

# **Parenting and Personhood: Cross-cultural perspectives on family-life, expertise and risk management**

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## **Abstract: Infertile parents and identity**

Fertility problems affect one in seven couples in the UK (HFEA 2013) and as techniques improve in the field of ART, the number of couples becoming parents through this is increasing. Those who have undergone IVF will have faced greater psychological, physical and often financial demands which may alter the culture of parenting and heighten expectation for this group. In addition it may be that previous experiences of infertility (sense of failure and frustration, cyclical nature of hopes raised and dashed) and the associated interventions (high anxiety, medical intrusion, relinquishing of control) influence the transition to parenthood.

For most couples, there is an assumption that once in a committed relationship, financially secure and living independently, having children will follow. Any difficulty with achieving this causes stress and distress. Individuals need to move from a sense of self as 'normal' to an acceptance of fertility issues. Burnett (2009) suggests the term 'struggling with infertility' as it implies an active rather than a passive state. For couples, it may be 'natural' to want a child but they face 'unnatural' ways to achieve this. IVF may provide couples with a child but it does not cure the problem - they remain a couple unable to conceive spontaneously. Jauniaux and Rizk (2011) describe IVF as a 'somatic answer to a subjective problem'.

Hjelmstedt (2004) found that negative feelings associated with previous infertility continued to have an effect on some parents - on their sense of self and their parenting. Parenting itself is morally loaded, with parents subjected to societal pressures. This moral pressure may be even greater for those parents of a child conceived by IVF, an assumption that having actively sought parenthood, one should be obliged to be 'good' at it. Miller (2007) highlights how this moral pressure leads to a disjuncture between women's experiences and existing discourses, this may be greater for those whose 'cost' of pregnancy was greater.

The paper will expand upon these ideas of identity as individuals move from being a couple to being parents, but via IVF and the implications this may have on them and their parenting.

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## **Biography**

Liz Gale is a Senior Lecturer in Midwifery at the University of Greenwich. She has a particular interest in social aspects of midwifery and the transition to parenthood. This paper draws on work from her ongoing PhD which is looking at parental expectations and the perceived reality of early parenting in couples with a pregnancy conceived using in-vitro fertilization.

Introduction – my background in health may bring a different perspective to that of many of the presenters, I do not have a ‘pure’ subject degree and my writing comes from many years of working with couples, women in particular, as they become parents.

## Paper

An individual’s understanding of the meaning of infertility alters depending upon their own socialisation and expectation, their fertility or fecundity, and their professional perspective (eg. Bewley 2005). Infertility can be understood as a sense of loss, a loss of hope or expectation of a child, but also a loss of the ‘normality’ of the experience of pregnancy and birth. This is described by Menning (1980) as a life crisis which requires a staged process towards adaptive coping. However, infertility is not only loss, it is also linked to psychoanalytical notions of gender identity and the social and psychological desire to pass on one’s genetic heritage (Raphael-Leff 1991). It may be that for some there is a conflict between it feeling ‘natural’ to want a child but they need to negotiate ‘unnatural’ ways to achieve this.

Within pronatalist society, an individual’s social worth becomes intrinsic with their fertility. Whilst IVF may be welcomed as offering the potential for choice over one’s fertility, indeed may be perceived as a right to a choice, this is posited alongside an assumption that motherhood should be an obligation to pursue, despite associated physical and psychological risk (Neyer and Bernardi 2013) Motherhood remains a key concept of femininity and failure to become pregnant may challenge women’s perceptions of self (see Gillespie 2000 cited in Maher and Saugers 2007). For some, the existence of ARTs as processes undertaken on or to women, is interpreted as a ‘maternity mandate’.

The findings of Rich et al (2011) found that childless women identified negative characteristics in the discourse of their situation, even if it wasn’t their experience - unnatural, unwomanly, undervalued, together with an assumption that they were mothers on the basis of their age and gender. Potential causes of infertility may be used to ‘blame’ women for their situation; a rise in STDs or delaying parenthood for career success. The critique of older mothers in the media is not matched by critique of older fathers. The pressure on women of being ‘responsible’ for their infertility can be seen in the interpretation of individual behaviours; the stress of investigations interpreted as obsession, and attachment to pets interpreted as ‘substitute children’ (Woollett 1991). Whilst ARTs may offer choices to women, it may remain a choice of a spontaneous pregnancy at an earlier point in one’s life with a transient partner or taking a chance on waiting for a more appropriate personal situation and possible interventions. Broad choices for the population as a whole are of limited benefit to individual women’s lives as they try to come to terms with ‘what if’s’.

