

PSYCHOLOGICAL AND SOCIAL CONSEQUENCES OF INFERTILITY

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Abstract: In the current thesis we aim to analyze the psychological significance of infertility and the psychological causes and consequences of infertility. In the second part of the research, the experimental part, we make the comparison between the level of quality of life perceived by the infertile women and men, before and after their participation to a medical program of fertilization. By analyzing the results, we obtain significant differences between women and men, from the 4 indicators point of view: emotional, mind-body, relational and social.

Key words: infertility, counseling, quality of life

I. Introduction

Infertility significations

The demographic transition has become a more complex process, an integrated part of the economic and social development process, of society modernization. The decrease of birthrates is accompanied by a reorganization of the fertility model. The Romanian fertility has always been early, having its highest values at the ages 20 – 24. After 2000, we notice an increase of fertility share to the ages over 25. In the meanwhile,

in the urban environment, the curve of fertility rates has already moved away from the early model, having the features of the spread model, with higher values for the age group of 25 – 29, and this is an intermediary phase towards the tardy model, typical to west-European peoples. The intermediary model is also embraced by the country side population. Less children, preferably one, giving birth to an older age, it has become the rule to govern the behavior of the young couple, in a society that rapidly adopts the values and attitudes system of the developed countries.

Infertility is a medical and psychological experience, which requires the couple to redefine, as individuals as well as partners, the psychological and social identity. Infertility could be considered a crisis of generations, bringing damage in the loss of family's future.

Infertility is considered to exist when a pregnancy has not occurred after at least one year of unprotected coitus. In primary infertility, there have been no previous conceptions, in secondary infertility there has been a previous viable pregnancy but the couple is unable to conceive at present. Sterility refers to the inability to conceive because of a known condition, such as the absence of a uterus. Researcher McLaughlin (1989) shows that about one out of five to six couples is infertile.

Infertility is a problem that strikes at the core of a couple's self-image and self-esteem. Psychological assessment will often reveal that one or both partners feel inadequate or angry and frustrated. Evaluating both, the men and the woman together may also be advantageous because they may feel more comfortable speaking about their problem together.

Causes of infertility

Nearly 15% of U.S. couples have experienced a problem with infertility. If infertility causes loss of self-esteem or self-concept, this means that many individuals are affected. A study conducted to investigate the effect of infertility on marriage and self-esteem involved a sample of 28 married couples seeking fertility counseling (the experimental group) and 17 married couples who were not ready for child rearing and thus had no concerns in this direction (the control group). Data were obtained by administering questionnaires to both groups.

The results of the study showed that infertile couples experienced less sexual satisfaction than the fertile couples. Infertile females exhibited a greater degree of discontent with infertility than males. The more investment in fertility procedures a couple had made, the greater was the female's discontent. The more the investment increased, the more the woman's self-esteem decreased, in contrast, the man's self-esteem

increased. (Hirsch A.M., Hirsch S.M. (1989), quote by Pillitteri A., 1992).

The published psychology literature provides a series of studies on the subject. Many researchers, among them Sabatelli R., Meth R., Gavazzi S (1988), quote y Mc.Daniel S., Doherty W., Hepworth J., Mihăescu V. (1996) showed that 60% of men and women from a sampling group reported a low frequency of sexual contact and low sexual satisfaction after finding out the diagnosis. Another study, conducted by Bents (1995) on a sampling group of 18 cases of masculine sexual dysfunctions and infertility show that the sexual dysfunctions considerably decrease, but do not eliminate, the possibility of conception.

Despite Romanian people's preconceptions in regards to the high frequency of feminine infertility, a study conducted by Anghelescu A, Coricovac A., Dracea L., Codreanu D., Marinescu B. (2014) on the examination of infertility causes distribution for Romanian population in comparison to other analyzed populations, has indicated that the masculine factor represents the most frequent cause of infertility.

There are previous studies on infertility causes distribution that have been conducted in fertility centers from different countries (Israel, Sudan, Thailand, France). Their results supported the masculine factor as being the most common cause of infertility.

Some of them highlighted a regress in the sperm quality throughout the last decades, for the general population. The majority associates this fall with certain factors that are related do the lifestyle: smoking, drug addiction, alcohol, and obesity. Some other research studies have associated the paternal elder age (over 40) with the infertility and the presence of neurocognitive affections for the successors, such as schizophrenia and autism, conditions that are determined by the instability of the spermatic DNA. In Romania, the big number of sexually transmitted diseases could justify the high incidence of infertile men.

