

The Remarried Family and Infertility

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One never knows how much a family may grow; and when a hive is too full, and it is necessary to form a new swarm, each one thinks of carrying away his own honey.

George Sand

HISTORICAL OVERVIEW

Over generations and throughout history, remarriage, the stepfamily, and infertility have been linked. Prior to the last half of the 20th century, mortality was the almost universal reason for remarriage. Wars, illness, famine, shorter life spans, maternal death during childbirth, and sterility were all factors influencing the incidence and necessity of remarriage. For men and women widowed at relatively young ages, remarriage served important societal functions: financial security (particularly for women and children), housekeeping and child care for surviving children (particularly for men), sexual release, and the opportunity for further childbearing¹. Remarriage for reasons of divorce was rare or nonexistent, except in cultures in which divorce was allowed when a marriage was childless or without an acceptable heir. The most famous historical example is King Henry VIII of England, who changed the religion of a nation and the destiny of an empire to remarry. There are Biblical accounts and cultures where divorce, remarriage, and even the taking of multiple wives occurred when a marriage was childless. And in all these situations, it was

usually the wife who was blamed for being 'barren'. In short, history is filled with accounts of infertility, death, divorce, and remarriage, all influenced by societal norms, circumstances, and acceptable 'solutions' to these events.

The second half of the 20th century has been marked by significant social changes, especially regarding remarriage. During the last 25 years in the United States, divorce rather than death has been the primary reason for remarriage: 50% of all first marriages and as many as 70% of all remarriages end in divorce. Today, remarriage after divorce outnumbers remarriage after the death of a spouse by 10 to 1^{2,3}. As in the past, age differences between spouses in subsequent marriages continue, with a remarried male likely to be as much as 6 years older than his wife³. However, there is a changing trend today, with older women marrying younger men either in a first or subsequent marriage, posing unique reproductive challenges for this couple. While a male's age may effect his motivation for having children, it is usually not an issue in his fertility, unless he is sterilized. Since infertility rises with maternal age, it may be a factor for a remarried woman. Finally, approximately

half of all remarried women of childbearing age give birth during a subsequent marriage: the majority within the first 2 years of the second marriage⁴. If the first marriage was ended by death, women in their childbearing years are 44% more likely to have a child in their second marriage than women whose first marriage was ended by divorce⁴.

In the general population, infertility affects 1 of every 8 couples and is generally attributed to delayed childbearing, non-barrier methods of contraception, and sexually transmitted diseases. While no statistics are available on remarriage infertility, women in second marriages tend to have lower fertility than women in first marriages, probably because they are generally older in remarriages^{1,3}. In addition, infertility in subsequent marriages is more likely to be due to surgical sterilization (vasectomy and tubal ligation) during first marriages. Thus, it appears that while a significant number of remarried couples experience infertility, the majority who present for treatment involve remarriages in which one partner has children and the other partner is childless.

Remarriage not only involves the union of adults but may also involve the *blending* or *reconstituting* of their families of procreation. *Stepfamily* is generally defined as a family in which children from previous relationships either live with or visit their parent, his or her subsequent spouse, and perhaps the spouse's children. As in the past, children from previous marriages are a significant factor in remarriages: At least 7 million American children, or 11% of all children under the age of 18, currently live in a reconstituted family³. Remarriages and reconstituted families face a number of challenges, including new definitions of the meaning of *family*, forming new and reconstructing previous kinship relationships, redefining family roles and respons-

ibilities, reorganizing family boundaries, and creating a new family identity. Not surprisingly, these challenges are often daunting, fraught with difficulties and obstacles for adults and children alike. The normal transitions and adaptations of new relationships are influenced by a myriad of factors in the individuals and the new family system, such as family history before remarriage and individual expectations of the new family. Therefore, additional stressors such as infertility can be particularly traumatizing and distressing, not only for the new husband and wife in the reconstituted family but for any children already in the stepfamily.

A couple faces significant challenges when struggling with the crisis of remarriage and infertility, including differing reproductive agendas, negotiating the developmental tasks of the reconstituted family, and revisiting past reproductive decisions or experiences. The therapist must understand not only the complicated and stressful intricacies of infertility but also the conflicts and struggles of stepfamily living.

This chapter will:

- apply current theoretical frameworks to remarriage infertility
- explore clinical issues regarding infertility in the remarried family
- identify therapeutic techniques for assisting families dealing with the tandem emotional process of infertility treatment and stepfamily integration.

REVIEW OF LITERATURE

Although the number of remarried couples presenting at infertility clinics for medical treatment is increasing, there remains a marked dearth of research on the impact of infertility in this population. Available research focuses on the separate issues of stepfamily adjustment and on the emotional crisis of infertility (see Chapter 1).

Research on stepfamilies has virtually exploded in the past 30 years as attention has turned from the effects of divorce on families to what happens when divorced people remarry and their families are reconstituted. The first study appeared in 1966 with Fast and Cain's⁵ pivotal article that offered insights into the role of the stepparent and the working of the remarried family. They believed that role confusion doomed a stepfamily—since there was no definitive, set behavior for steprelationships, people assumed stepparents would behave as biological parents would. Their work supported a new idea that the stepfamily needs to be considered a unique and structurally different unit for childrearing. Duberman⁶, another early researcher, paid attention to the ways in which social and demographic factors affected relationships between stepparents and stepchildren. She found that stepfathers were more likely to achieve better relationships with stepchildren than were stepmothers. Stepmothers' relationships were better with children younger than 13 than with teenagers, while younger stepmothers had better relationships with children of all ages. Other factors highly correlated with good stepfamily relationships were less education in stepfathers, a new baby, and two sets of children sharing a house. Duberman also found that stepmothers without biological children have a more difficult time than stepmothers with biological children, fathers, or stepfathers. Bohannon⁷ focused on the role of stepfathers and found that they viewed themselves and their children as less successful and happy, a view not shared by the children and their mothers.

