AJHS
Asian Journal of Home Science
Volume **9** | Issue 1 | June, 2014 | 272-275

e ISSN-0976-8351 | Open Access - *www.researchjournal.co.in*

A Review

Psycho-social experiences of infertile women

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Received: 11.06.2013; **Accepted:** 06.05.2014

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ABSTRACT : Infertility is a global health challenge which is rising and is rearing its ugly head particularly in developing countries. It is usually linked to a physical problem of one spouse or the other, but the stress and loss associated with infertility can have serious implications for both spouses on psychological, physical, economic and social well-being. Though this problem is not life threatening, but the intense mental agony and trauma associated with it can only be described by infertile individual. This paper is an attempt to gain a deeper understanding of the experience of infertility from a psychosocial point of view.

KEY WORDS: Infertility, Psycho-social experience

HOW TO CITE THIS PAPER : Joshi, Niharika and Kang, Tejpreet K. (2014). Psycho-social experiences of infertile women. *Asian J. Home Sci.,* **9** (1) : 272-275.

Infertility is a global health issue, affecting approximately 8-10 per cent of couples worldwide (Burns and Covington, 2006). Since antiquity, the problem of infertility has been described in literature, art and myths. However, lack of uniform definitions has always characterized research on infertility. It is accepted that the terms infertility, childlessness or sterility all refer to the incapacity of couples to conceive or bear children when desired. For example, the WHO (1991) has used a two year reference period to define infertility:

Infertility can be 'primary', if the couple has never conceived despite cohabitation and exposure to pregnancy (not contracepting) for a period of two years; primary infertility is also referred to as primary sterility.

Infertility can be 'secondary', if a couple fails to conceive following a previous pregnancy, despite cohabitation and exposure to pregnancy (in the absence of contraception, breastfeeding or postpartum amenorrhoea) for a period of two years; this is also known as secondary sterility.

Infertility is viewed differently in different cultures. The suggested causes of infertility have ranged from neuroses to witchcraft (Burns and Covington, 2006).The population of developed, developing and under developed countries hold different attitude regarding infertility. There have been talks about "Two worlds of infertility" which suggests salient differences between the experience of infertility in developed and developing societies. It may be justifiable to think in terms of two worlds of infertility. Developed and developing societies tend to differ in prevailing assumptions about childlessness. In developed societies voluntary childlessness is viewed as a more viable and legitimate option and women without children are often presumed to be voluntarily childfree. According to Riessman (2000), however, voluntary childlessness is rare in Kerala, India, since 'bearing and rearing children are central to women's power and well-being'. Leonard (2002) reports that in Chad there is pressure to prove one's fertility soon after marriage; menstruation is regarded as a 'bad sickness'. Because motherhood is so tightly connected to marriage in many cultures, the presumption voluntary childfree status is acknowledged, many women experience infertility as a 'secret stigma' (Greil, 1991). In cultures in which there is no concept of voluntary childfree status, it is impossible to hide infertility. The stigma and distress of infertility, therefore, is likely to be greater in developing countries (Dyer *et al.,* 2005).

In underdeveloped and developing countries, infertility may be linked to an act of God, punishment for sins of the past, prolonged use of contraceptives, distinct dietary habits,

and the result of witchcraft which is causing childlessness whereas people in developed countries viewed infertility as caused by biological and other related factors (Bharadwaj, 2000). Though this problem of infertility is not life threatening, but it causes intense mental agony and trauma that can only be described by infertile individual and because of this the researchers now no longer look to folklore to address infertility and note the need to address more fully the psychosocial components of infertility (Cwikel *et al.*, 2004).

Infertility is usually linked to a physical problem of one spouse or the other, but the stress and loss associated with infertility can have serious implications for both spouses on psychological, physical, economic and social well-being. Many studies have indicated that the problem of infertility is experienced as a crisis or major life stressor with potentially serious negative effects on the couple's relationship (Abbey *et al.*, 1991). Although infertility is primarily a medical condition, its diagnosis can greatly impact the emotional functioning of couples dealing with this problem. Infertility is often an unanticipated, stressful, and life changing event. Menning (1980) referred to infertility as a developmental crisis that can threaten a couple's future goals, while Shaprio (1982) described the impact of infertility as a brutal and unanticipated shock.

As parenthood is considered as one of the major transitions in adult life for both men and women. The stress of non-fulfilment of a wish for a child has been associated with feeling of anger, anxiety, social isolation. Both men and women experience a sense of loss of identity and have pronounced feelings of incompleteness and incompetence. Though both the genders experience it as a stressful experience however it has been reported that when faced with infertility, women experience greater psychological distress than men (Pasch *et al.*, 2002). Infertile women often feel guilt and worthlessness leading to low self-esteem, depression and anxiety. In terms of the economic impact of childlessness, childless women and their families may feel that they have a lack of social security and support in their old age.

Although it is a physical problem but its psychological impact on the individual cannot be neglected. Some authors suggest that the differences in reactions to infertility depend on who carries the primary diagnosis. When the infertility is male-related, Leiblum (1997) found that men experience stress and loss at levels similar to women who are diagnosed as infertile. Women, however, express higher levels of stress regardless of who carries the primary diagnosis of infertility. In the general population, major depression is twice as prevalent in women as it is in men. It has been reported that depression is a common consequence of infertility (Domar *et al.*, 1992). A study by Joshi *et al.* (2009) revealed that infertile women underwent higher level of distress due to their infertility problem and because of this they develop certain psychological disorders which affect both physical as well as mental health of women. According to Deveraux and Hammerman (1998) isolation is also common in women experiencing infertility. Many women will remove themselves from social interactions involving expectant mothers or mothers with young children. Infertile women often view the majority of women they see or interact with in social situations as being pregnant or having small children. Robinson and Stewart (1996) reported that women often feel guilty due to feelings of envy or anger towards pregnant women or women with children.

