

The Pain of Egg-Donation

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Abstract: Contemporary body practices providing an answer to the subjects' demand for assisted reproduction procedures, question the subjective experience of pain. The psychoanalytic approach of pain introduces the dimension of the unconscious in bodily experiences. Clinical field work and psychoanalytic psychotherapy with an infertile woman after failed egg-donation *in vitro* fertilization cycles, allows an understanding of psychic pain as analogous to somatic pain and considers the human body as a psychosomatic entity. In this case study, pain becomes a vector of subjectivation, allowing for the subject to negotiate acceptance of a gift impossible to receive.

Keywords: Case study, egg-donation, gift, infertility, psychic pain, subjectivity, unconscious.

1. INTRODUCTION

Operating a splitting of the very concept of “mother”, *in vitro* fertilization (IVF) following egg-donation signs a mode of female kinship marked by the absence of a hereditary link to the child and at the same time, by the presence of a link in-body, through the experience of pregnancy that it renders possible [1]. Along the process, failures, postponements, somatizations etc., become medical and subjective symptoms of the new medical possibilities' limitations, posing for each woman the issue of subjectivation. Beyond the way in which the procedure is mounted in a given country, egg-donation IVF always refers a woman to her desire for a child in its unique relationship to symbolic inconceivable debt and body objectification. Nevertheless, the discrepancies in egg-donation practices internationally call for a reflection on potential abuses both on subjective as well as collective levels, together with the consequential issues of explicit and implicit body commodification [2].

The author's previous research focuses on the psychological specificities of egg-donation as experienced by recipient women; it approaches egg-donation in terms of a gift so transcendental that it creates life rather than keeping alive, installing trans-generational debt. In egg-donation with donor compensation, egg-donors receive financial indemnification for donating their oocytes. Within this exchange, one can identify a gift that finds its essence in the obligation of reciprocity and counter-gift, such that Marcel Mauss [3] introduced it in the foundation of social bond. This paradigm can be put into perspective with relational egg-donation as it is often practiced in France, where a relative or friend donates her oocytes for the infertile couple, and not to the infertile couple; the collected oocytes are then attributed anonymously to a different couple. In this case,

the gift is rather considered in the sense that Jacques Derrida [4] attributed to it, namely that a true gift does not take place within a circle of exchange, expects nothing in return and is thus impossible. As a gift whose origin remains anonymous, thereby excluding any possibility of counter-donation, egg-donation raises for the subject the question of debt, since as Maurice Godelier [5] indicated, a gift elicits a debt that a counter-gift can never cancel.

Albeit in clinical work with subjects immobilized in the gift's omnipotence, the notion of the gift's limit as it was developed by Jacques Lacan [6], seems to shed some light on egg-donation failures. The author has proposed the general hypothesis that for as long as the gift's limit is not assumed and the already existing debt is not recognized, the gift remains impossible, blocking the access to pregnancy. For it is only when the subject embraces the pain caused by the gift's limit, in other words once its limits are defined and symbolized, that it will be possible for it not to be experienced as a painful ripping off. The present paper aims at understanding pain within egg-donation procedures for a recipient woman, by examining the psychic function fulfilled by pain when the gift is inconceivable.

The avoidance of pain and the quest for pleasure was, for Freud [7], the basis for the development of the complex human psyche. According to Freud, pleasure was the perceived reduction of unpleasure (or pain), the aim of the pleasure principle being to maintain the psychic apparatus at its lowest level of tension. The psyche developed thereof as a mechanism for reducing pain [8], and psychic functioning as a whole would be governed by the pleasure principle. Instinctual excessive fluctuations experienced as pleasure or displeasure, manifest a disruption of the stimulus barrier, to which the ego replies by experiencing pain. Therefore, “displeasure is not pain”, the latter being rather an “uncontrollable tension within a psyche that is upset” [9]. By following the Freudian elaboration of pain in “Beyond the pleasure principle” [10], pain becomes a residue that neither

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the pleasure principle nor masochism can account for, laying beyond the displeasure-pleasure principle. In “Inhibitions, Symptoms and Anxiety”, Freud [11] went as far as drawing a direct analogy between psychic pain as the pain caused by object loss, and somatic pain as caused by bodily tissue injury, in terms of invariable libidinal cathexis [12].