Other studies found that families were inadequately prepared for remarriage and reconstitution. Messinger and colleagues⁸ studied couples' reactions to the upheaval involved in forming stepfamilies. As a result of finding inadequate preparation for

remarriage, they developed group techniques to clarify steproles, offer support, and educate about the structural differences between biological and stepfamilies. They found that the combination of support, factual information, and opportunity to interact around emotions was reassuring to couples and assisted them in feeling less alone and better able to cope. Similarly, Cherlin⁹ emphasized the confusing and murky path for stepparents as they attempt to create a workable relationship with stepchildren. He contended that stepparents often feel they have little assistance in forming a working stepfamily out of an association of biologically and legally related persons. Finally, Visher and Visher¹⁰ examined discipline of children in a stepfamily and the ambivalence of the biological parent. They concluded that the presence of parental guilt had the potential to cripple stepfamily formation. They also concluded that there is an absence of guidance for stepparents from mental health professionals. Consequently, resources regarding the counseling process were generated and the field of stepfamily counseling was born¹¹⁻¹³.

THEORETICAL FRAMEWORKS

A theoretical framework for understanding remarriage infertility must be developed by applying models from both stepfamily and infertility psychology. While stepfamilies go through a developmental process founded on loss, the emotional process of infertility follows a parallel course.

Stepfamily Developmental Model

Theoretical frameworks of the stepfamily have been influenced by the groundbreaking work of Papernow¹⁴, who developed a life-cycle model describing the normative changes in the formation of a

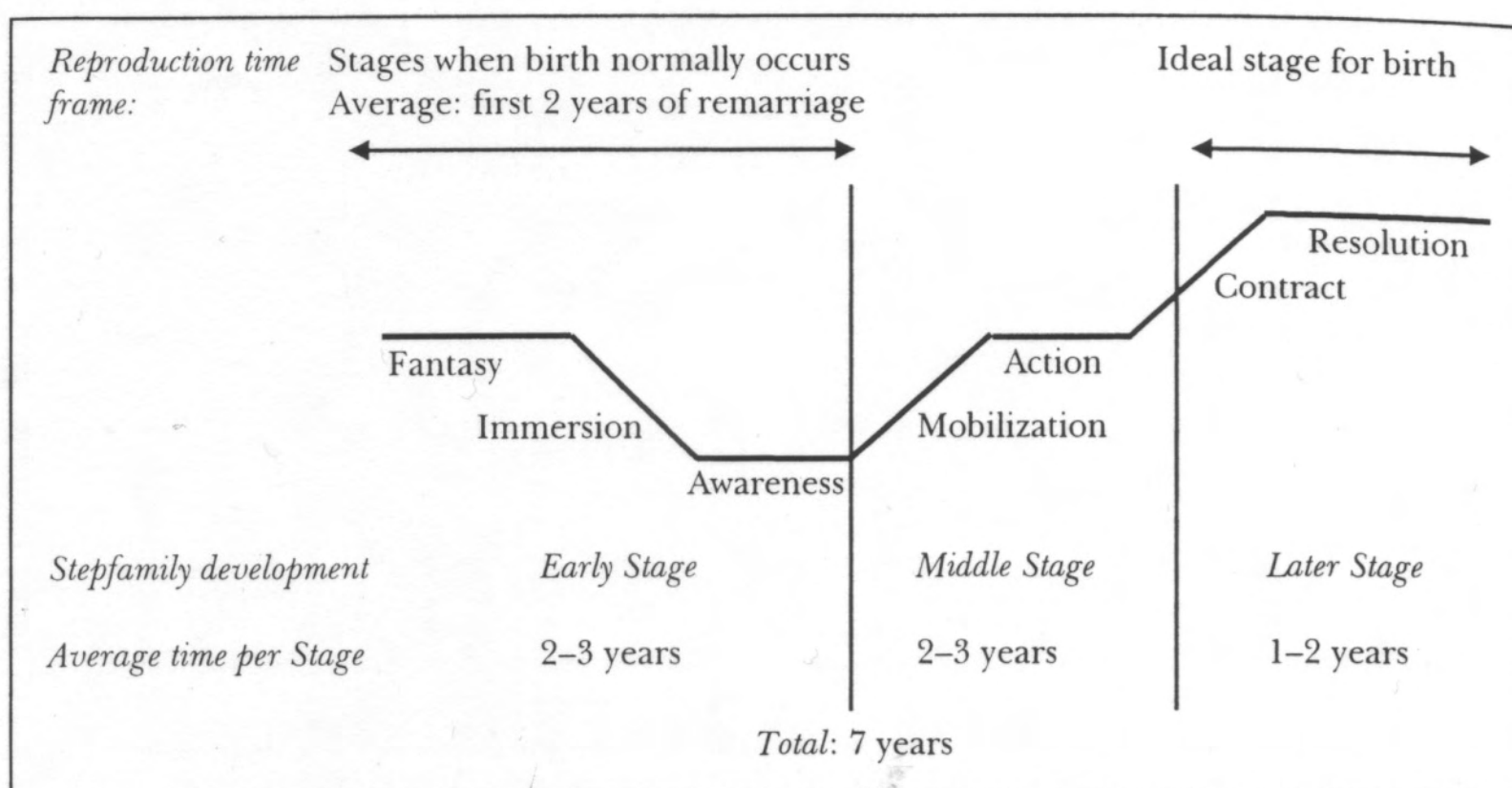


Figure 1 Developmental stages in remarried families and fertility. (Adapted from ref. 14, with permission)

well functioning stepfamily unit, a process taking 4–7 years (Figure 1). Papernow divided stepfamily development into: early stages (fantasy, immersion, and awareness), middle stages (mobilization and action), and later stages (contact and resolution).