The causes of feminine and masculine fertility are both biological and psychologic. **Biologically**, infertility increases with age. Because of this gradual decline in fertility, approximately one third of women who defer pregnancy to their mid to late thirties will have an infertility problem (Kuczynski, 1989). Women who have been taking oral contraceptives should know that they may have difficulties in getting pregnant for several months after discontinuing the pills, because it takes this long to restore the normal body functioning.

Men psychological problems and debilitating diseases may result in inability to achieve ejaculation. Failure to achieve ejaculation may be a relatively easily solved if it is associated with stress that can be released. If the failure of ejaculation is caused by a deep-seated psychological issue

(psychogenic infertility) a solution to the problem will include psychological or sexual counseling and may involve long term care. Premature ejaculation (ejaculation before penetration) is yet another problem usually attributed to psychological causes. This may affect the proper deposition of sperm (Stine and Collins, 1990).

The factors that cause infertility for women are analogous to those causing infertility for men: anovulation (faulty or inadequate production of ova), problems of ova transport through the fallopian tubes to the uterus, uterine factors such as tumors or poor endometrial development and cervical and vaginal factors that immobilize spermatozoa. In 10% of couples, no known cause for infertility can be discovered. Within this couples, this is probably because both partners have minimal problems that by themselves would not be significant, but when combined with a partner's difficulty, they become significant enough to create infertility. It is obviously discouraging for couples to complete a fertility series and to be told, that there is no reason for the difficulty that could be explained. Such couples need support from health care providers to help them find alternate solutions to childrearing, such as adoption or agreement on childless living when this occurs.

Couples are in a vulnerable position when they call a health care facility to ask for help with infertility. The couple may be worried about the future of their marriage or relationship. For example, each partner may wonder whether the other will be able to accept marriage if he or she turns out to be the "infertile" one. (Pillitteri A., 1992)

From a psychological and social point of view, the modern women postpone giving birth to their first child till the age of 35 to 40, out of the desire of having a career and financial security, ignoring the consequences of such a delay in regards to having a family.

At a psychological and social level, women find it more difficult to accept the infertility issues, in comparison to men, because the social perception on the woman's role, transgenerational transmitted, is associated to procreation and mothering. Several studies state that many women have the experience of infertility as a role failure (Miall, 1985, Greil, Leitko and Porter, 1988), they develop a feeling of concern related to the sexual disorders. Myers show that one of the most difficult problems of men, caused by infertility, is their wives' pain. For others, *the denial and the moments of silence* can reflect strong feelings of infertility being unacceptable for them, as men and as husbands. Whereas women are preoccupied by the topic of infertility, men deny or avoid the feelings they have, caused by a diagnosis of infertility. There is a category of men who loose self-confidence and develop addictive

behaviors, and another category who tries to accept the situation but are not ready for adopting parenting roles.

Consequences of infertility

The psychosocial experience of infertility has been described by clinicians McDaniel Susan, Doherty W., Hepworth J., Mihăescu V (1996) as being, from the genetic traumatology point of view, similar to the death of a beloved person or to a chronic disease diagnosis. The patients experience several emotions associated with the mourning period, after being diagnosed: denial, shock, fury, negotiation, depression and acceptance (Kubler-Ross, 1969, Myers, 1990). During the treatment, they go through a cycle of hope, loss, each 28 days. Same as in case of a trauma determined by a chronic disease, they must adapt their lifestyle, cooperate within the couple and they mustn't blame the other one.

From a psychosocial point of view, the couple develops a series of expectations as well as oscillations between the parental rights and the fear of infertility. Mathew R. and Matthews A. (1988) label this experience as a transition to the position of not being a parent. The transition towards the involuntary acceptance of the lack of parental experience is painful and traumatizing, for the majority of couples. This experience is different from the voluntary absence of children, because in this case, alternatives are missing, disappointment, a sensation of lacking life hope, and fear of the future appear, associated with infertility. Psychosocial research from the past 20-30 years (Myers, 1990) focus on the psychosocial consequences more, and less on the infertility antecedents.

The diagnosis procedures can be overwhelming, embarrassing and stressful. There are also certain myths among patients, Menning, 1977, citing McDaniel Susan, Doherty W., Hepworth J., Mihăescu V (1996) showed that a big number of patients believe that infertility is a punishment from God for a sexual mistake or a mistake of any other nature.

Infertile couples counseling

Infertility testing is an intense psychological stress period for couples. Support from health care personnel is necessary during this time, not only to help couples go through the experience on an individual basis, but also to help them maintain their relationship as a couple.