For couples seeking help with their fertility there is a move from the very personal situation of trying for a child to the public arena of seeking help (Crawshaw 2009); what was once a

personal or social concern is embraced as a biomedical disease, a recognition by others that, whilst offering the hope of treatment, also underlines their bodies' failure (Becker and Nachtigall 1992). Individuals move from being a couple to being patients, and from there rapidly to woman as patient and man as supporter. Allan (2009) describes the assisted reproduction clinic as a place of 'liminality'; an area where individuals are experiencing a transition although one which, whilst having a desired endpoint, carries no guarantee of successful conclusion.

Much of the discourse on infertility focuses on it as a pathological condition requiring treatment by the medical profession rather than as a personal and psychological crisis. Increasing treatment options and the development of IVF in particular, has strengthened this perspective. Some have argued that the increasing use of IVF is not clinically justified, that increasingly it is being used for couples with mild or unexplained infertility, who may have conceived in time anyway (Kamphuis et al 2014). There is evidence that both women and men over-estimate the likelihood of success if they needed IVF treatment and it has been proposed that they may delay parenthood in the belief that IVF can offer them a 'fallback option' (Weston and Qu 2005). Lisa Jardine, a previous chair of the HFEA, spoke in 2013 of her frustration at being unable to balance the positive media perspective of IVF so that prospective couples were entering into IVF treatment unaware of the chances of success or otherwise. She described IVF as a '*market, a market in hope. Those who enter it deserve to be fully informed of its potential to deliver grief and a sense of failure, as well as success*' (Jardine 2013). Contrary to NICE guidance (2013), few areas are offering the recommended number of IVF attempts and cost is a significant factor for many couples. The commercialisation of this health sector may influence this, where the subsequent child becomes a commodity. The role of the HFEA in regulating clinics and monitoring outcomes is used by couples as they seek an appropriate provider, in this case the couples identity is one of, not just patient but, customer. It may be argued that commercialism may be keeping assisted parenthood the preserve of the affluent (Connolly et al 2009). Infertility as a disease is unique; it is the absence of a particular state rather than the presence of symptoms that leads to the help seeking. The symptom is the distress or social stigma, perceived by the couple themselves. It is a 'couple' condition, irrespective of biological cause and unusually within medicine, cure or intervention need not be the only answer, acceptance of a child-free life or adoption may be equally valid choices. Once a condition is labelled as medical it can reduce the sense of stigma or individual feelings of blame and open up potential sources of help, support or treatment. However, the consequence of this is disempowerment, as control is handed over to the medical profession. For both prospective parents and doctors, in accepting the medicalization of infertility, success equates to a child; adoption or remaining childfree is a failure for both individuals and the profession.

For many couples, failure to become pregnant comes initially as a shock. Often having used contraception for several years previously, most assume that pregnancy will naturally follow cessation of contraception (Daniluk 2001, Glover et al 2009). Infertility treatment can

become a conveyer belt, in which the decision to stop becomes difficult. In Daniluk's (2001) study of couples reflecting on their unsuccessful infertility treatment, all explained that they found themselves moving on to more complex treatments that they'd initially not intended to pursue, whilst for several respondents it was described as taking over their lives. As treatment for infertility, both the necessity for scheduled intercourse and the intrusion of medical investigations, can remove the normal connection between the psychological and physical act of intercourse itself, sexual identity may be affected. Effects on the relationship may be guilt or resentment if either is identified as the cause of the infertility (although greater stresses may be seen in those for whom no cause is found) and questioning the meaning behind the relationship in general (Watkins and Baldo 2004, Glover et al 2009). The rapid increase in IVF implies (wrongly) that the distress of infertility has been eliminated by medical advances. Consequently, for those for whom IVF does not work, the social stigma may be increased, as Heitman (2002) phrases it, they 'fail the treatment' rather than the treatment failing them.