Early Stages

The early stage of stepfamily development takes 2–3 years to evolve, while the family structure remains biologically oriented. This is characteristically a tumultuous time for families and yet is the time when most births occur⁴. During the first phase, *fantasy*, the task of the stepfamily is to become aware of and articulate the fantasies and dreams that each member has for the new family. Unrealistic hopes must be grieved and abandoned. The *immersion* phase is characterized by frustration and distress as the stepfamily members confront their differences amid intense feelings. The goal of this phase is to endure the emotional intensity, struggle through uncomfortable feelings, and continue to connect with each other. During the

awareness phase, members become curious and empathic about their own role in the stepfamily and about the roles of others. Goals become clearer and mutual understanding forms the foundation necessary to move on to the middle stage.

Middle Stages

While early phases are marked by biological organization within the family, as the family matures major reconstruction takes place. The middle stage, averaging 2–3 years, entails the family's changing from a collection of biologically organized mini-families to a working stepfamily unit. In the *mobilization* phase, the stepfamily airs its differences openly and discusses step-issues with sophistication. Differences between previous families, adults, and children—insiders and outsiders—are reviewed, and the new stepfamily begins to form a new identity. By the time a family reaches the *action* phase, it is ready to loosen biological ties and establish new boundaries around step-relationships. New traditions, new family rituals, and new customs become

the norm. Still, some of the old family structure must be in place so that all members can feel comfortable.

Later Stages

By the later stage, biological ties loosen, while firm, new boundaries are established to define step-relations. The *contact* phase is characterized by intimate, authentic step-relationships—the stepfamily is working and enjoying the connections that it has forged with each other. By the time the *resolution* stage is established, the stepfamily is a fully functioning unit. Boundaries are permeable: Children are secure members of two households and move back and forth with little stress. The important task of this stage of development is retaining the new family ties across life-cycle events, such as graduations and weddings. These occasions also provide opportunities to work again on old issues which may threaten the functioning of the stepfamily.

Stepfamily and Infertility Loss Theory

Pioneering work on stepfamily counseling developed by Visher and Visher¹⁵ provides a theoretical perspective that has important implications for counseling the remarried family facing infertility. According to these investigators, the stepfamily is born of loss and created over the grave of a previous marriage. Grief feelings of anger, hurt, loss, and guilt are common. Whether the prior marriage was ended by divorce or death, feelings of loss and grief affect all members of the original family unit. Further, the stepfamily experiences a sense of disequilibrium as the old family system reorganizes and the new family system is defined. For people who prefer order and are uncomfortable with ambiguity, being a stepparent (or an infertility patient) can be very difficult.

While the stepfamily goes through a developmental process founded on losses

that must be grieved, infertility often involves a parallel process. For example, infertility is frequently described as an 'emotional roller coaster', similar to the early tumultuous stages of stepfamily development. Around the same time when stepfamily theory was first being published, theory about infertility was changing: The psychological sequelae associated with infertility were likely the *consequence*, not the *cause*, of infertility, as earlier believed. The first work in this area was done by Menning¹⁶, who wrote about the life crisis of infertility as a developmental block affecting future plans, self-esteem, and self-image that must be grieved. Mahlstedt¹⁷ described infertility as fraught with losses affecting multiple aspects of a person's being and a couple's life. The myriad losses—control, health, self-worth, sexual well-being, hopes, dreams, relationships, and so on—are experienced as a grief reaction with normal feelings: shock, anger, guilt, blame, anxiety, depression, and despair. However, the grief is more chronic in nature: the losses emerge slowly over time as the couple identifies infertility as a problem, seeks medical treatment, and looks for solutions¹⁸. Furthermore, infertility is stressful and played in the high-stakes world of rapidly advancing reproductive technology, which presents complex choices and physical, emotional, and financial demands for couples.

Feelings of anger, hurt, guilt, and disbelief common to infertility can be exacerbated by the losses and ambiguity of the stepfamily experience. If the first marriage ended by death, infertility in the remarriage may revive past losses, enhancing the cumulative effect and exacerbating feelings of vulnerability by denying the life-long, life-affirming connection of a child. A further complication, common to both infertility and the reconstituted family, is the *lack of a shared-loss experience*. It is difficult for the losses of a previous marriage to be shared or grieved by

the new spouse, just as the losses of infertility are often individual for each spouse. Further, if only one of the partners has children, infertility will not be a shared loss. This may mean that the level of investment in rectifying the condition of childlessness may differ within the couple. The inequitable level of investment may contribute to feelings of anger, betrayal, loss, and guilt. For remarried couples facing infertility, the lack of a shared loss can contribute to increased marital divisiveness and instability. Finally, as in other infertility situations, the ability to procreate is seen by society as completion of a developmental process of attaining adult status^{4,16} and completing one's family¹⁹. Remarried individuals or couples also may feel that a baby is required to 'validate' a new marriage in the eyes of society or as a solution to the myriad struggles of the reconstituted family⁴. Thus, the inability to have a mutual child may be experienced as a block to the process of development both as an individual and as a stepfamily.

CLINICAL ISSUES

The two emotional minefields of stepfamily adjustment and infertility pose unique clinical challenges for infertility counselors. The differences in first and subsequent marriages, including the differences in the experience of infertility, need to be addressed to discern the unique aspects of remarriage infertility. In addition, therapists must understand the meaning and implications of infertility for all members of the stepfamily: the biological parent, the children, and the stepparent.

