; Demyttenaere *et al.*, 1998; Matsubayashi *et al.*, 2001; Wischmann *et al.*, 2001; Fassino *et al.*, 2002). It challenges deeply held beliefs about oneself and the world (Diamond *et al.*, 1999). Support, satisfaction and communication within the relationship are affected (Andrews *et al.*, 1992; Meyers *et al.*, 1995a; Diamond *et al.*, 1999) and important changes in the sexual relationship (Leiblum *et al.*, 1998; Tuschen-Caffier *et al.*, 1999; Lee *et al.*, 2001) as well as in the social network around the couple are reported (Meyers *et al.*, 1995b; Fekkes *et al.*, 2003). Secondly, the diagnostic procedures and medical treatment frequently represent an unforeseen source of stress for the majority of couples undergoing it, since couples gradually ascending the diagnostic and treatment ladder (particularly for the women) are confronted with increasingly invasive techniques, and time- and money-consuming procedures (Meyers *et al.*, 1995a; Brighenti *et al.*, 1997; Fekkes *et al.*, 2003).

The attention to the emotional distress as a consequence of infertility and its treatment has led worldwide to the recommendation to provide psychosocial interventions for infertile couples. Moreover, a lot of couples themselves have expressed their wish to receive more psychosocial help (Laffont and Edelmann, 1994; Sundby *et al.*, 1994; Souter *et al.*, 1998; Hammerberg *et al.*, 2001). However, <25% of patients take up psychosocial services offered (Sundby *et al.*, 1994; Hernon *et al.*, 1995; Boivin *et al.*, 1999) or have the intention to use them (Schmidt *et al.*, 2003). Also, these patients tend to experience more personal, social and/or marital distress (and marital benefits) than those who do not request counselling or attend support groups (Berg and Wilson, 1991; Laffont and Edelmann, 1994; Boivin *et al.*, 2001; Pook *et al.*, 2001; Schmidt *et al.*, 2003). Until now, a wide range of psychosocial interventions for infertile couples has been developed (Boivin *et al.*, 2001; Boivin, 2003). They vary from provision of information (Daniluk, 1988; Takefman, 1990), emotion- and problem-focused interventions (McQueeney *et al.*, 1977) or supportive group interventions (Ferber, 1995), to psychological and sexual counselling (Sarrel and DeCherney, 1985), couple therapy (Diamond *et al.*, 1999; Stammer *et al.*, 2002), cognitive–behavioural therapy (Tuschen-Caffier *et al.*, 1999), and mind–body therapy (Domar *et al.*, 1992b). Only a few of the reported interventions are empirically supported (Boivin, 2003). The programme of Domar and colleagues, which is based on relaxation responses, cognitive restructuring, emotional

self-care, and group support, was not only found to be efficacious in the treatment of the emotional aspects of infertility, but also resulted in increased conception rates (Domar and Dreher, 1996; Domar *et al.*, 2000).

As part of standard care at the Leuven University Fertility Centre, patients and couples have the opportunity of attending a clinical psychologist and/or a mind–body-trained therapist during the treatment. However, in order to meet the wish of many infertile couples to share their feelings with other affected couples, a marital group intervention was developed in 1998 (Vervaeke, 2002). This programme was originally adapted from the mind–body approach as described by Domar and colleagues (Domar and Dreher, 1996; Domar *et al.*, 1992b, 2000), but was also strongly influenced by the body-oriented therapy, art therapy and multi-family group therapy tradition of the University Clinic (Vervaeke, 2002; Lemmens *et al.*, 2003a,b).

In this article, the therapeutic foundations, treatment goals and practical implications of the body–mind marital group intervention will be outlined. The detailed description of the body–mind marital group intervention aims to invite and/or stimulate other counsellors to integrate the described therapeutic techniques in their practice.

Therapeutic foundations and goals

The three major characteristics of the body–mind programme are: (i) the use of art therapy techniques, (ii) the use of body-oriented techniques, and (iii) the use of a marital group format.

