

# Conceptions of the mind



*The role of hypnotherapy  
interventions in  
medically-unexplained,  
functional and  
psychosomatic  
infertility*

By  
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## Summary

A total of 40 female patients aged between 26 and 42 years (mean 32 years) who had been experiencing either primary infertility (30 patients) or secondary infertility (10 patients) and had been receiving standard infertility investigations and treatments for between two and 12 years (mean 3.5 years) were referred from Fertility clinics at the Charing Cross and West London hospitals for hypnotherapy, which was to be employed in association with further standard medical treatments in applicable cases.

Of this group, 26 patients went on to achieve successful full-term pregnancies after an average of nine sessions of hypnotherapy, giving birth to a total of 28 healthy children. There was a very low spontaneous abortion rate of seven per cent (two instances).

Nine of these successful patients received additional medical treatments (GIFT, DI, IVF, corticosteroids and minor surgery), the effectiveness of which appeared to have been greatly enhanced following hypnotherapy.

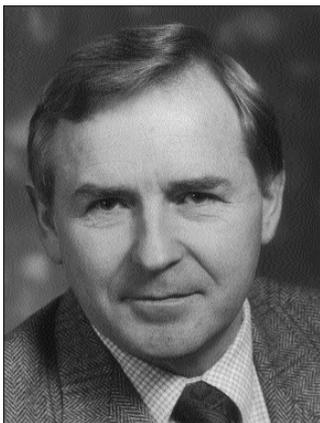
A further eight patients on the programme achieved constructive outcomes in ways other than by achieving pregnancy.

Successful patients generally reported a high level of satisfaction with their experience of pregnancy, labour and birth.

Other benefits from the hypnotherapy reported by 17 of the participants, including several of those who did not achieve pregnancy or other satisfactory outcome, included the alleviation or resolving of various menstrual and gynaecological problems.

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**Foreword**

**I**NFERTILITY (the incapacity to produce a live child – authors' definition) is a highly distressing and emotive condition that is said to affect around 17 per cent<sup>1</sup> of would-be parents. Where there have been no previous children, the condition is described as Primary (1°) infertility; where there is difficulty in producing a second or subsequent child, it is referred to as Secondary (2°) infertility.

Despite advances in medical expertise, success rates continue to remain low in patients who have been referred on for *hi-tech* treatments such as In-Vitro Fertilisation (IVF), Gamete Intra-Fallopian Transfer (GIFT) and Artificial Insemination using Donor sperm (DI) after failing to respond to the standard surgical and other procedures more widely available in NHS infertility clinics.

According to recently-published data<sup>2</sup> provided by registered British clinics, in 1991 the *live birth* failure rate per treatment cycle for the above forms of assisted conception over a six-year period between 1985–1991 was 88.7 per cent (GIFT), 95.1 per cent (DI) and between 81.4 per cent and 90.8 per cent for IVF. The same data shows that a high proportion of all the referred patients still failed to respond even to repeated treatments: in 1991 these figures were 83 per cent (GIFT), 89 per cent (DI) and 85 per cent (IVF).

Around 28 per cent of patients presenting with infertility have no apparent medical cause for their problem (medically-unexplained infertility). For such patients, the overall medical success rate in terms of live births (rather than just conceptions achieved) is reported to be much lower than the norm: one study<sup>3</sup> has put this at 20 per cent; another<sup>4</sup>, based on a much higher sample over a longer period, indicates only a 3 per cent success rate. Allowing for a generally accepted spontaneous abortion rate of about 25 per cent (apparently not taken into account in the published figures) a more recent study<sup>1</sup> has indicated probable live birth success rates of around 55 per cent (patient age group 25–34 years), 37 per cent (35 years or older), 32 per cent (where the duration of infertility is 3–5 years) and 22 per cent (where the duration of infertility is five years or more).

<sup>1</sup> Hull M.G.R., Glazener C.M.A. et al. "Population Study of Causes, Treatment and Outcomes of Infertility" *BMJ* 291:1693-1697. 1985.

