Male Reactions During Infertility Treatment As Interpreted By Their Female Partners

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INTRODUCTION

The research serving as the empirical background for this proposed paper is part of a larger research project[1] that is mainly the basis of my PhD research. The broader research aims to achieve a comprehensive and in-depth understanding of medically assisted reproduction within the context of Hungary. In accordance to this goal the proposed primarily exploratory research project aims to broaden, reassess and significantly deepen our knowledge and understanding about infertility and its treatment foremost through the in-depth and rich analysis of the experiences and constructions of infertile patients within the different branches of the Hungarian health care system. In the paper proposed here one very important aspect of infertility treatment is explored, namely how this long and emotionally taxing process influences the gender roles and through them the nature of the partner relationship.

BACKGROUND

In the world of natural sciences the topic of reproductive technologies has been a popular question in for decades. Even if one attempts only a birdseye view of the field it is noticeable what an enormous corpus of medical literature has accumulated in the last few decades. The advances in medical biotechnology have become special and influential topics of research in both natural and social sciences. There has been a myriad of research trends dealing with human reproduction and society.

While the topic of childlessness and infertility has been the focus of several sociologists (the topic of childbearing has been popular among demographers) within the Hungarian social scientific community (Spéder- Kapitány 2007; Pári 2011; Kapitány 2012; Szalma- Takács 2012a; 2012b), but there is still a large unfilled gap when it comes to systematically reviewing the different aspects of medically assisted reproduction.

Childlessness can be viewed as a state when due to diverging factors the individuals did not have children throughout their life-course. The literature makes a clear distinction between voluntary and involuntary childlessness (Szalma- Takács 2012a, 2012b). ***Involuntary childlessness*** is to be distinguished from childlessness according to the underlying factors that have led to the state of the individual or couple not having children. Within involuntary childlessness it is also necessary to make a distinction of those who are involuntarily childless due to biological problems and other factors. In my project I will reflect on those who have conception problems due to these biological factors.

In the paper I use the concept ***infertility*** according to the wide-spread medical definition of the term as the *failure of a couple to conceive after trying to reach pregnancy for at least one year regular unprotected sexual intercourse* (HCOG 2012). According to a 2012 clinical protocol issued by the Hungarian College of Obstetricians and Gynecologists, 10-15 percent of the couples who are trying to conceive can be estimated to be infertile in Hungary, being diagnosed as infertile is at the end of a rigorous examination and evaluation process that has a very clear and distinct protocol to be followed by the medical professionals (HCOG 2012).

Due to the rapid development of these new technologies prospects have changed for individuals and couples with fertility problems (Hudson et al. 2009). The International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) have suggested the following definition for ***medically assisted reproduction*** (MAR): “reproduction brought about through ovulation induction, controlled ovarian stimulation, ovulation triggering, ART procedures, and intrauterine,

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intracervical, and intravaginal insemination with semen of husband/partner or donor" (Zegers- Hochchild, 2009:1523).

As having children is considered an inherent and accepted stage in family development the inability to have children can be considered as a crisis on both a family and both an individual level. Childbearing has been considered the normal course of social development, and an important step in the maturation (Reed 2012) and thus involuntary childlessness has been known to have significant and irreversible social and psychological consequences (Golombok 1992; Greil et al. 1988; Elek 1996). Infertility and involuntary childlessness is globally perceived as a unique form of tragedy and loss.

As the recent decades have shown a significant medicalization of health problems including infertility, a general tendency has been that members of society view themselves more in control of their condition. Prior infertility was seen less as a treatable condition and more as a punishment (in certain cultures a will of God) (Miall 1994). Though viewing it as a medical condition or an object of fate diverges greatly there are some common socio-psychological traits. One of the major consequences of infertility is the element of surprise that the patient may feel over losing control over their own body (Mathews- Mathews 1986). The literature although does not agree fully to what psychosocial consequences there are of infertility, there are some common grounds. Psychological factors associated with infertility are well documented. Holter et al (2006) claims the following psychological consequences: infertility is ranked as one of the greatest stressors in one can experience throughout the lifecourse, according to researches it is comparable to divorce and death in the family and experiencing terminal somatic diseases such as cancer and HIV. Hungarian research has also suggested that coping with infertility has similar methods to that of dealing with death (Mata-Boga-Bakonyi 2001).
Infertility of a couple can be caused in equal percentile because of male and female infertility (Papp, 1996; HCOG, 2012) yet it is perceived differently. According to Greil et al. (1988) and Miall (1994) society also takes a different view on male and female infertility: women are more prone to sympathy, while infertile males experience less support and are more often the subject of ridicule, causing greater stress. Patients' construction of and response to their own fertility is also divergent, gender specific (Greil et al. 1988; Mata-Boga-Bakonyi 2001; Reed 2012). Coping and dealing with infertility is also different according to dissimilar gender roles adopted by the patients (Peterson et al. 2006; Pottinger et al. 2006).

Just as childlessness, the decision to engage in or to bypass the use of these new technologies can mean significant and diverse psychosocial and ethical challenges to these couples and families (Fathallah 2002; Bartels 2004). The literature agrees on the notion that decisions made with regard to engaging in treatment using MAR or omitting such solutions are complex and have several influencing forces, including both personal and societal elements (Becker 2000; Rauprich et al. 2011; Zegers-Hochchild 1999). Some of these may even raise several ethical, interpersonal and emotional issues that can cause the patients significant distress especially if the societal acceptance and support is low (Beckman- Harvey 2005; Peddie et al. 2005). Among them being the medical and non-medical risks involved throughout the treatment, but prior research conducted by Becker (2000) found that in both women's and men's decisions these risks were weighed as small compared to the problem of infertility, remaining childless. Rauprich et al. (2011) also emphasize that the such patients may not be able to make reasonable and balanced choices, Wingert et al. (2005) on the other hand view some choices to be consumer conscious. The process of decision-making is also unique since it does not only involve one individual but are most frequently decisions of a couple (Beckman -Harvey 2005; Throsby-Gill 2004), causing a stressful family event (Wingert et al. 2005). During the decision traditional male-dominated gender roles are questioned because based on prior research regarding decisions during pregnancy it was women who most often contributed more to the difficult decisions (Reed 2011).