The stresses of infertility show gendered differences. For men it is perceived as a threat; to his masculinity and to his expectation of life, often for men it is the importance of a child that is genetically his own that is the focus. Women's responses are interpreted as a sense of loss, of a need to mother or nurture another (Glover et al 2009). The decision to seek help for infertility is predominantly made by the woman (Daniluk 2001), whilst Throsby and Gill (2004) identified that decisions on stopping treatment, tended to be suggested by the male partner, although from a protective rather than authoritative perspective. Parry (2005a) refers to how an individual's social construction of family can change and become more 'fluid' following the experience of infertility treatment. For those who did have biological children the 'ideal' became a justification for their efforts, whilst those who remained childless or adopted began to embrace a wider understanding of family.

The increasing realisation of fertility problems, the investigations, interventions and the additional stresses that these cause, may precede successful IVF for several years. Consequently, despite excitement at the much wanted pregnancy and birth, it can be accompanied by considerable anxiety (McMahon and Gibson 2002, Gameiro et al 2010). A source of that anxiety is focussed on infant survival with a significant proportion of IVF mothers being anxious about early fetal loss; as Dornelle et al (2014) explain, the baby's survival depends upon the mother's body, which previously failed to work as expected. McMahon et al (2002) describe IVF mothers of having learned coping strategies to help manage the repeated stresses of assisted pregnancy attempts. Having had difficulty becoming pregnant they anticipate pregnancy as being equally difficult and may be reticent in looking too far forward. Transition to a confident maternal identity may be more difficult if preceded by a more tentative pregnancy, this is suggested by Bernstein et al (1994, cited in Fisher 2008) as 'the persistence of an infertile [sense of] self'.

Parenting is morally loaded, with parents subjected to societal pressures evident through increasing media attention. It may be that this pressure is greater for those parents who conceived through IVF – a perception that having actively sought parenthood, one is obliged to be ‘good’ at it. For parents of IVF babies the transition to parenthood may be more challenging, both emotionally and practically. They tend to be older parents who may have less support from their own parents who are older or from peers whose childbearing preceded their own. During the process of infertility investigations, couples may avoid babies and children as a psychological protection (Brian 2011) and it may be argued this may affect not only parenting ‘skills’ but also a realistic expectation of the demands of babies and young children. For those who subsequently become parents following infertility treatment, the positives of a much wanted child is located within a framework of ‘luck’ albeit luck resulting from considerable efforts and stress on their part (Redshaw et al 2006).

The concept of good parenting is socially constructed. Good mothering is interpreted as complete dedication to the role of ‘mother’, an expectation that Miller (2007) argues is incompatible with modern life and whilst aspirational pursuit guides the rest of women’s lives, motherhood is focussed on selfless nurturing. Miller (2005) herself suggests that it is within this juxtaposition of what women expected and experienced that the cultural norm is challenged. There are two dominant discourses influencing motherhood, the concept of technology and biomedical advice and the other of nature and instinct, both it could be argued are represented as patriarchy; one as the scientific expert, the other as the inevitability of gender (Barker 2011). Having relied heavily on a medical model to become parents, IVF parents may be more reliant on an expert model of parenting. Within McMahon et al’s (2003) study of children aged 5. The only noticeable finding was an increased number of IVF mothers who showed an external locus of control in comparison to other mothers, a finding that McMahon had also noted in pregnancy. This concurs with the loss of control previously noted as an associated response to infertility treatment. It may be that if IVF is characterized by medical intervention and the placing of control into the hands of experts, the same coping mechanism is employed in making sense of parenthood - turning to ‘experts’ rather than one’s own intuition (Segev and van der Akker 2006).

It is proposed by Darvill et al (2010) that the transition to first time motherhood commences early in pregnancy, this may have implications for those with more ‘tentative’ pregnancies. Specific risk factors for making the transition to parenthood more difficult include: difficult birth (Flykt et al 2014), breastfeeding difficulties (Hjalnhult and Lomborg 2012) and sleep quality (McDaniel and Teti 2012). Those with an IVF pregnancy may be more likely to be affected by these issues; the increased risks to the pregnancy identified previously will increase the chances of difficult birth, of labour interventions, and of instrumental or caesarean birth, correspondingly reflecting increased postpartum pain and discomfort. This will affect sleep quality, often more difficult for older mothers, who are disproportionately represented amongst IVF mothers.