Use of art therapy techniques

The features that make art therapy (e.g. drawings of emotions in the body) so powerful are its facility as a non-verbal therapy, its ability to work with unconscious processes, and its capability to bring together domains of experiences—both the consciously observed and the unconsciously experienced (Woodcock, 2003). It is a powerful form of externalization providing the couples with an alternative channel for communication which might otherwise not be accessed or where words might not be enough (Manicom and Boronska, 2003). It is through the use of non-verbal communication that thoughts and feelings concerning the infertility may surface, offering an alternative route for stories to be told and to be acknowledged (Guttman, 1975; Campbell, 1995). Not only form and voice may be given to ‘unspeakable’ or ‘problem-related’ stories concerning the impact of infertility on their lives (Jennings, 1995; Meyers *et al.*, 1995b; Newton, 1999; Vervaeke, 2002), but also stories relating to strengths and resilience that the couples might have forgotten in their crisis may emerge (Donnelly, 1989). Further, art is a creative and therefore playful process that gives containment to feelings and emotions and brings greater intimacy in the couple (Landgarten, 1987).

Body-oriented approach

The body and the stressful bodily emotions related to infertility diagnosis and treatment are an important focus of attention in the body–mind programme. Some central ideas in

body-oriented therapies are: the oneness of the body (‘we are our body’) (Meyer, 1982; Meyer and Lienard, 1993), that reading the body gives information about the psyche (‘our body language conveys a message’) (Greene, 2001; Mattson and Mattson, 2002), that eliciting relaxation responses reduces stress-induced physiological arousal (Kabat-Zinn, 1990; Benson and Stuart, 1993; Domar and Dreher, 1996), that verbal expression of bodily emotions and concerns can be stimulated and body images and self-concepts be changed by using its techniques (Vandereycken *et al.*, 1987; Bauman, 1994; Petzold, 1997). Couples involved in infertility programmes often experience strong anger and anxiety, but sometimes these emotions seem to be denied (Chiba *et al.*, 1997) or repressed (Fachinetti *et al.*, 1992). Focusing on the body by non-verbal techniques not only enables infertile couples to quickly gain more access to and become aware of their infertility-related emotions (Pasini and Andreoli, 1993; Steinbauer *et al.*, 1999, 2000), but also stimulates the process of verbalizing and discussing them. It aims to help the couples to differentiate their ‘narrowed’ and ‘overwhelmed’ emotional life (e.g. tension can be a result of anger, sadness, grief, or failure) and to better integrate both negative and positive emotions. Thus, the ‘body work’ activates cognitive processes and changes (Greene, 2001). The inclusion of the relaxation exercise, at the end of each session, brings the focus back on the body after the discussion. It not only may help to reduce possible stress caused by the group discussion, but also to increase the skills of the couples in dealing with the infertility- or treatment-related bodily stresses and discomfort (Benson and Stuart, 1993; Pasini and Andreoli, 1993).

Marital group format

It is an explicit choice to invite the marital dyad to the group, so both partners and the relationship simultaneously may benefit from the body–mind programme. It has the additional advantage of reframing the infertility problem as a relational issue rather than a male or a female problem. Further, the marital group format provides an ‘artificial’ social support system to the couples and acts as a source of social acceptance, which may help to overcome stigmatization by infertility (Asen, 2002; McFarlane, 2002; Boivin, 2003). Also, the group offers multiple opportunities for experiencing communality with other couples. It may help the couples to feel that they are not alone in suffering from an infertility problem, to realize that their reactions, feelings and struggles are normal, and to feel less isolated (Lentner and Glazer, 1991; Steinglass, 1998; Lemmens *et al.*, 2003b). For some couples the body–mind group was the first opportunity to come into contact with other infertile couples. Also, the variety of different and similar stories (‘infertility-related’ as well as ‘non-infertility-related’) between the couples stimulates different cognitive processes (such as self-reflection and insight), which may help the couples who are often only focused directly on the infertility problem to broaden their viewpoints and to generate different perspectives (Leichter and Schulman, 1974; Stanton, 1992). In addition, the couples may benefit from learning from others’ experiences in coping with infertility, since the marital group

format offers particularly good opportunities for identification and modelling and exchanging of experiences (Lemmens *et al.*, 2003a). Finally, the marital group creates a forum for discussing different topics, which may be difficult to attain within a single couple. Moreover, discussing these issues in the marital group context has the effect of normalizing communication patterns and contents within and across couple boundaries (Asen, 2002; McFarlane, 2002).