Differences Between Initial and Subsequent Marriages

Remarriage is different from, and more complicated than, an initial marriage for a number of reasons²⁰. First, an initial marriage and subsequent marriages take

place at different points in an individual's life and within different social and historical contexts. Age, life experience, social status, and maturity are factors that cause individuals to see similar events in strikingly different ways. This seems particularly relevant in terms of infertility, in that the failure to conceive at age 25 may not have the magnitude or urgency as it does at 35 or 45 years of age.

Second, a current marriage bears the continuing imprint of previous marriages, in that the prior marriage is an experience that can be compared and contrasted with subsequent relationships, often contributing to unhealthy comparisons and unfair expectations. Although couples usually make an effort to differentiate marital styles, it is not always possible, as each partner may bring 'remarriage baggage' to the new relationship. Remarriage baggage may involve a belief that one's previous partner was completely to blame for the disintegration of the first marriage, freeing the individual from painful self-examination and contributing to the 'same marriage, different partner' phenomenon. The imprint of this first marriage experience has the potential for creating havoc in the second marriage, especially if infertility is used by a spouse as the 'cause' of marital problems, and therefore a defense against self-examination or addressing marital issues.

Third, when a previous marriage involves children, there is a constant psychological presence in the remarriage of the 'other' biological parent, whether that parent is dead or alive¹¹. It is a common myth that it is easier to reconstitute a family when a parent has died because an idealized deceased parent is impossible for a stepparent to compete with. In addition, it is a fact (often difficult for subsequent partners to accept) that formerly married partners with children continue to have some sort of relationship with each other,

linking their previous and present partners together in a 'remarriage chain'^{7,21}. The challenges and demands of this remarriage chain can be considerable for the infertile remarried couple. The infertile partner may feel envious of the ex-spouse who was able to have a child or may disapprove of the ex-spouse's parenting style, magnifying a sense of loss. Further, the infertile partner may resent a spouse's relationship with their children, highlighting issues of loyalty, commitment, and love.

Differences of Remarriage Infertility

The etiology of and emotional response to infertility in remarriage usually differ from those of a first marriage. Often, infertility in a stepfamily is due to *prior elective sterilization*, which is usually a decision made after careful thought and consideration. Most individuals decided on sterilization at a point in their lives when parenthood or their desired family size had been achieved. However, if the marriage ends and the sterilized person marries a partner who longs for children, a dilemma results. There may be the wish to make a new partner happy by having another child, while feeling ambivalent about starting a family all over again. Assisted reproductive technologies may be an option to having a child together, albeit at great financial and emotional costs, and may create conflict over how far to pursue treatment. For example, if tubal reversal is not possible or successful, in vitro fertilization (IVF) can be considered. However, if a vasectomy reversal is not successful, male fertility can be affected and render a man sterile. Under these circumstances, artificial insemination by a donor or adoption may be the only solution for childlessness. The husband may have been reluctant to have a genetic child but is even more resistant to parenting a nongenetic child. If the wife is

older and uses a donated oocyte, pregnancy can still be experienced, although issues still remain in raising a child that is not genetically related to both parents. Hence, there would not be a mutual child in this stepfamily who was related to everyone as the couple, no doubt, originally intended.

Age-related infertility may be a significant factor in the reconstituted family because at least one of the partners in subsequent marriages is usually older and potentially less fertile. While age is usually a more significant factor for women than men, it contributes to pressured feelings to proceed with infertility treatment before a stepfamily has emotionally adjusted. Finally, *preexisting infertility* may be a factor in the breakup of a first marriage, and thus a pivotal influence in reproductive decisions and childbearing time-lines in a remarriage. Sometimes, a partner may leave an infertile marriage in an impulsive attempt to prove his or her own fertility, to punish either oneself or a former spouse for being infertile, or because reproduction is so highly valued. While there may be no surprise that infertility is a factor with which to contend, the history of preexisting infertility can be a heavy legacy to bring into a new marriage.

Infertility in the Stepfamily

Infertility treatment in a stepfamily is similar to a movie production on a busy set. The co-stars act out their drama in the midst of directors, technicians, and bit players. The couple feels exposed in front of a cast of characters that includes an ex-spouse without fertility problems, stepchildren, in-laws, friends, and neighbors. The drama is public, chaotic, lonely, misunderstood, and expensive. The substantial needs of children do not cease because a stepparent is undergoing treatment; their lives and demands

continue, and resentments may build. Stepparents and biological parents may also become resentful as their needs are thwarted by the experience of infertility.

The subject of money is an emotionally charged issue in stepfamilies, with or without infertility. The emotional overtones begin long before a stepfamily is formed, and the bitterness can endure into adulthood. There may be alimony payments to a former spouse, child-support payments to children living outside the home, and child-support payments coming in. Sometimes, no payments exist, which means that the new couple provide all support. The exchange of money—or lack of it—binds the former spouses together and fuels feelings of guilt and anger¹¹. To complicate matters, the cost of infertility treatment is anxiety-laden and can be extraordinarily expensive. Decisions about the investment of financial resources may become a minefield: A childless partner may wish to use financial resources in the pursuit of parenthood, while a spouse with children feels obligated to use the money on current, not future, children. Further, a charged similarity between these two—stepfamilies and infertility—may create a dual battleground: the former spouse and the insurance company.

Issues for Biological Parents

Parents in an infertile remarriage may have markedly different levels of investment and motivation in having a *mutual child*. A parent may feel ambivalent or even opposed to 'repeat parenthood', while at the same time wishing to please or fearing the loss of the new partner if she or he does not agree to having more children. Ambivalence or reluctance may involve the biological parent's personal goals: a return to diapers and preschool is less appealing than launching young adults and considering the joys of an empty nest, not wanting to share their partner

with a new baby, or, if older, feeling it irresponsible to have a child later in life. At other times, ambivalence and reluctance to be a 'repeat parent' involves concerns about their current children and their needs: regret or guilt about neglecting their needs, lingering conflicts in their relationship related to the divorce, and an overwhelming sense of financial and emotional responsibility to their children in general.