<sup>2</sup> Human Fertilisation and Embryology Authority, Paxton House, 30 Artillery Lane, London E1 7LS. Second Annual Report, 1993 (which includes data supplied by the Office of Population Censuses & Surveys, 10 Kingsway, London WC2B 6PJ)

<sup>3</sup> Jones G.S and Pourmand K. "An Evaluation of Etiologic Factors and Therapy in 555 patients with Primary Infertility" *J. Fertil. Steril.* 13:398, 1962

<sup>4</sup> Warner M.P. "Results of a Twenty-five Year Study of 1553 Infertile Couples". *N.Y.State J.Med.* 62:2663, 1962

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<sup>5</sup> Neale C. and Bettendorf G. "Comparison of the Results of Gonadotropin Therapy under Various Conditions." *Clinical Application of Human Gonadotropins*. Stuttgart: Thieme, 1970

<sup>6</sup> Pawson, Michael "An Holistic Approach to Infertility" *Holistic Medicine*, 1:211-218 (1986)

The inability to make a diagnosis in medically-unexplained infertility and the low success rates in these and other resistant cases tends to indicate that both the cause and to a large extent the cure in many such instances may lie outside the scope of allopathic medical approaches. Yet for many years various authorities<sup>5,6</sup> have repeatedly proposed that psychosomatic and functional factors should not be ignored – even in those instances of infertility that appear to have a physical basis. One<sup>6</sup> has warned that where potentially *protective* psychosomatic conditions (such as some cases of secondary amenorrhea) are successfully overridden by medical treatments in an attempt to restore fertility, psychological decompensation may result. Successful but inappropriate medical interventions may thus be responsible for the higher levels of post-partum psychosis that are associated with assisted pregnancies, perhaps as a direct consequence of overwhelming the various forms of *psychosomatic contraception* that may have unconsciously been activated in the patient's self-interest by her own psyche.

In the United Kingdom, Infertility Counsellors – appointed under the terms of the Human Fertilisation and Embryology Act 1990 – may now assist couples to cope emotionally and practically with diagnostic and treatment procedures, or help them ultimately to cope psychologically with childlessness. However the psychosomatic and functional origins of infertility have continued to remain largely unaddressed.

One attempt to remedy this situation resulted in this collaborative project between the combined fertility clinics of two London teaching hospitals (Charing Cross and the West London) and a hypnotherapy practitioner.

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## The Philosophy behind the programme

**The principles on which the hypnotherapy programme was based turned conventional wisdom on its head. Rather than viewing infertility as either a disease or an inherited malfunction, the programme considered the possibility of infertility being a purposeful, possibly functional, condition having useful antecedents.**

This was in response to personal observations and what is now a general understanding that the procreative and the nurturing instincts of all mature non-human creatures, domesticated or otherwise, can be radically and adversely affected either by suddenly raised arousal levels (acute shock/extreme anxiety) or by the stress resulting from chronic arousal.

In the wild, situations such as the loss of a mate, the presence of excessive predators, nest disturbance, overcrowding, migration or other unsettled environmental conditions, can cause procreative activity

(including courtship rituals, mating and nest-building) to cease.

Also an already pregnant female may re-absorb or abort her foetus; or any live progeny may be abandoned or destroyed. Yet it seems that any such apparently negative outcomes of arousal and stress may paradoxically be essential to species survival: released from the encumbrance of dependants during adverse conditions, the sexually-mature adult has a far better chance of personal survival and may thus live to breed again (and restore population numbers) when those conditions improve.

One is inclined, somewhat mystically, to attribute the patent wisdom behind this harsh reality to the external force of *Mother Nature*. More realistically, these responses are automatically internally activated under certain conditions by genetic pre-programming, developed following generations of exposure to such factors. In a more specific way, this *genetic wisdom* may be illustrated for example by a young chimpanzee's inherited snake phobia or a newly-hatched chicken's inborn fear of hawks, both of which are also innate survival responses.