Thus, the central goals of this marital group intervention lay not primarily in increasing conception rates, but are rather to: (i) improve communication within the couple and with the physicians; (ii) achieve a general reduction of stress in both partners; (iii) be more conscious of the treatments consequences and more actively involved in decision taking during the different treatment steps; (iv) support the mourning processes; (v) restore the body image; (vi) strengthen the ability to cope with childlessness and fertility treatment; (vii) help the couples to realize that they have a life beyond infertility and medical procedures; (viii) create healthier stories about themselves, their relationship and their lives, instead of the dominant 'wishing for a child' story.

Organization of the group

All couples who are involved in a treatment programme at the Leuven Fertility Centre of the University Clinic Leuven (Leuven, Belgium) and had at least three treatment failures (failure was defined as no pregnancy after any form of medical procedure including common insemination, IVF or ICSI) receive an invitation to participate as a couple in the body–mind group programme. No other inclusion or exclusion criteria are used. A group starts after a minimum of five and a maximum of eight couples have given written informed consent to participate. Because it is mandatory to participate as a couple, both partners pay ~€8 each after reimbursement of the National Health Insurance for each session. Also, if one partner drops out, so does the couple.

The group is led by a body-oriented therapist, who was trained in mind–body therapy at Harvard Medical School, in cooperation with a nurse/treatment coordinator of the fertility centre and a family therapist. Both the nurse and the mind–body therapist are working at the fertility centre. The family therapist joined the group for his experiences with couple and multi-family group therapy. The treatment coordinator provides information about treatment issues.

The programme consists of six group sessions, each of them focusing on a specific topic or theme. The sessions are held monthly in the evening at the University Clinic. All sessions last ~120 min with a break after 60 min and are similarly structured: a go-round, a non-verbal task, presentation and group discussion, coffee break, a relaxation exercise and conclusion of the session. Every session starts with a go-round, during which the couples are asked how they are doing, or if something related to the infertility has happened since the previous session. The social nature of the talk adds to the bonding of the group and helps to neutralize possible negative feelings such as anxiety or helplessness (Strelnick, 1977). It also gives couples an opportunity to talk about something at that time relevant or important to them.

Next, a non-verbal task is given to the group. This non-verbal task is discussed by the therapeutic team before the session and is based on the experiences during the previous session and/or previously conducted body–mind groups. Every task is performed separately by each group member in the hope that new information will emerge. After its presentation, during which questions can be asked by the other group members, the discussion mostly focuses on differences and similarities between the stories of the group members. Group members often feel supported, recognized and understood by the similarities whereas the differences stimulate new learning, other coping mechanisms, or help to create new perspectives (Lemmens *et al.*, 2003b).

During the break, the therapeutic team leaves the room and the couples have some time to socialize. To reduce any tensions caused by the discussion, and to increase coping strategies in stressful moments, an individual or a couple relaxation exercise is done after the break. It refocuses attention on the body. A range of different exercises is used: a body awareness exercise, a body scan relaxation (Domar and Dreher, 1996), a Jacobson relaxation exercise (Jacobson, 1938), yoga, an active breathing exercise, meditation (Kabat-Zinn, 1990) or a Schultz exercise (Schultz, 1958). Finally, the session ends mostly with some take-home messages in the form of a summary, a recommendation, or a story telling.

Description of the group sessions

In order to provide a better understanding of the therapeutic process in the body–mind group, the sessions of one conducted group programme, which included six couples, are described below.

Session 1: Introduction and selection of themes

After everybody, including therapists, had introduced themselves, the organization of the group was briefly explained to the couples. The group was then divided in two, based on gender. Both groups were asked to separately discuss the themes they would like to address in the next five group sessions. The goal of separating men and women was to stimulate information about gender-specific differences to emerge (Meyers *et al.*, 1995a; Stammer *et al.*, 2002), and to help the partners, particularly the men, to speak more freely. Further, it aimed at creating supportive peer subgroups within the group from the start of the programme.