Reaction to infertility is also conceptualized as grief, including for many intangible disenfranchised losses. The losses include the experience of pregnancy, childbirth, breastfeeding; a generation and genetic continuity, the state of parenthood and the relationship it entails and an element of gender identity which will never be realized and is substituted with a flawed infertile identity (Olshansky, 1987). Women who are less socially isolated have reported higher levels of life satisfaction and have employed more adaptive coping skills in response to stress associated with infertility (Daniluk, 1997). Individuals may fear losing significant relationship in particular with the partner, physical attractiveness or a negative sexual relationship (Mahlstedt, 1985). Some may offer to allow their spouse to partner someone else in order to have a child. Fertility difficulties can exert a pervasive negative effect on quality of life planning and commitment to other life activities. The effect is observable in both men and women but more in women (Abbey, 1992).

According to Upton (2001) in settings where women are subordinated they are highly likely to be blamed for infertility. They may be divorced because of their failure to bear children which itself is highly stigmatizing or their husband may marry a second wife. According to Hart (2002) guilt and inexpressible blame can have insidious effects on intimacy. The infertile partner may feel rejection or may feel obliged to offer the other a divorce so that he/she can achieve genetic parenthood with someone else. For individuals whose personal identity is closely connected to their ability to be parents, infertility can threaten their self-esteem and they report feeling "damaged" (Matthews and Matthews, 1986).Women reported that infertility represents a threat to self-concept, sexuality and important life goals (Stanton, 1991). Williams (1997) found that women experience anger and resentment, feelings of inadequacy and worthlessness and envy of other mothers. Women often experience infertility as a stigmatizing condition and as a threat to their sense of self, their social role and their ability to be successful as a woman (Miall, 1994).The inability to perform their roles as child bearers and rearers is the common misconception that infertility is always the shortcoming of

the female is observed to take a huge toll on the woman in terms of loss of self-esteem, grief and feelings of failure (Jejeebhoy, 1998). In addition to studying lowered self-esteem as an outcome variable of the infertility experience (Pasch *et al.*,2002) some research has examined self-esteem as a predictor or protective factor for adjustment to infertility. High levels of self-esteem along with an internal locus of control, higher socio-economic status and moderate age were linked to higher infertility adjustment whereas low self-esteem, advanced age and undifferentiated sex role identity were connected to high levels of anxiety and distress (Koropatnick *et al.,* 1993).

Infertility also tends to affect the coping strategies of an individual. A study by Shahrzad *et al.* (2010) reported that infertile women use defense mechanisms more than fertile women. Pottinger *et al.* (2006) in their study found that infertile women adopted immature defense mechanisms. The coping styles of infertile and normal women differ on some dimensions. Infertile and normal women differ on their problem solving and problem focusing strategies.

Along with coping, infertility also has an impact on subjective well-being which is considered to be relatively stable over time (Lucas *et al.*, 2004) and personality represents one of its strongest predictors (Veenhoven, 1994). A robust body of literature suggests that external circumstances hold the potential to affect subjective well-being (Diener *et al.*, 1999) and one study reported that only 10 per cent of its participants remained in a single happiness category across time (Landua, 1992). Most infertility research broadly defines life satisfaction and does not follow the strict construction of well-being as consisting of positive and negative affect and life satisfaction. More generally, life satisfaction has been used interchangeably with happiness, subjective well-being and adjustment (Kahlor and Mackert, 2009). Moreover, physical health is one of the most reliable predictors of life satisfaction (Fernandez *et al.*, 2001), with perceptions of health rather than objective health status having a stronger association with life satisfaction (Brief *et al.*, 1993). Theoretically, infertility could be viewed as a health condition that could affect life satisfaction. Diener *et al.* (1999) noted the importance of moving beyond the debate about whether subjective wellbeing is a state or trait to gaining a deeper understanding of the circumstances surrounding negative life events' associations with life satisfaction. Among women who have ever met the criteria for infertility and perceive a fertility problem, life satisfaction is significantly lower for non-mothers and those with higher internal medical locus of control and the association is weaker for employed women.

Since infertility is often associated with psychological distress, psychological interventions represent an attractive treatment option, in particular, for infertile patients. A study by Domar *et al* (2000) revealed that group psychological interventions appear to lead to increased pregnancy rates in infertile women. Boivin (2003) showed that psychosocial interventions were more effective in reducing negative affect than in changing interpersonal functioning (e.g., marital and social functioning). Pregnancy rates were unlikely to be affected by psychosocial interventions. It was also found that group interventions which had emphasised education and skills training (e.g., relaxation training) were significantly more effective in producing positive change across a range of outcomes than counselling interventions which emphasized emotional expression and support and/or discussion about thoughts and feelings related to infertility.

Conclusion:

Infertility is a major life stressor, the experience of which can have implications for all areas of functioning. In addition to the physical implications, the psychological and social functioning is also negatively impacted. The lack of acknowledgment of the losses associated with infertility may damage family interactions, particularly if family members use negative coping techniques such as blaming, side-taking, denial or avoidance. However, psychological interventions and support systems the improve the experience of infertility for the individual and it also has the potential to bring out the best in the family system, promoting growth and well-being for the members.

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