<sup>7</sup> von Baer K.E.  
 "Entwicklungsgeschichte  
 der Tiere  
 (Embryology of Animals)"  
 1828

It seems reasonable, given our evolutionary kinship<sup>7</sup> to other mammals and their reptilian predecessors, that there are psychological, behavioural and physiological human equivalents to all the above phenomena, including the condition described as medically-unexplained infertility.

### Survival response

More specifically, other unconsciously-prompted effects of this inherited survival response may include ambivalence to parenthood, loss of libido, male infertility factors such as poor sperm quality (azoospermia, etc), sexual dysfunction, menstrual irregularities, failure to ovulate, hormonal imbalances, mucus hostility and antibody reactions to sperm, impaired lactation, child abandonment, baby-battering and both ante-natal and post-natal depression.

A more complex intelligence and a more demanding social system may subject the human psyche to a more comprehensive range of potential stressors and arousal-activating stimuli than those experienced by other creatures existing at a subsistence level.

In subsistence-living it seems that only immediate threats or challenges have relevance. Thus, in non-human and in comparatively primitive societies, the stimuli that activate arousal and consequent stress inevitably involve only 'here and now' situations. These include those stressors that may result from genetic pre-programming and, in mammals, the current effects of both conditioning and traumatisation.

However, in a more advanced culture the more highly-developed human brain can add a significant additional dimension to current stressors. This stems from the otherwise invaluable ability of the verbal, analytical *conscious* human intelligence (often referred to as the left brain) to anticipate potential future events.

When used positively and for planning purposes this facility can prove highly advantageous; but when combined with a negative/morbid inclination and a failure to take practical action, anticipatory thoughts can become anxiety-provoking worry, (the *What if...?* syndrome).

The stressful or inhibitory effects of each of the three main groups of potential stressors are:

**PAST – unresolved traumas and negative conditioning.**

**PRESENT – negative or unfulfilled expectations/desires and unresolved current situations.**

**FUTURE – pathological worrying.**

These are always deemed to be potentially materially relevant in any therapy situation.

One objective of the hypnotherapy approach was to identify where possible any typical situation in any of these three groups that could be relevant as a causative stressor in infertility. Another objective was to incorporate early in therapy a relaxation-training strategy that would help to compensate for – thus reducing the negative effects of – stress from whatever source.

### Difficult duplication

*As a result of wide variations in upbringing, experiences, intelligence, education, expectations and coping skills, no two individuals can be relied upon to perceive and respond in an identical way to any given situation or to any specific type of stressor.*

Similarly, unlike scientific experiment, the art of individual therapists is not always capable of exact duplication by others; one may succeed where the other fails and vice-versa. The absence of meaningful constants together with difficulties of design and execution made valid controlled studies virtually impossible to incorporate in this project. It was therefore decided that the results would have to speak for themselves and be judged accordingly.

Although male factors (sperm defects/dysfunctions, coital failure, etc) are significant (about 30 per cent) as a cause of childlessness in couples<sup>1</sup>, a decision was made for the purposes of this project to concentrate on female patients.

For simplicity's sake and in view of the source of referral, the term *patient* was retained in preference to the more usual *client*.



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## Therapy Procedures

### First session.

(a) *The initial consultation (Time: up to 1.5 hours).*

A history-taking session, facilitated by the use of a subjective check-list form <sup>†</sup>(AAH) completed by each patient.

This gave background information on medical history including current physical symptoms/ailments/medications; the frequency/degree of arousal affecting the patient and the effects of that arousal; the patient's level of stress; arousal and stress-coping strategies; relevant personality factors; family background; and past/current stressors.

Further enquiries provided specific information regarding infertility investigations and treatments received by both partners; and any factors having a possible connection with infertility/subfertility or its causes, including sexual dysfunction, gynaecological conditions, domestic/matrimonial/relationship difficulties, past relationship problems and relevant fears or worries.

In each case, the time/date associated with the onset of various symptoms, problems or conditions was closely examined with a view to locating possible stressors, unresolved traumatic experiences and other sources of arousal stimulation.