Penetrating the body envelope, pain is thus situated between anxiety and the suffering of mourning, between narcissistic cathexis at the locus of the trauma and object cathexis following object loss and its subsequent mourning [13]. In order to account for this ambiguity, Pontalis [13] advances that “pain is rupture; it presumes the existence of limits: body limits, ego limits; it entails an internal discharge, what could be called an effect of implosion”. Pain appears to hold a specific status within the psychoanalytic approach of mental suffering, a limit-concept or a concept of the limit. Egg-donation being characterized as a gift bearing its own limits, does not really question pain as an operational concept; it is actually the patients themselves who invariably report their painful feelings during fertility consultations, pain emerging in the session rather than being expressed in response. This particularity opens to a multitude of research possibilities, since, in order to manipulate the polysemy of an object of study such as pain, the researcher is led to turn to the subject and his/her lived painful experience as it is recounted in spoken words.

2. MATERIALS AND METHODOLOGY

This paper accounts for the results of an intrinsic case study [14]: it is based on a unique particular case, on which the author bore intrinsic interest in order to address the issue of psychic pain.

2.1. Case Selection and Data Analysis Procedures

The case is a woman admitted in the IVF Unit in which the author has been working as an infertility psychologist. She requested consultation after her first failed egg-donation IVF attempt at the clinic, where she undertook a psychotherapeutic procedure that lasted over the period of a year and five months. Hourly psychotherapy sessions took place once per week and were followed by detailed process notes being taken. In parallel, material stemming from the patient’s medical history files as well as from staff meetings on the patient’s medical and psychological follow up was also collected and analyzed. Throughout the course of therapy, notes were taken on the patient’s evolution, the therapy setting and the author’s own subjective responses to both patient and setting. Data gathered from the psychotherapeutic sessions were subject to detailed discourse and enunciation analysis: the manifest and latent content that was brought by the patient was analyzed, as of the first contact with the patient up to the therapeutic process termination, aiming to identify the main themes that arose, by identifying signifying keywords. Verbatim material supported this analysis.

2.2. Case Study Specificity

Case studies based on therapeutic psychoanalytic sessions adhere to the methodological principles of “free association, abstinence, fixed frame, dream analysis, etc.” [15]. The specificity of psychoanalytic research based on

long-term therapeutic sessions lays in the fact that, whereas in clinical research interviews, participants are solicited by the researcher in order to reply to his/her own demand for research material, participants analyzed for the needs of a case study are foremost patients having addressed a demand for psychoanalytic treatment to the researcher being foremost a therapist. This fundamental difference obliges a methodological questioning based on Rapaport’s [16] classic paper, stating that “methodology tries to establish how much of the material that is obtained is determined by the method used; how the selection of the observational material depends on the method used” [16]. In the case of long-term treatment material, the researcher’s first and paramount goal is a better understanding of unconscious meaning and intrapsychic processes which are then conveyed to the patient “in order to effect therapeutic change” [15]. Therefore, the therapist actively participates in the patient’s formulations of his/her own life story, by proposing constructions that are validated throughout the course of therapy, with respect to the therapeutic effect experienced and described by the patient. In the case of psychoanalytic research based on long-term therapeutic sessions, research goals are secondary to therapeutic goals yet mutually enlightening; taking this specificity into account allows to formulate research questions as corollary to the therapeutic process itself.

2.3. Research Questions

With this intrinsic case study, the author strived for a deeper understanding of the psychic processes at play in the present case and of the ways these processes interact with their contexts. Therefore, the research questions, instead of consisting in oriented hypotheses that would narrow the focus on the intricacies between subjective responses and circumstance, became issues [14] that were selected for their potential to provide conceptual structures. Issues addressed with this case are the following:

- Can pain become an outcome and a subjective response to impossible gift situations?
- How does pain become necessary in face of the unconscious conflict inherent to the gift of gametes?
- How to accept a gift one has not asked for?
- Can a child be conceived for someone else?
- Does pain represent an absent or a present object?