Taking part in such a long treatment process (where there may be several failed cycles or treatments) also takes a toll on the psychosocial well-being of the seekers, it being both exceedingly stressfull as well as emotionally demanding (Weaver, 1997; Verhaak et al., 2007). According to the findings of Verhaak et al. (2007) 20% of women reported feelings of depression six months after an unsuccessful treatment. Reports of feeling high levels of stress and emotional volitilty was found during research done among women participating in internet discussion groups, focusing mainly on feelings of hope or despair and emotions of anxiety and frustration towards the health system and the feeling of objectification from members of the medical community (Bauer, 2013). The psychological reactions and adjustment levels vary greatly with respect to the outcome of the treatment as well as the examined time-period (short-term and long-term

effects are different according to the literature, the patients show good coping in longer term) and the gender of the patient, the psychological research results showing large diversity (Holter et al., 2006; Verhaak et al., 2007). As reported by treated patients the physical afflictions also caused severe emotional distress for the patients contributing to their feelings of powerlessness and isolation (Bauer, 2013). Listed below are some of the elements that may also have a great effect on how patients may view treatment: surprise, denial, anger, isolation, guilt, grief, depression, resolution. Isolation is a key phenomenon in their emotions, which potentially can affect the patients' view of their treatment. Isolation can also appear from family, as infertility has not only effect on the individuals identity, but significant consequences on the well-being of the couple, on the functioning of the relationship (Holter et al, 2006).

Significantly less empirical evidence has been gathered from a gender role perspective on the subject as well as looking at the well-being of couples during their treatments. A collection of literature has accumulated that studies how changing gender roles appear during and after pregnancy but to my knowledge no literature examined changing gender roles during conception employing medically assisted reproductive technologies. A corpus of literature has demonstrated that fathers have discarded the traditional male role during pregnancy (that is a less involved father figure), and decisions regarding health during pregnancy, achieving a new type of gendered division of labor (Reed 2011; Reed 2012). When a pregnancy is not achieved through natural means and there is significant emotional and temporal contribution required from both sexes, the male partner must adapt a new type of attitude and new roles within the partner relationship. The described research looks at these roles and attitudes by examining the reactions they trigger from their female partner. This type of design (elaborated to greater extent in the next section of the abstract) allows the researcher to bypass potential biases and also defer from causing marital distress among the subjects of the research as reported earlier by Hirsch (1993).

DATA AND METHODS OF ANALYSIS

Qualitative inquiry in general provides the researcher with an opportunity to get closer to the participants' subjective opinions, experiences and views on the world (Vicsek 2006). As Snape and Spencer (2008) argue: the lived experiences of subjects are of main significance, that are always influenced by their unique historical and social contexts. Qualitative methods give more than just a snapshot of a question in the views of Miles and Huberman (1994). According to Erickson (1977) social meaning lays in what people actually do, or in this context say (Miles – Huberman 1994). The method of qualitative data analysis is particularly useful for identifying similarities in wording and phrasing, common topics and themes as well as uncovering certain patterns in the data-set (in the case of this research the texts of the forums) (Miles–Huberman 1994).

Internet communities provide a way for a group of peers to communicate with each other without ever meeting (Robinson 1991). The use of internet discussion groups is a phenomenon that has implications and consequences that have recently been examined in detail (a rather large corpus of scientific literature is now dedicated to the issue). Many studies have concluded that the users on the internet talk about subjects similarly to in real life, but significantly more freely. Sensitive topics are discussed easier due to the anonymity that the online discussion groups provide. They have suggested that people harness their emotions for instance their anger less on the internet (Wallace 2006). Among many functions of internet communication, one is to offer help and support to others with similar problems. One example of this are the online-support groups, of which health related issues is a common topic (Wallace 2006).
Health-related online forums present a special segment within online forums, because of the nature of the discussed topics. Tanis (2008) has reported that the main reasons for using health related forums online were the following: information gathering; emotional support; inclusion; supporting others; convenience; passing time. Anonymity is a central appeal of these groups and the reason for this can be to avoid stigmatization from society, and also to find people who also need to cope with similar situations (Wallace 2006). The effect of social stigmatization regarding childlessness and infertility may lead to subjects feeling that these discussion groups are the only place to talk freely about their fears and hopes, and analyzing such conversations will allow the researcher a view at the subjects' unveiled and truthful perceptions, without the shackles of social constraint.

The gathered data will be analyzed using the qualitative data analysis software Nvivo, relying on the tools and techniques of grounded theory. Application of grounded theory requires all the theories and results to emerge from the data and the not predispositions of the researcher (Charmaz 2006; Glaser – Strauss 1967;

Strauss – Corbin 1998). To achieve this a series of codes and categories are defined based both on inductive and deductive reasoning (Miles – Huberman 1994).

Expected results will be the emergence of a theory that shall show what type of reactions male partners produce during the long treatments and how these are interpreted by their female partners. The theory will allude to what attitudes seem to help or hinder the female coping processes.

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