(b) *The induction of hypnosis and preliminary training in trance management (Time: around 20 minutes.)*

Following the induction (AAH) of hypnosis, patients were trained to achieve a trance state in response to a combination of verbal and other cues. Instructions (AAH) designed to protect the safety and integrity of the patient in subsequent trance states were then built-in during this session and later reinforced.

The patient was then supplied with a double-sided audio cassette tape with two standard therapy programmes (AAH) designed to enable each patient to quickly achieve and maintain a trance state in appropriate conditions.

Side one of the tape – the Foundation Programme – reinforced both the induction cues and the safeguards and enabled the patient to develop the trance state and manage it.

Side two was a relaxation training programme designed to counteract and compensate for the effects of any ongoing arousal/stress and to assist the patient in developing more constructive attitudes and responses to potential stressors.

*The patients were asked to use the tape at least once each day, both sides if possible, at the times they found most appropriate and beneficial.*

### Second and subsequent sessions

*Analysis and additional therapy. (Time 1.0 – 1.5 hours each)*

Often based both on feedback and the information obtained from previous sessions, these periods focused on investigating the possible psychosomatic and functional causes of infertility.

The three essential groups were examined:

#### (i) Past experiences

Utilising hypnosis where necessary, both verbal and non-verbal (e.g. ideomotor signalling) techniques of analysis were employed to locate relevant reactive (traumatic) memories. These were defused using various abreaction techniques and redefined along more positive lines in order to reduce future occurrences of arousal and to lower stress levels.

#### (ii) Current stressors

“Denial” often meant that some current problems (e.g. relationship difficulties) were not always frankly disclosed during non-hypnosis interviews, although they were often indicated by an interpretation of the initial consultation subjective checklist. In such cases they usually became quickly apparent during hypnosis analysis sessions, often with a clear subconscious indication as to their relevance to the block on fertility.

Often, the simple realisation as to the potential significance of leaving such matters unresolved prompted the prevaricating patient to take action. Sometimes a common-sense problem-solving approach on the part of the therapist was acknowledged by the patient as being of value; but occasionally other forms of catalyst in the form of assertiveness training, etc., were needed before the patient felt able to face up to and to deal with the problem situation.

#### <sup>†</sup>Note

Items marked (AAH) indicate formats and therapy processes adapted from those developed by the Association for Applied Hypnosis. Limitations of space prevent them from being detailed in this paper.

**(iii) Negative anticipations and pathological worrying**

Fears relating to the future of the baby, the outcome of hospital treatments, possible financial difficulties, loss of love or attention, childbirth pain, miscarriage, child deformities and other worries were common sources of stress.

**Patients for whom habitual worrying was a serious problem often had a related difficulty in getting to sleep at night and simple reassurance to quell such fears was inevitably inadequate.**

Three techniques were used to help patients to minimise this problem:

1. As taking 'action' reduces the incidences of arousal, strategies<sup>(AAH)</sup> to convert *worrying* into *planning* were taught to patients, with a supportive audio tape being provided for their use.
2. Similarly, strategies to convert *negative* (that which undermines life or well-being) thinking into *positive* (that which enhances and supports life and well-being) thinking were also taught, again with a supportive therapy tape being provided.<sup>(AAH)</sup>
3. Whereas the previous two approaches were essentially directed to the conscious mind, further instructions were given under hypnosis to restrain the sub-conscious mental processes from responding inappropriately to anxieties pertaining to the future. Again, a supportive hypnotherapy tape<sup>(AAH)</sup> was provided to assist the positive conditioning.

**Final session**

*(Time: 0.5 hours)*

Of those 26 patients who conceived during or following the therapy programme, those who wished it (20 patients) were provided with a further taped hypnotherapy programme<sup>(AAH)</sup> designed to facilitate pregnancy, labour, birth and the post-natal period.

**Results**

Out of the 40 participants of the hypnotherapy evaluation project:

**Outcome Number 1**

Twenty-six of the patients (65 per cent) aged between 26–41 years conceived and went on to have a total of 28 live births. All births were straightforward but one was delivered by Caesarian section on medical advice and one baby (of twins) required a plasma exchange.