2.4. Ethics

Ethical issues of anonymity and confidentiality for this case presentation have been assessed on the basis of Gabbard’s recommendations: the strategy chosen to protect the participant’s privacy has been that of disguise [17], namely falsification of elements identifying the patient and irrelevant to the case analysis.

3. RESULTS

In this section, the main elements of the case history and its evolution will be presented and analyzed. Mrs N. (52 years old) has had an intimate relationship with Mr P. (39 years old) over the past 19 years. The couple has been living together for 4 years now, along with Mrs N.’s two children

from her previous union, namely a young woman aged 27 and a young man aged 30. Mrs N.'s relationship with Mr P. began when she was still married: they fell in love and soon wished to be together, so she filed for divorce after 11 years of marriage.

Not only was she unhappy in her marriage, but she was neglected by her husband and frequently verbally abused, being insulted and belittled. If her former husband neglected and verbally abused her, she will encounter this pattern again with her lover under a different form: it will take him more than 15 years to commit to her and their relationship, an engagement that she evaluates on the basis of his wish to have a child and move in together. Herself, on the other hand, has never concealed her desire to have a child with him and remarry. Frustration as to the imbalance in this love relationship will be exaggerated by her still painful mourning process and working through, in therapy, of the two abortions he forced her to go through with, against her will, at 38 and 41 years of age. She wanted to keep those babies but he felt too young to build a family with her and could not really assume their age difference. Their relationship is rejected by his own mother because of their age difference and the fact that Mrs N. is already a mother of two. She is equally questioned by her own children for choosing this man so passive and emotionless, failing to integrate and assume any responsibility in their household.

The first time he actually expressed a desire for a child, was after they moved in together when Mrs N. had turned 50 years old, as if he could begin to wish for it from the moment it would no longer be naturally possible for her to conceive. Indeed, they had to turn to fertility treatments and underwent four negative IVF cycles. It so appeared that the only way they could keep trying to have a baby would be through egg-donation IVF. He agreed to the prospect of egg-donation without hesitation, whereas she deeply suffered from it, engaging in a painful mourning process related to her menopause and that reactivated the loss of the babies she had naturally conceived with him when she was younger. His easy acceptance was experienced by her as undermining her feminine identity and participation in the conception of the child that would be born. More so, his persistence to try egg-donation IVF, considering that donated oocytes would "not make any difference", made it clear to her that the only way she could continue to be with him was by accepting egg-donation.

When they finally underwent an egg-donation IVF procedure, Mrs N. got immediately pregnant but pregnancy ended in a miscarriage at 6 months, a miscarriage so dangerous that it threatened Mrs N.'s life. Severe abdominal pains had led her to the maternity unit in urgency, she described how labor was induced and how she could listen to the fetus' death rattle, how she felt and saw a dead baby falling from within her on the floor. Reminiscing the atrocity of this moment of losing the baby, tears her apart in unbearable pain; her guilty feelings for giving death instead of life to the baby, meet Mr P.'s accusations of her for having unconsciously provoked it, never really desiring this baby to be born.

Devoted to this man, subordinated to his desire, she will have to sacrifice her genetic bond to the baby. Being a mother of two, she cherished the genetic bond as she

cherished her own children. Not founding her maternal identity on genetic grounds, egg-donation entails for her to take a step further and she will only be able to take it by integrating a radical splitting: at the same time giving birth through the body and transmitting nothing of her own physical self. How can she accept such gift when the gift is inconceivable? Although she will receive it in order to make of it a gift of love to him, she is unable to forgive the subjective "erasure" to which he submits her. She will repress her difficulty to assume motherhood through egg-donation, she will even grow attached to the baby developing in her womb, feel the need to protect it, but the real event, the unspeakable event - miscarriage at 6 months of pregnancy - will speak within her, in her place. Could it not be precisely thought of as a radical, painful rejection of the unconscious gift?