In addition, investment and motivation for a mutual child may change dramatically if it becomes clear that it will not be a genetically related mutual child. A remarried parent's age or prior sterilization may result in sterility, and donated gametes or adoption are the only solutions to childlessness in the current marriage. These parents may be resistant to consider alternative family building when the opportunity for the genetically-shared mutual child to 'solidify' the stepfamily is eliminated.

The *unshared loss of infertility*, when one partner has children and the other does not, presents other issues. Often, a new set of guilt feelings emerges: an infertile spouse desperately needs emotional support, and the parent may not have it to give. The guilt may be due to ambivalence and inequitable motivation for having a mutual child or to the emotional demands of their children that leave little energy for their partner. Also, children from a previous marriage represent one partner's reproductive ability, a fact that may distress an infertile partner. Infertile partners may resent these children who symbolize what they are unable to achieve or feel jealous or bitter of their partner's fertility, or they may feel angry and resentful if their inability to have a child is due to their partner's sterilization during the previous marriage.

Issues for Children

The challenges for an infertile remarried couple are even greater when children from a previous marriage are involved.

Undeniably, children from previous marriages involve a constant psychological bond, financial obligation, and emotional presence, as well as a continuing relationship with the other biological parent. Whatever the age of children, a host of emotional responses may occur: dependent children with physical, emotional, and financial demands, and adult children with emotional reactions to their parent's starting another family.

Children of all ages typically have feelings about their parents trying to have a baby and recreating a new family. Older children may resent the financial costs or energy spent on infertility treatment or, more primitively, be offended by their parent's obvious sexual activity. In fact, infertility and the motivation for parenthood can become a decisive roadblock in the development of rewarding relationships in the reconstituted family. Children from previous marriages may feel (or actually are) ignored or unappreciated, and normal parent-child conflicts may be exacerbated by infertility issues. Children ready to dislike a stepparent for his or her part in destroying the fantasy of a 'nuclear family reunion' may resent the potential mutual child as a further threat to this fantasy and the exclusivity of their relationship with their biological parent.

A unique issue for an infertile remarried couple is the consideration of family-building alternatives in terms of the needs and demands of the stepchildren. Frequently, these children live with the infertile remarried couple on a part-time or full-time basis and are aware, in varying degrees, of infertility issues. Often, children have thoughts or feelings about the issues that may precipitate a variety of responses from the infertile couple. As in all family communication, parents who ignore their children's feelings or opinions, dismiss them as irrelevant, or avoid dialogues risk a disturbed relationship with their children.

Further, the infertile remarried couple must consider the ages, circumstances, and their relationship with current children, when exploring medical alternatives, especially those involving donated gametes. For example, is a decision not to disclose the circumstances of the child's donor-conception realistic and feasible if children from a previous marriage are aware or may be told by an angry ex-spouse of the parent's prior sterilization? Although all infertile couples must explore the issues of raising a child who is not genetically linked to both parents, these issues are more complex when children from previous marriages are part of the equation.

Issues for Stepparents

The primary task of a new spouse in a remarriage is establishing a relationship with stepchildren that is workable, rewarding, and positive. However, this task can be exceedingly challenging and usually involves a number of unique stressors²²⁻²⁴. Common problems include feelings of exclusion from original parent-child relationships, difficult relations with stepchildren, struggles over discipline of stepchildren, life-cycle disequilibrium with their spouse, and financial problems. Cherlin²² argued that stepparents face role ambiguity and have no socially approved means to establish a system of behavior that allows a satisfactory reconciliation of roles or provides a clear role definition. Frustrations with role ambiguity (operating as a responsible parent without being acknowledged as one) and the desire for social acceptance as a parental figure may become motivating factors in the pursuit of a biological or mutual child for the reconstituted family. This is an important issue for stepmothers who tend to assume greater responsibility for childrearing than stepfathers in reconstituted families.

Expectations of the steprelationships can be an additional significant issue in the

reconstituted family. Stepparents who believe that a good stepparent feels 'instant intimacy' with a stepchild become disappointed and believe that they have failed when the fantasy is not realized²⁴. Further, women often work very hard to dispel the image of the 'wicked stepmother' and find themselves feeling disappointed, angry, hurt, rejected, and guilty when the instant intimacy does not occur. These feelings may exacerbate the longing for a mutual child who will heal the pain and provide the intimacy the stepchild does not. By contrast, some stepparents enter a reconstituted family not wanting or expecting intimacy from stepchildren and are ill-prepared for the parenting needs and demands. Other stepparents enter the remarriage situation with a belief, either explicit or implicit, that stepparenting will meet their needs to regenerate and parent. Months or years later, when the dynamics of the situation or the longing for one's own child becomes paramount, the entire reconstituted family can be thrown into turmoil. A biological parent may feel betrayed that the stepparent wants to change the original agreement, while a stepparent feels cheated and manipulated that he or she agreed to something that goes against one's primal needs. It may seem that there can be no 'win-win' solution to rewriting the marital contract. Making the struggle over having a mutual child can be difficult to resolve²⁵.

Successful stepparenting appears to involve consistent change and adaptation to behavior and role performance over time. Initially, during the first year, a position of interested and invested 'friend' seems to promote good functioning. Over time, the role of stepparent involves more active parenting, including discipline and decision-making^{26,27}. Stepparents who attempt to hurry the process are often disappointed and fail to be integrated into the family unit.