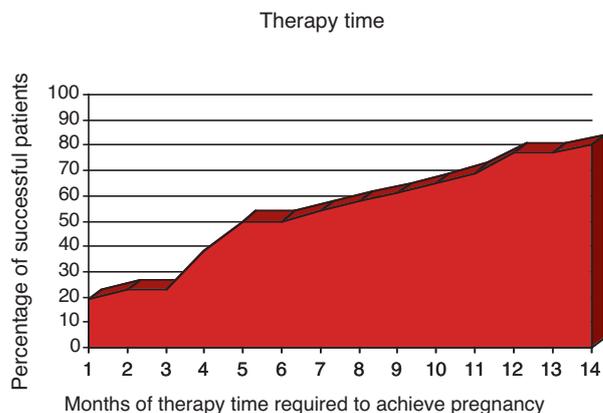
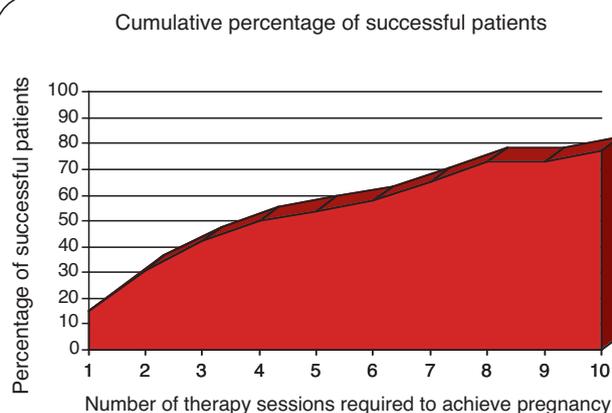
*a)* Of these successful patients, 20 had experienced between two and eight years of 1° infertility (mean 3 years) prior to commencing hypnotherapy. An average of ten sessions of hypnotherapy was required by these participants, although generally the younger patients (aged 26-35 years) required considerably fewer sessions than the older patients.

**Nine of this sub-group conceived following combined hypnotherapy/medical treatment (including a total of four GIFT, six IVF, one DI session, one course of steroids, and one minor surgery); prior to therapy, four of these patients had already received between them a total of nine IVF sessions, nine DI sessions and two AIH treatment cycles without success.**

*For further details of this combined hypnotherapy/medical approach, see Outcome Number 8.*

*b)* The other six successful patients had experienced 2° infertility for between two and five years (mean 3 years). None of these patients received additional medical treatments. Two gave birth to twins. The average number of therapy sessions received was five.

*c)* Eight of the total 26 successful patients conceived within two sessions of therapy, despite previously having had medical investigations and treatments for infertility for between two and seven (mean 3.5) years prior to commencing hypnotherapy.



### Outcome Number 2

Of the 26 patients who went on to achieve live births, two had other pregnancies that resulted in spontaneous abortions.

One of these patients, having conceived naturally eight weeks into the hypnotherapy programme following three years of infertility, miscarried after seven weeks but conceived again with three months.

The other patient miscarried at 11 weeks after her first GIFT treatment cycle but went to term following her second GIFT treatment (*see Outcome number 8b*).

This spontaneous abortion rate (7 per cent) compares favourably with the generally acknowledged miscarriage rate for all confirmed pregnancies of around 25 per cent (or for GIFT patients 30.3 per cent) in 1991<sup>2</sup>.

### Outcome Number 3

Two further 2° infertility patients (5 per cent), who had been participating in medical investigations and treatments for three and four years respectively prior to commencing therapy, subsequently revealed during therapy a personal ambivalence towards having further children that they had previously been loathe to disclose.

In one case, the patient's partner also admitted such an ambivalence: it transpired that each had been supporting what they believed to be the other partner's wishes. In both cases the parties concerned happily discontinued both therapy and medical infertility treatments.

### Outcome Number 4

Six further patients (15 per cent) came to terms during therapy with what they felt to be long-term and insurmountable personal relationship problems. They had been receiving infertility investigations and treatments prior to therapy, between three and twelve (mean 5.5) years.