Mothers with an IVF pregnancy are more likely to initiate breastfeeding. During pregnancy, women with assisted pregnancies, despite being ambivalent at mode of birth were committed to breastfeeding as a means of reasserting their natural mothering in the face of an interventionist conception (Barnes 2013). However despite this increased initiation of breastfeeding they were less likely to maintain it. Hammaberg et al (2011) suggest that this may be linked to both antenatal and postnatal anxiety affecting in particular, women's confidence in their ability to nurture a baby which may have been affected by their inability to conceive naturally. This may be further exacerbated by the increased likelihood of caesarean section for these mothers, caesarean delivery itself being a recognised risk factor for early cessation of breastfeeding (Fisher et al 2013). Difficulties with breastfeeding particularly for those who were keen to, has implications for postpartum wellbeing and adaptation. This may be particularly significant for those who conceived with IVF, for whom feelings of depression or anxiety may be difficult to express, having undergone so much to achieve a child. Ulrich et al (2004) in their study of transition to parenthood for IVF couples, commented on how unremarkable were the differences between IVF parents and the control group of parents with spontaneous conceptions. However IVF parents were more guarded in their responses, suggesting a reluctance to divulge any negatives to researchers and also their partners, increased use of avoidance styles being noted in their relationships at one year.

Parenting is a known stressor on the marital or partner relationship (Cowan and Cowan 1992, Lawrence et al 2008, Mortensen et al 2012, Bateman and Bharj 2009) with a reduction in intimacy and of communication, often compounded by the time demands of a new baby (an estimated 40 hours a week - Nomaguchi and Milkie 2003) and tiredness (Houlston et al 2013). For couples undergoing infertility treatment, the relationship is reported to be strengthened (Schmidt et al 2005, Repokari et al 2007), although this may reflect couples who have been able to negotiate the stresses of treatment together, those unable to may have separated early in the process. Familiarity with the life changes and challenges of new parenthood may be less for those who may have avoided friends and family with small children as a self-protection during infertility treatment (Brian 2011). McMahon et al (1997) identified decreased levels of perceived parenting competence corresponding to the numbers of IVF attempts, each failed attempt corroding parent's confidence. However, this is less evident in more recent studies, possibly demonstrating how, as IVF has become more common, more accepted and more successful, clear psychological differences have reduced. Hjelmstedt et al (2004) found no differences between ART parents and those who conceived spontaneously when using a recognised stress questionnaire, but later interviews with parents identified persistent negative feelings associated with the infertility. It may be that face to face contact with a researcher rather than anonymous completion of a questionnaire gives differing results. Whilst research results are conflicting there does appear to be some evidence of increased stress and distress in IVF parents (Fisher et al

2005, 2008, Monti et al 2009, 2008) although these appear to reduce over time. Relationships within the mother infant dyad show little difference compared to spontaneous conceptions, whilst any minor differences may be mediated by unfamiliarity with young children (Cohen et al 2001), fetal effects of increased stress (Glover 2014), greater parental input (Sutcliffe et al 2004) or greater tolerance of child following difficult conception (Glover 2014).

Interestingly, parenting stress appears less so for lesbian couples undergoing IVF than it is for heterosexual couples, either IVF or spontaneous conceptions (Borneskog et al 2014). It may be that having not expected to have one's own child (until recent societal and legal changes) lesbian couples embrace the experience of motherhood. Alternatively, the decision to have a child when in a stigmatized situation, such as a lesbian relationship, reflects the self-efficacy of the parents to be. Previously infertile couples may fall between these two groups, of those who know they'll need medical treatment and those who conceive unaided, being a group who initially assumed their natural fertility and were challenged when discovering intervention would be necessary.

Parenting can challenge notions of identity for all couples, it would seem this may be an even greater challenge for those with an IVF baby who may have negotiated several additional identities in the process, potentially increasing expectations of their newly acquired role.

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