Non metabolizable pain of being an infertile woman imploring this younger man's love, provokes an instinctual entanglement where life and death are so close that they become indiscernible. A baby that did not survive pushes her own capacity for survival to the limits. But long before the mourning process of losing this baby will have been completed, she will undergo a second egg-donation IVF attempt, under Mr P.'s pressure. Pregnancy will not be achieved this time; aged 54 by then, taken down by the successive IVF failures, bereaving the prospect of having a baby together, herself and Mr P. will decide to put an end to the fertility procedures. The therapeutic goal was then to assume the consequences of this renunciation, permit and set the frame for the mourning process, rediscover meaning in their relationship and focus on restructuring it. Therapy will be terminated once she will be at ease addressing her desire with respect not only to Mr P., but also to her children as well as in social situations in general.

4. DISCUSSION

Freud in 1926 [11] assimilated the model of physical pain to that of psychic pain. Psychic pain being "experienced as if it concerns somatic pain", somatic pain becomes the metaphor of psychic, unarticulated, pervasive pain, embodying an unthinkable anxiety as experienced by the baby [12]. The pain of not being able to be loved by Mr P. for what she cannot give him, the pain of not being understood and being pushed into yet another IVF attempt, finds its place within this man's denial of her pain and his own, inherent to the miscarriage trauma. For Mrs N., the only way to escape denying the trauma will be through pain. The miscarriage pain, simultaneously physical and psychic, becomes a metaphor of the gift's failure and its very limit, a bodily inscription of a limit imposed by the subject on herself, "a sign showing that the experience one is going through is a test", bringing about a change in the subject [9]. Pain can thus be thought of as protruding when words fail or are missing. In this respect, Akhtar [18] considers pain as different from anxiety in the sense that it is immediate, lacks readily available discursive content and is a response to a trauma that has already taken place. Wille [12], along the line of Winnicott's elaboration of the fear of breakdown as fear of a breakdown that has already happened [19], also advocates that actual pain is a pain that has already occurred.

The pain that has already occurred is no other than the pain of separation with the first other. "I hurt because I lose one of the sources of excitation and supply of my desire's power, because the psychic mirror reflecting my images collapses, because the symbolic rhythm to which vibrates the power of my desire is lost, and thus I lose the symbolic other who demarcated and provided entity to my unconscious." [9]. As Widlöcher [20] puts it, Mrs N. seems to know which object she has lost; she has lost the baby she was carrying, although it is unclear what she has lost "in the object": "We are not in pain due to the loss of the beloved object, but because of the consequences provoked by the loss in us.": it is not only a baby that she is mourning, but also the possibility of short-cutting the limitation pertaining to her advanced age for procreation and having a child with Mr P.

If the emergence of pain is actually a reactivation of past pains, for Burloux [21] any pain "makes the subject enduring it regress. This regression is temporary, and allows for the childhood objects to be found again. To end up in an infantile position, is equally to reoccupy forgotten psychic positions: need for care, mothering, need to complain, all fulfilling a defensive function." Wille [12] considers actual psychic pain as rooted in preverbal, intra-uterine even experiences of pain to which the emotionally attuned pregnant woman or mother will respond by holding and soothing the fetus or baby. Therefore, the capacity to endure psychic pain is rooted in the earliest phases of human existence when soma and psyche are undifferentiated, in such way that somatic and psychic pain coincide. A sufficiently comforting (m)other is then internalized, allowing for the capacity to tolerate psychic pain to develop, capacity which will be put to the test again and again for Mrs N.

"We are never so badly protected against pain as when we are in love" [22]; to love him and be loved back in return, is to cross her limits and accept the impossible gift of gametes. At the critical moment of the miscarriage, when the stimulus barrier is brutally attacked, she will be unprotected, left without psychic resources. Indeed, at this moment of psychic disorganization, fantasies melt in with reality: her description of having felt and seen the dead baby seems to be fantasized and belonging to her psychic reality, rather than actually lived. The disoriented organism will respond with pain, whose function will be to provide a limit to the body and containment, in the sense of the Skin-Ego introduced by Anzieu [23] as a mixed bodily and psychic entity. Containing and contained, the Skin-Ego becomes a barrier ensuring unity and entity, following the primary infantile position of body fragmentation and insecurity [24]. It is this pain that by rupturing the ego's sense of integrity, will reactivate the containing Skin-Ego function, by forcing its holding capacity to operate again. The therapeutic setting will ensure a renewable holding situation, where Mrs N. will be able to come back to, and where she will strive to elaborate and work through past painful experiences.