It is important to point out that a reconstituted family does offer an excellent opportunity for stepparents to experience the joys and rewards of parenting, as well as participating in the lives of children. Although these relationships may not be the same as those of biological parenthood, they can be exceedingly warm and rewarding, especially when the children have experienced parental relationships that were disappointing, painful, or disturbed. In these cases, the affection and emotional investment of a caring stepparent can be a child's saving grace, mutually rewarding and healing for both parties, and a welcome substitute for what 'might have been'. The rewards of these relationships are often difficult for stepparents to see or accept, especially if they are focused on relationships with children that are defined only in biological or genetic terms. While adoption may not be feasible for an infertile remarried couple, investing in stepchildren is a source of relationship rewards that can last a lifetime.

THERAPEUTIC INTERVENTIONS

Helping individuals who previously belonged to another nuclear family carries the potential for complex family dynamics. New roles are assumed, new territory is defined and new relationships are formed. A systems framework is helpful, and traditional techniques are not always sufficient, given the many intimacy issues in stepfamilies¹³.

Helping infertile couples and individuals in a stepfamily requires a thorough understanding of infertility, as well as familiarity and knowledge of stepfamily dynamics. The diversity of stepfamily needs and the emotionally laden quality of these needs requires a therapist who is active, resourceful, flexible, and capable of

directing emotionally volatile sessions, utilizing different modalities^{28,29}. Problems in the reconstituted family frequently stem from the wish to view or experience the stepfamily as a reworking of the nuclear family³⁰. Families need assistance in avoiding the longing for instant unity and intimacy, which stems from the desire to avoid pain, vulnerability, and the fear of another failure. Losses need to be grieved and fantasies examined so that more realistic goals and expectations of normal adjustment can be adopted by all family members.

Tandem Processes of Infertility and Stepfamily Integration

Since most births in remarriage occur within the first 2 years of the marriage, it is reasonable to assume that this is the most likely time period of infertility. In Papernow's¹⁴ stepfamily cycle (see Figure 1), this stage is also the most volatile, conflicted, and unstable period, marked by the greatest risk for marital breakup and the greatest likelihood of more children entering the family. Thus, couples need assistance in understanding that they are coping with two highly stressful situations replicating similar feelings.

Loss of control, anger, guilt, ambiguity, and a cycle of disappointment are but a few of these 'simultaneous' feelings. Step-parents often feel a lack of control over stepchildren and issues related to their spouse's or ex-spouse's involvement with these children. Similarly, a common feeling expressed by infertile couples is the loss of control over how infertility treatment has taken over their lives. Anger is very much a part of the divorce, stepfamily, and the infertility experience. Anger may be directed at people close to the situation or at intangibles, such as the unfairness of the

experience. Guilt may be experienced on many different layers: guilt at the way one is dealing with others; guilt over ambivalent, conflicted feelings toward having another child; lack of positive feelings toward innocent stepchildren; and guilt over past deeds (e.g., sterilization, abortion). Further, these feelings facilitate an ongoing cycle of disappointment and sense of loss for the fantasized stepfamily and wished-for mutual child. It may be difficult at times to distinguish the origin of these feelings—is it infertility or the stepfamily?—resulting in emotions that are ambiguous and projected onto each situation. Infertile remarried couples need assistance in identifying the origin of their feelings and channeling them in appropriate ways.

Both stepfamily members and infertile couples report that validation and normalization of their feelings and experiences are essential for effective adjustment^{14,18,30}. Additionally, clarifying issues and insights, understanding of self and others, and depathologizing the stepfamily experience are helpful²⁸. Intense emotions—anger, guilt, grief, and a sense of being out of control—are critical to acceptance, understanding, and integration of the experience. Often, these feelings run parallel in a family: to integrate a stepfamily and resolve infertility, couples must run an emotional gauntlet that is intense and similar.

Grief work is necessary to let go of fantasies and accept losses^{12,16,17}. Families must be able to identify the dreams, acknowledge the feelings, and communicate the experience to be able to mourn the loss of the nuclear family and the mutual child. It is only through the communication of these feelings, shared in an effective manner that is received and validated, that resolution will occur.

Communication, Conflict Resolution, and Decision-Making Skills

Effective communication, decision-making, and conflict resolution are essential family-living skills that may be taught by the therapist and modeled in therapy. Clients learn to safely express their thoughts and feelings, be acknowledged and validated, and receive feedback on their behavior³¹. For effective communication to take place, three sequential components must occur:

- Each person must know how she or he feels.
- The person must be willing to share the feelings.
- Each person must feel that she or he has the ability to share feelings effectively.

For individuals who are unable to distinguish or do not know how they feel, individual or group therapy and personal exploration strategies such as journal writing may be useful for learning how to identify feelings. A reluctance to share feelings or thoughts requires exploration as to the meaning of the unwillingness or inability to communicate. Often, the barrier relates to trust and safety issues in the relationship where the person feels it is too risky to share. The ability to communicate effectively is a matter of experience and can be addressed through communication-training exercises in therapy or as 'homework'. Difficult situations are better understood and resolved by learning these communications skills.