Three of these patients admitted clinging to the hope that a baby would act as a uniting force and restore their marriages, whilst a fourth believed another child would supply a need no longer fulfilled within her marriage.

The latter sought to satisfy her personal needs by developing a fulfilling career; the other five separated/divorced from their partners.

### Outcome Number 5

Patients generally reported a high level of satisfaction with their experiences of pregnancy, labour and birth, including one patient who had experienced eight miscarriages/neo-natal deaths prior to commencing hypnotherapy.

### Outcome Number 6

Sixteen of the forty participants at the initial consultation complained of either menstrual problems (pre-menstrual tension, dysmenorrhoea, menorrhagia, amenorrhoea and erratic menstrual cycles) and a further six suffered from various gynaecological conditions (chronic and recurring fungal infections, vaginismus and endometriosis).

Twelve of the former group and five of the latter reported either worthwhile improvements in their condition or complete cures (including one case of endometriosis which apparently resolved itself without medical treatment just prior to the patient successfully conceiving).

A total of 14 of the 17 patients who had benefited in this way went on to achieve full-term pregnancies.

### Outcome Number 7

#### Non-successes:

- \* One patient withdrew prematurely from therapy, having found it emotionally too difficult to continue.
- \* Two patients moved – one abroad – and could not be traced. The ultimate success or otherwise of the therapy they had received could not therefore be determined.
- \* One patient after two failed IVF treatment cycles went on to adopt a baby and did not therefore continue infertility treatment or therapy.
- \* One patient with a prevailing blood condition (venous thrombosis and lupus) did not conceive following 15 sessions of therapy.
- \* One patient did not conceive, for reasons unknown, following 17 hypnotherapy sessions.

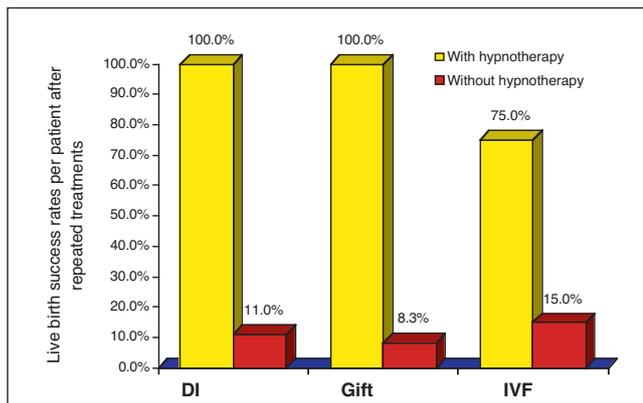


Figure 1: Outcome Number 8 – Successes per patient

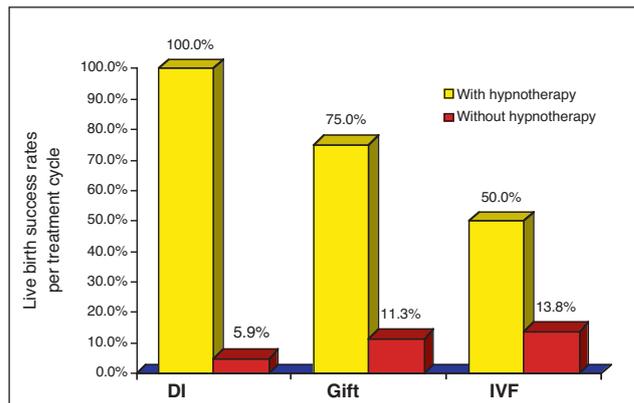


Figure 2: Outcome Number 8 – Successes per treatment cycle

### Outcome Number 8

Combined Hypnotherapy/Medical approaches (see Outcome Number 1a)

#### a) Hypnotherapy/DI combinations

DI statistics for 1991<sup>2</sup> indicate that only 11 per cent of all DI patients achieve a live birth. For those that are successful, an average of 17 DI treatment cycles are necessary for this result to be achieved by a patient of this age.