The different themes of each group were anonymously presented by a therapist to the whole group. Men apparently focused more on the impact of the infertility and the treatment on their partner, the relationship and their life. They asked for concrete advice, whereas the women seemed to be more preoccupied with their disrupted internal emotional processes. This is consistent with the finding of Stammer *et al.* (2002) that men tend to want concrete assistance in coping with the crisis their partners are going through and women rather tend to look for emotional support in overcoming their 'bouts of depression'.

During the following discussion, most women started criticizing the men for mentioning that the child wish was

dominating their lives. To hear their husbands saying this was very threatening for them and they felt that it showed that the men did not care very much about the infertility. However, after the therapist reframed the comment rather as a concern for their wife and relationship than as having no interest in them and the infertility, the women were somewhat surprised and felt pleased with the men's concerns. Their perspective changed.

After this session, the themes for the following sessions were selected by the therapeutic team. The themes were (a) emotions, (b) impact on the relationship, (c) reactions from others, (d) place of the 'child wish' in their lives, (e) the limits of the treatment. One couple left the group after the first session because the wife became pregnant.

Session 2: Emotions and infertility

After all couples had approved the selected themes, each person's feeling about the infertility was explored by drawing a 'tree of life'. Each partner imagines him/herself as a tree. They then have to decide what sort of tree. Is it seasonal? Does it have flowers? Is it fruit-bearing? What's the landscape surrounding the tree? Is the tree alone? Individually, everyone drew the tree with crayons. Trees are a symbol of fertility in most cultures (Jennings, 1995). By choosing this metaphor, we automatically link the emotions with infertility problems, and vice versa.

Grouped in a small circle, the women were firstly asked to describe and discuss their drawings. The men formed a bigger circle around them. This 'goldfish bowl' technique (Colahan and Robinson, 2002) forces the outside group to adopt a silent observer position of the inner groups' discussion. It promotes better listening. Finally, the men took their places in the inner circle. Some examples of the drawings are described below.

'A man shows a drawing of himself as a little green tree, on both sides surrounded by enormous trees with big trenches, which close him completely in. In the distance there is a little tree, symbolizing a possible child. During the description of his drawing, he bursts into tears and explains that there never will be a little tree because of him. Recently, he was told by the physician that he is 100%infertile. Now, his wife is considering sperm donation but he says that he needs more time to grieve about it.'

'A man draws two similar trees with a horizontal connection between them in a wood. The two trees symbolize himself and his wife, the connection refers to their relationship, and the other trees represent his family and friends'. His partner also draws two trees in a wood, representing families and friends. But this time a big, healthy tree symbolizes her husband, and a small one with broken branches leaning on the big tree symbolized herself. She explains that the infertility problem has drastically changed her personality and has made her more depressive and withdrawn, unlike her husband, and that she demands a lot of attention and support from him.'

During the discussion, the group members expressed feelings of guilt and sadness. One woman mentioned that she

was also getting more and more angry with others, sometimes for no reason. It may be helpful to hear for some couples, in particular for those avoiding conflicts, that anger is a 'normal' reaction and that its expression is often quite a relief.

After the break, the group members were allowed to add something to another group member's drawing. A tree was coloured, or a sun or flower added. It is a symbolic way of supporting each other, and an opportunity to give another perspective on the person's emotions. A body scan relaxation (Domar and Dreher, 1996), which scans the different parts of the body and releases areas of tension with the help of deep breathing, was performed as relaxation exercise. It helped the couples to be more conscious of the different parts of their body. At the end of the session, one man mentioned that the session was almost too emotional for him, while another woman had the impression that for the first time she could be herself, not pretending that she doesn't care about her childlessness.

Session 3: The impact on the relationship

During the go-round, one woman reported that since the last session she had started to realize that her desire for having a child had put a lot of pressure on her husband. Her husband had noticed that she tried to avoid doing so and said that he now felt more relaxed about his infertility.