At times, infertile stepfamily couples reach an impasse or stalemate, especially when dealing with how far to pursue infertility treatment and family-building alternatives. They may not be able to reach a compromise or agree on a win-win solution that is satisfactory or acceptable to all parties. One useful technique is to persuade each partner to 'walk in the other's shoes'. In this situation, a dialogue

occurs in which each person assumes his or her partner's position and role-plays what he or she knows and understands the partner to feel. The therapist may ask them to change seats as they change identities and talk about the problem. The process is then discussed after the content dialogue takes place, exploring how it feels to be in the other partner's position, what they heard, and what they learned from the exercise. To facilitate the process, the therapist may assign the couple homework to continue the role reversal outside the session. During this period, each partner pursues learning more about the other's position: reading books or articles on the subject, attending information meetings or support groups, or just being open to think about the positive associated with their partner's viewpoint. For example, one partner may want to pursue donor conception, while the other partner is resistant to more children and has only been amenable to a genetically-shared pregnancy in this marriage. The task will be for the 'resistant' partner to learn all that he or she can about the issues of donor conception, while the 'donor' partner pursues an understanding of the benefits of remaining childless in this marriage and investing in stepparenthood. This technique is often helpful in facilitating the process of conflict resolution and decision-making.

Another helpful technique in facilitating conflict resolution is educating couples on the important elements of good decisions and the consequences of unilateral, default, and mutual decisions. Unilateral decisions, in which one partner makes a decision affecting the couple, are authoritarian decisions that may seem effective in the short-run but will result in the non-participating partner's becoming angry and resentful, potentially undermining the decision so that it becomes ineffective. Passive or default decisions occur when one

or both partners relinquish participation in the decision-making process, frequently to avoid conflict. While short-term consensus may have been achieved by inaction, it often results in later regret and guilt by the failure to invest in the decision-making process or allowing a unilateral decision. Compromises or mutual decisions, in which each party gets something of what he or she wants or needs, are the most effective decisions with the highest long-term compliance.

For infertile remarried couples who have polarized their positions, finding a win-win situation can be exceedingly difficult, especially if the partners have difficulty addressing 'bottom lines'. In some situations, a compromise may be that the couple reaches an agreement to reevaluate the decision in a given period of time (e.g., 3-6 months). For example, it is common to find couples polarized when one partner has children and the other does not, the *lack of a shared loss* situation. Here, the infertile remarried couple may decide not to pursue further treatment at this time and to realign priorities so that the stepparent feels more a part of the reconstituted family and is given more time or attention by the parent. The couple may then set a date for reviewing this arrangement to assess its success, as well as the stepparent's satisfaction or comfort with remaining childless. At that time, it may be that the noninfertile partner has not realigned priorities or that the infertile partner believes that she or he cannot live without a biological child, and the decision-making process is begun again.

Genograms

A family systems approach that can be useful in assisting people in understanding the complexities of stepfamily life involves the construction of *genograms*, diagrams indicating relationships between current or

former family members¹. In addition, genograms can be helpful in visualizing complex family relationships and assist the therapist in organizing large amounts of data from complicated histories. The genogram also allows the therapist to shift attention from the individuals and the presenting problem to thinking of the larger family system. It usually takes only a few minutes of the therapy hour, and if the therapist allows the clients to see the developing genogram, their participation may elicit more information. While creating the genogram, the therapist can ask questions such as: 'And how did this (remarried) relationship begin? 'Can you tell me about the individuals in the family group who experienced any problems with alcohol, drug abuse, legal difficulties, mental or physical health?' 'Can you give me a "Reader's Digest" version of why this marriage ended (whether it is the client's prior marriage or their parents')?' This additional information provides not only useful family history but a glimpse of the family's overall functioning and stability.

An example of a typical genogram of remarriage infertility involves an older husband, divorced, with children and a younger, childless wife (Figure 2). This genogram can assist in exploring issues of shame and guilt and the circumstances under which original families were created and dissolved and new relationships begun. It can also be useful in exploring the fantasies and beliefs about what a new baby will bring to the relationship. It is a common fantasy that the wished-for child will cement the relationship and be the glue that binds the new family together³². However, the likelihood of a new baby's increasing or decreasing the glue in a stepfamily depends very much on the developmental stage of the family when the baby is born, ongoing family relationships, and relationship expectations in the reconstituted family. It can be helpful to