The successful hypnotherapy/DI patient (age 26) had experienced six failed DI treatment cycles prior to commencing therapy.

*Following three hypnotherapy sessions this patient achieved a live birth with just one additional treatment cycle.*

#### b) Hypnotherapy/GIFT combinations

According to GIFT statistics for 1991<sup>2</sup>

1) Only 8.3 per cent (about 1 in 12) of all GIFT patients achieved live births, even after repeated treatment cycles.

*All three Hypnotherapy/GIFT patients (ages 32, 37 and 39 years) did so.*

2) For those GIFT patients who were successful an average of 8.8 treatment cycles were generally needed to achieve a live birth.

*a) Two of the Hypnotherapy/GIFT patients achieved this after one treatment cycle.*

*b) The third (aged 39) did so following her second treatment cycle. (See Outcome Number 2)*

#### c) Hypnotherapy/IVF combinations

According to IVF statistics for between 1985 and 1991<sup>2</sup>

1) Only 15 per cent of all IVF patients achieve a live birth as a result of IVF treatments.

*Three (i.e. 75 per cent) of the four Hypnotherapy/IVF patients (ages 37, 41 and 42 years) achieved this result.*

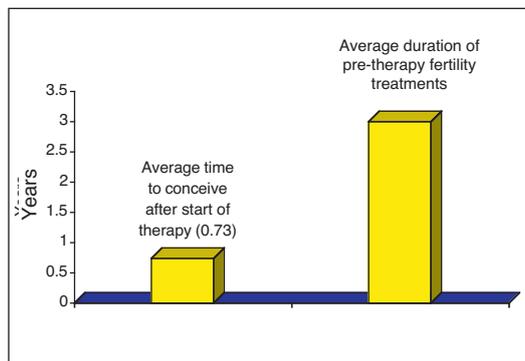


Figure 3 Outcome Number 8 – Time take to conceive

2) Between 30 per cent and 43 per cent of IVF pregnancies achieved by patients in the 35–44 age group were lost as a result of miscarriages, ectopics and perinatal deaths.

*None of the Hypnotherapy/IVF patients suffered such losses.*

3) An average of 7.1 IVF treatment cycles were required for successful IVF patients in the 35–39 age group to achieve a live birth.

*The 37 year-old Hypnotherapy/IVF patient achieved this result following one IVF treatment cycle.*

4) An average of 9.5 treatment cycles were required for successful IVF patients in the 40–44 age group to achieve a live birth. The two older patients in the Hypnotherapy/IVF group had respectively already received five and four treatments without success prior to commencing therapy. Following hypnotherapy:

*a) The 42 year-old patient succeeded with one further treatment cycle.*

*b) The 41 year-old patient achieved this result in four further treatment cycles, two of which (from a hypnotherapy viewpoint) were considered premature.*

## Observations

1. At the initial consultation most of the patients acknowledged that, apart from other active stressors in their lives, they experienced varying degrees of distress from the consequences of the infertility problem itself.

These included:

▫ **Personal and relationship strains imposed by the standard medical diagnostic procedures and treatment régimes.**

▫ **Frustrations caused by associated problems, including delays between appointments, lack of continuity due to staff changes, etc.**

▫ **Severe disappointment following each treatment failure**

▫ **Guilt and loss of self-esteem at their perceived 'abnormality'**

▫ **Accumulating depressive feelings about their continued inability to have a family, uncertainty regarding the future, their inability to make long-term commitments concerning work, etc.**

▫ **Envy of and feeling the need to avoid pregnant women or women with babies**

▫ **Feelings of isolation from close relatives or long-time friends now having young children**

▫ **Well-meaning enquiries and exhortations regarding their starting a family by persons ignorant of their problem.**

In the absence of an infertility counsellor who might have addressed and helped to resolve such issues prior to the commencement of hypnotherapy, the hypnotherapist was required to fulfil this role as well to deal with other stressful life experiences, and to locate and resolve underlying psychosomatic and functional issues

specifically affecting fertility.