It is important for the psychologist to spend some time alone with each patient, in case there is anything they wish to discuss privately. This might be the only opportunity they have to ask "silly" questions or express fear that they felt too foolish to ask or express in front of their

partner. Diagnoses related to problems of infertility are likely to focus on psychosocial issues associated with the inability to conceive and the long, arduous process of fertility testing and management. Possible diagnoses include “Fear related to outcome of infertility studies”, “Decreased self-esteem related to the inability to conceive”, “Anxiety related to the heavy schedule of planned testing”, “Sexual dysfunction” and might be applicable if a specific problem is revealed in this segment, or if therapy become so overwhelming for a couple and their relationship (including sexual patterns) begins to unravel. The feeling of “being powerless” when facing repeated unsuccessful attempts of achieving conception and “hopeless” when no viable alternatives are perceived, may also be relevant. Couples who are told that an infertility problem has been discovered are predisposed to suffering a great loss of self-esteem. They must be offered support and guidance into focusing on other aspects of their lives, where they are successful, in order to help them realize that even though they may not be efficient in accomplishing fertility, they are productive healthy people in every other way.

In 1974, Kernberg stated that “the ability to love, to be eligible for love and to maintain an intimate relationship reflects the individual development level of a person. Falling in love and remaining in a relationship require achieving a certain level of maturity and emotional depth.” In a couple, especially in the beginning of a relationship, the two partners are attracted to each other, mainly physically. Subsequently, there can be an intellectual attraction, the desire for common interests and aspirations, the fusion, the emotional addiction mentioned by Erich Fromm, as follows: “this desire of interpersonal fusion is humans’ stronger aspiration. It is the fundamental passion, the force that holds together the human race, the clan, the family, the society.” H. H. Wolf shows that a well-defined self-identity supports “a healthy interaction within the couple, it contributes to solving crisis situations that appear within human relationships in general and within the family relationships.” (citing I. Mitrofan 1997).

Self-identity includes the following dimensions: the physical, the psychosexual, the social, the vocational, the moral-spiritual dimension. They mirror in the psychological and behavioral characteristics that support the individual him/herself and his/her personality.

Klein R. (1990) considers that within the couple, the partners bring sanogenous or pathological experiences inside the relationship, through the referral to the conditions in which they had formed their self-identity. These experiences can influence in an ambivalent way the partners’ perception of the couple relationship’s evolution: it can either be a healthy, appropriated experience, having a development and growth

potential for each partner, or insecure, disharmonic, loaded with frustrations and personal dissatisfactions.

The psychological counseling process of the infertile couples focuses both on overcoming conflicts, traumas (generated by infertility) that determine a disharmonic relationship as well as on the harmonization, the strengthening and developing the couple that wants to have a family.

One of the major objectives of the *psychological counseling* focuses on the partner's capacity to admit and accept the real personality of the lifetime companion and also *to develop their own personality in relation to their spouses' personalities*.

In a sanogenous partnership, the two individuals have a tolerant, flexible personality, both within the conjugal couple, and also in relation to the external world.

During counseling, they communicate each other the values and the ideals in life and experiment the social feelings and behaviors that will prepare them for developing new social roles, the parental ones, both in the case of child birth or child adoption.

With the help of the demographic research, it was revealed that fertility rehabilitation is the only option capable to improve the country's demographical situation and eventually, to stop the upcoming demographical decline. A fertility rate of 1,5 children for each woman can only decrease the proportions of demographic decline, as a consequence in 2050, Romanian population will be of 14 million inhabitants. A fertility rate of 2,1 children for each woman stops the decline and reassures the situation's recovery, as in 2050 the population of Romania would be of 15 million inhabitants. A possible economic recovery could determine mortality decrease, and fertility – usually sensitive on a higher life standard – would react moderately. Fertility growth can only be achieved through demographical politics, through incentive politics, with respect towards the individual or the couple's right to making their own decisions, with information and access to the modern contraceptives.

II. Experimental research

Research objectives

- a. The evaluation of the representative indicators of infertile people's quality of life.
- b. The evaluation of the differences in people's perception of quality of life, before and after the medical treatment.

Research hypotheses

1. We assume that there are significant differences between the level of certain indicators (negative emotions, the mind-body relationship and the impact on infertility, the couple relationship and the impact on infertility, the impact of infertility on social interactions) between men and women.
2. We assume that there are significant differences in people's perception of quality of life, before and after the medical treatment.

The sample

The sampling group is composed of 49 people (24 men and 25 women), between 29 and 48 years old.

Evaluation instruments

1. The Fertility Quality of Life Tool Questionnaire (FertiQoL) , J. Boivin, J. Takefman and A. Braverman 2011, translated to Romanian.
2. Discussions about the consequences of infertility on couple's life.