Pontalis [13] proposes that certain repetitive sufferings, namely sadomasochistic suffering where the subject remains his/her own stage director and master of his/her scenario, would fulfill the function of "evacuating psychic pain", as if to suffer a lot - as much as necessary - could shield the subject from suffering in excess and indefinitely.

Sadomasochistic suffering would thus allow to canalize generalized, unsymbolized suffering. Freud in "The economic problem of masochism" [25] considered the experience of pleasure in pain, where "pain and unpleasure can be not simply warnings but actually aims": physical pain (like any other sensation) could be sexualized as in erotogenic masochism, and evolve into mental pain in moral masochism [8]. Lacan [26] will see enjoyment (*jouissance*) beyond the pleasure principle in the repetition compulsion, in a way that he distinguishes pleasure from *jouissance*, which "moves beyond the pleasure principle in order to reach the lost object and brings pain with pleasure" [8]. What *jouissance* would be at play for Mrs N., repeating five painful IVF attempts one after another until she engaged in the painful experience of egg-donation? Would this quasi-sadomasochistic repetition allow her to canalize her pain for the loss of the family she couldn't create with Mr P.?

"Every time pain emerges, it means that a threshold has been crossed, that we are going through a decisive test, the test of separation with an object, which by losing us abruptly and indefinitely, upsets us and compels us to reorganize" [9]. The painful experience of losing the baby she wanted to offer as a gift to the man she loves, encompasses all the previous pains of abortions and egg-donation acceptance. She had accepted the gift of gametes in ambivalence, and felt narcissistically devalued by her companion not acknowledging the importance of the lack of genetic connection to the baby. However, as the course of therapy and the modalities of its termination demonstrate, this pain will force Mrs N. to restructure herself, leading her to reorganize her own subjectivity as interrelated yet autonomous, and to assume her own desire. The indescribable pain of miscarriage will be her price to pay in order to take on her desire, namely not to cede the genetic bond to the child by undergoing egg-donation IVF.

CONCLUSION

Pain becomes necessary for Mrs N. as a subjective response to the unconscious conflict inherent to the perceived ambivalence of egg-donation. The subject responds by experiencing pain to a gift she has not asked for, one she is pushed to receive. She does not only experience the pain of losing a present object, namely the fetuses that cannot survive in her womb, but also that of losing an object that is absent, related to the idealized couple she has created imaginarily. An all-dreaded fantasy becoming reality, her miscarriage in immense bodily pain, an implosion [13] such an internal eruption, seems to be the paradigm of psychic pain for it collides with bodily pain unto death. Therefore, the case presents pain as "a mixed phenomenon", at the border between body and psyche, in such a way that there is no actual difference between bodily and psychic pain [9].

A subjective response or else a symptom, pain can take various forms and always possesses a signification [27]: it can be the result of an organic lesion, a hysteric conversion symptom in substitution for a lost object, or a condition in-between these two extremes. In the latter, the psychosomatic therapist has difficulty distinguishing between the degree of psychic disorganization caused by pain and the extent of cathexis that pain would be subjected to. As a symptom, that is an externalization of unconscious conflict [9], pain will be

a compromise, the price to pay for an impossible gift. The subject suffering in pain, is unwilling to give up his/her symptom, holding on to it as one holds on to their subjectivity. Hence a questioning on the distinction to be drawn between suffering and pain is introduced: would their difference be a matter of affect intensity? If psychic pain has an existential connotation, in the sense of a suffering inherent to life, suffering from life [12], pain would be a certain mode of affirmation of subjective existence, of subjectivation: saying "I am (in) pain" will always allow to say "I am".

CONFLICT OF INTEREST

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PATIENT'S CONSENT

Declared none.

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