The older the patient and the longer the period of infertility the more complex and time-consuming in therapy such factors tended to be. Generally speaking, the older 1° infertility patients (36–41 years) tended to need considerably more therapy time (mean 13.4 sessions) than either the younger 1° infertility patients (mean 6.7 sessions) or the 2° infertility patients (26–35 years) who required a mean of 5 sessions.

## Inability to respond

2. Surprisingly, despite their other psychosomatic or behavioural consequences not all stressors appeared to have a specific inhibitory effect on fertility; for example, even heavy work-related stress seemed irrelevant as a possible causative factor in infertility.

Other stressors, most particularly phobias resulting from past pregnancy, sexual traumas, or anxiety and insecurity created by unsatisfactory aspects of personal relationships and domestic situations, often proved highly significant.

With regard to the latter, situations where expectations and needs were not adequately met tended to be a significant factor both in intelligent, educated patients with high expectations and in those insecure patients with neurotic needs resulting from childhood deprivation or trauma.

**In each case much of the stress resulted either from inaction on the part of the affected patients (e.g. failing to discuss their needs with others concerned) or from the failure or inability of others to respond adequately to the patients' expressed needs.**

Most patients were affected by the influence of more than one unresolved stressor. It was noticeable however that pregnancy often followed quickly after certain factors, or combinations of factors, had been resolved. (Number of instances – see box on next page)

It seemed evident from this that the deciding factor as to whether or not arousal/stress influenced fertility negatively had little to do with the severity of the stress but whether or not it was in some way focused on the reproductive system. This focusing factor may in some cases have been physical, for instance spontaneous

PAST EXPERIENCES:	Rape/sexual assault traumas ...	(3)
	Abortion traumas .....	(5)
	Miscarriage traumas .....	(5)
	Previous pregnancy/birth traumas .....	(3)
	Childhood traumas and deprivation.....	(4)
CURRENT INFLUENCES:	Resolvable relationship problems .....	(5)
	Unsettled living conditions...	(4)
NEGATIVE ANTICIPATIONS:	Fear of surgery/hospitals.....	(1)
	Fear of not conceiving.....	(2)
	Fear for child's future.....	(4)

happen again and projections, e.g. *I suffered, so my children will suffer in the same way*

This *Stressor + Expectation* combination could explain some anomalies, such as the apparent irrelevance of some stressors in unexplained infertility and the particular significance of others more likely to create negative expectations.

Similarly it could explain another paradox: why it seems, anecdotally at least, that it is easier to conceive an unwanted child than one which is desperately wanted. *A fear of becoming pregnant*, which actually betrays a positive expectation of pregnancy, may actually stimulate pregnancy while a *fear of not becoming pregnant* (indicating a negative attitude often perversely associated with obsessional desires) may inhibit the reproductive processes.

It certainly seems that a change in expectation, from negative to positive, can quickly produce previously-denied results: two successes not included in the published figures concerned women who, having expressed hopelessness at their situation after some years of infertility, telephoned eagerly for an appointment to join the therapy project which by then had earned a reputation for success with "difficult" cases and had been highly recommended to them.

Prior to attending the first appointment, made for approximately six weeks later, each cancelled with the happy news that in the interim they had conceived.

tension associated with intercourse following an earlier rape ordeal.

In other cases it might have been a negative expectation created as a result of an experience and directly related (often unconsciously) in some way to procreation, creating an inhibitory effect. Such negative expectations could include assumptions, e.g. *It's happened before so it will*

## Conclusion

**As costs had to be privately funded, this study was limited. Some would argue that more comprehensive research would be necessary in order to confirm the value of hypnotherapy interventions in cases of infertility. Yet, limited though this study was, there are still strong indications that both the personal and financial costs of infertility treatments might be considerably reduced by combining a hypnotherapy approach with medical procedures.**

**Higher and more quickly-obtained success rates (measured in terms of acceptable outcomes rather than simply pregnancies achieved) would be of obvious benefit to all concerned: patients and their partners would suffer less and be less penalised financially; the burden on N.H.S. services would be reduced; and private fertility clinics with higher success rates would attract more patients.**