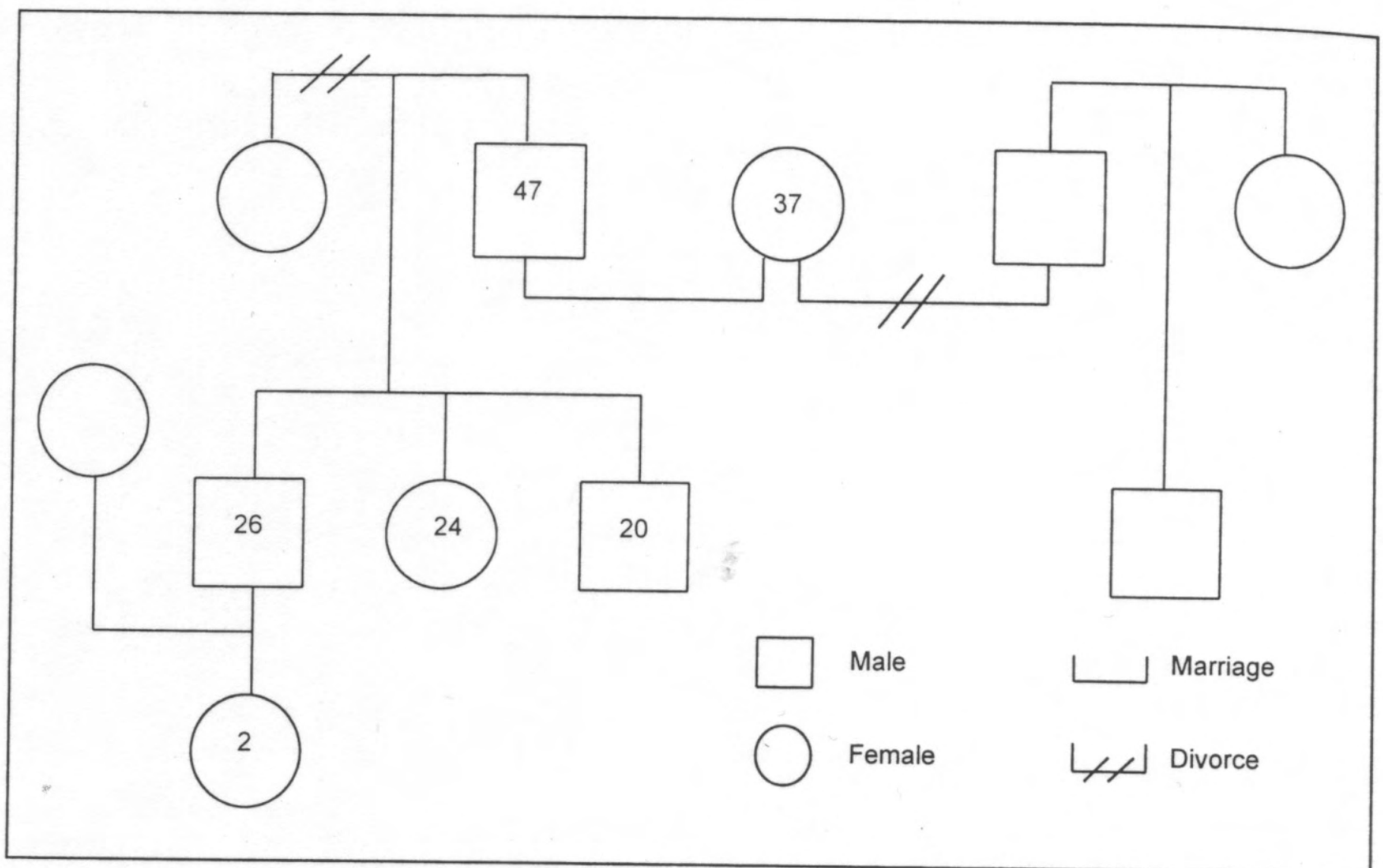


Figure 2 A typical genogram of remarriage infertility

have couples describe how they see their own family picture or genogram with a new child. Often, each member of the stepfamily has a different image of what the new family will or should look like: the stepparent may see it as 'you, me, and our new baby', while the biological parent may see it as 'you, me, our new baby, and my children'¹⁴.

Finally, for some infertile remarried couples, the reality may be that the rewards of the marriage cannot outweigh the costs of childlessness or the demands of the stepfamily. In these cases, the best that the therapist may be able to do is assist the couple in ending the relationship in a respectful and nondestructive fashion that protects the well-being of both partners and the stepchildren. The considerable demands of the reconstructed family and the emotionally damaging effects of infertility can leave remarried couples at risk during a particularly vulnerable point in a stepfamily's life cycle. Understanding these

circumstances can diminish blame and enhance understanding for both partners. Ultimately, infertile remarried couples, like other couples experiencing infertility, may have to accept the unacceptable: there may be no desirable alternative, and their course in therapy will be to resolve the losses of the wished-for child and family.

Infertile remarried couples are under extraordinary stress as they become a stepfamily, while dealing with infertility. The tandem process of stepfamily development and infertility experience is complicated by the duality of feelings on both issues—loss, anger, guilt, grief, blame, lack of control, ambiguity, and hurt. These families must develop skills to deal with these negative feelings and develop a clear understanding of the process and dynamics of their situation. Without this knowledge, they are at risk of a continuing cycle of despair and failure—another failed marriage and thwarted reproduction.

FUTURE ISSUES

Given the high incidence of remarriage and infertility in the general population, it is reasonable to expect that infertility counselors will encounter a significant number of remarried couples and reconstituted families in which infertility is an issue. There is a void of research on this population and an enormous need to examine the implications of the dual experiences of infertility and remarriage for couples and their children or stepchildren. Complicating the picture further is advancing medical technology that makes family building and thus family dynamics and kinship ties increasingly more complex. The issues of donor conception, surrogacy, gestational carrier, conception from deceased spouses, and possibly cloning add new meaning to the words 'reconstituted families'. Infertility counselors must be prepared to assist these families with the complex task of integration and adaptation to a new, healthy family unit.

SUMMARY

- Research on stepfamilies and infertility has exploded in the last 30 years, providing information on counseling and assisting these populations. However, no research is presently available on the impact on stepfamilies of the combined issues of infertility and remarriage.
- Initial marriages differ from remarriages in that they (1) take place at different points in an individual's life and involve (2) the 'continuing imprint' of previous marriages and (3) the presence of a 'remarriage chain', of former spouse, children, and remarried parent and stepparent.
- The etiology of infertility in remarriages is more often the result of (1) prior elective sterilization, (2) age-related infertility, and (3) preexisting infertility.
- Stepfamily integration takes from 4–7 years, the most difficult time being the first 2–4 years of the remarriage. The majority of new births take place within the first 2 years (when infertility would typically be experienced) during a period of considerable transition and disequilibrium.
- Parallel feelings occur during the process of stepfamily development and infertility that may confuse and hinder healthy progress, including feelings of anger, loss of control, guilt, hurt, blame, grief, ambiguity, and disappointment.
- Dual issues exist between stepfamily integration and infertility, which are often weathered in tandem and are experiences born of loss that must be grieved. Stepfamilies require assistance in understanding and managing the duality of these emotional challenges.
- Infertile remarried couples need to develop skills in effective communication, conflict resolution, and decision-making.
- Geograms can be useful in history taking and providing a visual representation of the complexities of stepfamily life.
- Infertility counselors must have a thorough understanding of infertility as well as knowledge of stepfamily family dynamics to effectively counsel infertile remarried couples.

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