In order to connect the emotions with one's own body and to view the body again as the centre of all emotions (Vervaeke, 2002), everybody was asked to draw his/her own body and to indicate where which emotion was present. The drawings of each couple were displayed side by side and both partners were allowed to add more emotions to each other's drawing, together with some important characteristics of their relationship. An example:

'A woman writes the following comments on her drawing: 'often preoccupied with it' (head), 'hope, now more happy, but not as positive as my husband' (smiling mouth), 'pain, a heart that is bleeding' (red coloured heart), 'physical pain, angry that my body lets me down' (gastric area), 'towards my husband' (right hand), 'though no disabled body' (body). Her husband's comments are: 'hope, happiness' (smiling mouth), 'pain, but relative' (red coloured heart), 'broad shoulders are support' (shoulders). He draws a tear ('sorrow') on his wife's drawing and she writes 'accept the situation' (heart) and 'supportive' (hand). By adding more emotions on each other's drawing, observable and hidden emotions can be discussed.'

All couples indicated that the wish of having a child was profoundly influencing their relationship and social activities. The men often tried to please their wives and to protect them against possible problems or difficulties. They admitted to pretend to be strong and not showing any negative emotion, fearful that they might upset their wives. Most women, preoccupied by the infertility, recognized that they gradually isolated themselves from their husbands and social activities. They also made it clear that sometimes feeling sad did not automatically require their husband's protection and support. They were still capable of handling things properly and their

men might also even ask for their support in difficult situations. The women often had the impression that their partners had difficulties in showing their emotions, as if it were too upsetting for themselves or as if they were not able to show them. The discussion made it clear that the men felt strongly about the infertility. Importantly they started to express their emotions about it and to perceive their wives differently. On the other hand, the women had also gained more insight into their grief and its impact on the men.

After the break, the couples were asked to give some characteristics about their relationship which they definitely wanted to preserve despite the infertility and the treatment. In line with this, couples were also asked to discuss things that should not become lost or that they wanted to start re-doing. The session ended with two relaxation exercises for partners: a foot massage with a tennis ball, and hand-on-back respiration exercise. Some partners clearly had difficulty in engaging with the relaxation and could not let go.

Session 4: Reactions from others

Negative ('you are so lucky, kids are terrible', 'not asking anything at all', 'you are too nervous to get pregnant') and positive ('just being there', 'asking how you are doing') reactions about the infertility or treatment, which the couples had got from others, were written down on two billboards. Next, everyone was asked to draw some concentric circles with themselves in the middle and to write names of persons (e.g. friends, family, colleagues, and neighbours) of their social network within the circles. Each circle symbolized how close or distant the relationship with that person was: the smaller the circle, the closer the relationship. The couples were asked if the comments of the persons were 'understandable', taking into account the position of that person (close or distant). It was striking that some persons were unaffected by negative comments from close persons, whereas others did not accept any negative reaction at all. This was particularly apparent when negative reactions came from the mother.

In order to learn more adequate ways of responding to perceived negative comments and to gain some insight into the behaviour and feelings of the others, difficult situations were practised in role-plays. Specific rules were followed: the person who was bothered by a negative comment had to give the negative comment to another group member, who in his/her turn tried to respond more adequately to this comment.

'A woman has difficulty with her mother saying that she would be better stopping the treatment because there is no result. She is asked to play her mother whereas the other group members take her place and respond in different ways. This gives the woman not only the opportunity to experience her mother's position and to gain some insights into her mother, but different ways of responding are offered to her by the other group members.'

'A man, who has to respond on a negative comment, always takes a very defensive stance and responds very aggressively toward the person giving the negative comment. The other group members point to his aggressive behaviour. It

makes it clear to him that this is not a very successful way of responding. The man, previously not aware of his behaviour, is very pleased with the group's advice.'

After the break, a meditation exercise helped the couples to be less preoccupied with and more in control of their thoughts.

Session 5: The place of the child wish

One man mentioned at the beginning of the session that he was quite upset by the negative reactions of his wife when his sister recently became pregnant. It proved that she did not learn anything from the group. They had been arguing since. Some group members understood his wife's reactions and pointed out that these were normal and often only temporary. In favour of his wife was also that she is taking part in a new treatment procedure. Other men in the group had also experienced emotional, unpredictable or inadequate behaviour of their wives during a treatment. The group advised him to explain everything to his sister, asking for some understanding and patience, and not forgetting to show his happiness to his sister. Dealing with ambivalent feelings is often the case in couples with infertility problems and learning to accept them may be quite helpful.