Research results

The **Core FertiQoL** is the fertility quality of life across the **Emotional, Mind – Body, Relational** and **Social subscales**. *The Emotional subscale* score shows the impact of negative emotions (e.g., jealousy & resentment, sadness, depression) on quality of life. *The Mind-Body subscale* score shows the impact of fertility problems on physical health (e.g., fatigue, pain), cognitions (e.g., concentration) and behavior (e.g., disrupted daily activities, delayed life plans). *The Relational subscale* score shows the impact of fertility problems on marriage or partnership (e.g. sexuality, communication, commitment). *The Social subscale* score shows the extent to which social interactions have been affected by fertility problems (e.g., social inclusion, expectations, stigma, and support).

In order to interpret and validate the first hypothesis, we made comparisons, based on t test, between men and women, concerning negative emotions, mind-body relationship and the impact on infertility, couple's relationship and the impact on infertility, the impact of infertility on social interactions.

By analyzing the scores shown in Table no.1, we notice the existence of significant differences between the variables analyzed on a significance level $p=0,000$, as follows:

- Infertile women manifest a higher frequency of negative emotions, compared to infertile men (66,02 compared to 46,73)
- The mind – body relation is highly expressed by women, compared to men (67,66 compared to 47,82)
- Men claim that despite infertility, have a better level of communication inside the couple, compared to women (45,62 compared to 40,24)
- Women have a stronger need of socialization than men do (65,54 compared to de 52,6.)

Table no.1. Independent samples t test

Independent samples t tests		F	Sig.	t	df	Sig. (2-tailed)
Emotional	Equal variances assumed	,744	,393	-7,486	47	,000
	Equal variances not assumed			-7,323	38,532	,000
Mind_body	Equal variances assumed	1,190	,281	-4,488	46	,000
	Equal variances not assumed			-4,407	36,635	,000
Relational	Equal variances assumed	3,141	,083	3,312	47	,002
	Equal variances not assumed			3,237	38,186	,002
Social	Equal variances assumed	3,359	,073	-4,383	47	,000
	Equal variances not assumed			-4,297	39,570	,000
Total_core_score	Equal variances assumed	1,516	,224	-5,135	47	,000
	Equal variances not assumed			-5,041	40,105	,000

	Equal variances assumed	2,173	,147	-3,009	47	,004
Total_treatment_score	Equal variances not assumed			-2,973	42,661	,005

For the second hypothesis, by applying the t test we notice the fact that there are significant differences ($p=0,003$) in the perception of quality of life before and after the treatment (the global medium level of quality of life was 55,67 before the medical treatment, and it decreased to 52,3, after the treatment). Only for 40% of the subjects the quality of life improved, for the rest of the subjects, it decreased.

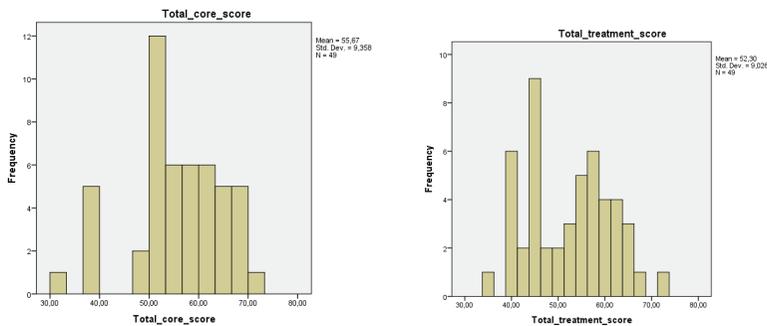


Figure no.1 The perception of quality of life before and after the treatment

Conclusions

‘Quality of life’ (QoL) was defined by the World Health Organization (WHO) as people’s perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.

The following dimensions of quality of life were analyzed:

1. Emotional impact on emotions (e.g. causes sadness, resentment, grief)
2. Mind-body impact on physical health (e.g. fatigue, pain), cognition (e.g. poor concentration) and behavior (e.g. disrupted daily activities)
3. Relational impact on partnership (e.g. sexuality, communication and commitment)
4. Social impact on social aspects (e.g. social inclusion, expectations and support)

5. Environment impacts related to treatment environment (e.g. access, quality, interactions with staff)
6. Treatment tolerability

The participants to the research claimed that there was no improvement in the infertile patients' quality of life and that a complex program regarding both psychological and medical counseling in infertility treatment is essential. From this perspective, we consider this to be a limit of the current study, and we aim to develop a further research, on the topic of a psychosexual counseling program.

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