As a task, everybody drew two circles and sliced them up like a cake with the individual slices representing their life, one before the treatment and child wish, one at this moment (Stammer *et al.*, 2002). Each slice symbolized the time which they spent on their partner, family, friends, social activities, or work.

'A woman indicated that before the treatment she has spent about 35% of her time on work, 15% on reading books, 50% on the relationship of which 15% was leisure activities, 15% friends, 10% holidays, and 10% family. At this moment her child wish takes 50% of her time, work about 15% and their relationship 35%. Her husband, who in previous sessions has often complained that his wife was far too much focused on having a child, surprisingly reports that he is spending at least 25% of his time on the child wish at the expense of time spent at work, family and leisure activities.'

The drawings made clear how much time the couples were spending on the child wish and what price they were paying for it. It questioned for the first time whether this was a good strategy. Were they prepared to continue paying this price or could they find alternative strategies to avoid that domination. At the end of the discussion the couples were asked which 'slice of the cake' (except the child wish slice) they wanted to pay more attention to in the next months.

The session ended with a Schultz relaxation exercise (Schultz, 1958) and a reflection on the fluctuations of the child wish, the need for taking care of yourself during treatment and taking your time to grieve after a failure.

Session 6: The limits of the treatment

One couple started the group by saying that they were happy to announce that the wife had become pregnant. All other group members were happy for them and congratulated them.

It was striking that, at the same time, the couple mentioned that they felt as if things could still go wrong and that they did not want to feel too happy about it. This couple's testimony suggested that the long waiting for the pregnancy and/or the medical interventions needed to induce pregnancy interrupted the normal joy of an 'ordinary pregnancy'.

Different cards were put on the ground in the middle of the group. Each card contained a diagnosis, a treatment proposition and/or a comment already made by a physician ('the quality of your egg cell is poor, but try again', 'the quality of your sperm is poor, you should consider sperm donation', 'you have little chance of becoming pregnant, but try again and then we can be sure that the treatment doesn't work', 'is adoption a possibility?'). Everybody was asked to take a card, read it aloud to the group, and to give his/her opinion about it. Other group members were allowed to join the discussion. This task resembles a gambling game: one takes a card out of several without knowing what is written on it. It aimed to confront the couples with the gambling character of the treatment and how they were dealing with the insecurities, the inherent hopes, and quitting it. It further aimed to stimulate them to ask questions about the treatment which they may not have dared to ask previously and to discuss treatment uncertainties.

Some couples in the group would be happy to receive embryo donation, whereas other couples mentioned stopping the treatment after having tried ICSI. The adoption of a child was no option for some couples whereas other couples were considering it. So, every couple somehow had built in some treatment limits, although they admitted that these limits had changed over time. Some couples were now involved in treatment programmes, which, before the start of the treatment, they had agreed never to participate in. The intense child wish and the hope-inducing promises of the physicians were seen as important contributors to this change. In their opinion, the physicians should from the beginning give clear and realistic information about the treatment of their infertility problem, without exaggerating the likelihood of success. The physicians should not camouflage negative and painful information because it aggravated the mourning process. Finally, they should share the responsibility to limit the treatment attempts per year or to temporarily stop the treatment. The couples in our group confirmed that they found it very difficult to be responsible for this decision. These remarks about the 'biased' information provided by the physicians may also reflect the patients' bias in overestimating their chances of success relative to information provided by the medical team. This bias is in keeping with the 'optimistic bias' thought to underlie well-being (Taylor and Brown, 1988). Nevertheless, this observation once more stresses how delicate and difficult the process of information exchange between the medical team and the couples may be.

The body–mind group programme ended with socializing for ~20 min during which some refreshments and sweets were offered to the couples. It also gave them the opportunity to exchange addresses and phone numbers. Until now, most group members have continued to meet outside the hospital context.

Conclusion

In this article, the therapeutic foundations, goals, content and course of a body–mind programme for couples with infertility problems were presented. This programme was the first in which non-verbal techniques and body–mind strategies were integrated while using a multi-couple format. Although the first clinical impressions about the usefulness of the body–mind group programme in fertility clinics seem to be promising, a more thoroughly scientific evaluation of its effectiveness is needed and is currently being undertaken in our centre.

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