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## Infertility: A developmental crisis related to parenting

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## Infertility: A developmental crisis related to parenting

### Abstract

The crisis of infertility strikes one in six couples of childbearing age. "Infertility, the inability to achieve pregnancy after one year of regular sexual relations, or the inability to carry pregnancy to a live birth" (Menning, 1982, p. 155), will be experienced by 15-20% of the population of childbearing ages 22-40 years (Bernstein & Mattox, 1982; Goodman & Rothman, 1984). Infertility was diagnosed as either primary or secondary. According to Bernstein and Mattox (1982) primary infertility occurred if a pregnancy had never been achieved. If a woman had been pregnant at least once, even if that pregnancy resulted in an abortive episode, secondary infertility existed.

INFERTILITY: A DEVELOPMENTAL CRISIS  
RELATED TO PARENTING

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by  
Barbara Jean Braband

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Infertility is a developmental crisis which results when a couple fails to achieve the important developmental milestone of reproduction (Fogel & Woods, 1981). Griffin (1983) reflected society's view toward persons who failed to conceive in the comments of columnist Erma Bombeck. "She writes, 'They're one of the last groups to come out of the closet...they get about as much sympathy as an eighty-pound woman trying to gain weight...and have heard as much advice as people with bad backs'" (p.597).

The main purposes of this research paper are (1) to increase awareness of the scope of the problem of infertility, (2) to enable professional helpers to understand and respond to the emotional reactions to infertility experienced by male and female partners, and (3) to present a composite profile of infertile couples obtained through a literature review.

#### Scope of the Problem

The crisis of infertility strikes one in six couples of childbearing age. "Infertility, the inability to achieve pregnancy after one year of regular sexual relations, or the inability to carry pregnancy to a live birth" (Menning, 1982, p. 155), will be experienced by 15-20% of the population of childbearing ages 22-40 years (Bernstein & Mattox, 1982; Goodman & Rothman, 1984). Infertility was diagnosed as either primary or secondary. According to Bernstein and Mattox (1982) primary infertility occurred if a pregnancy had never been achieved. If a woman had been pregnant at least once, even if that pregnancy resulted in an abortive episode, secondary infertility existed.

If a couple had access to expert medical care, 50-60% of all cases of infertility could be treated successfully (Bernstein & Mattox, 1982; Menning, 1975). Infertility was a problem for both the male and female partners. According to Griffin's statistical evidence (1983), 35% of infertility causes were attributed to males, 35% to females, 20% to the combination, and 10% were unknown. Cases of unexplained infertility existed when no apparent cause was discovered. This led to intense frustration and agony for the couple. D.R. Carp and H.J. Carp (1984) found that 95% of all couples who eventually achieved pregnancy, did so within five years.

#### Manifestations of developmental crisis

Couples experiencing infertility struggled through repeated crisis states during their infertility investigation and treatment (Fogel & Woods, 1981). When couples failed to achieve the developmental milestone of parenthood, a developmental crisis resulted (Frank, 1984). Goodman and Rothman (1984) stated that when the ego faced a maturational task it couldn't master, the developmental crisis remained unresolved. Failure to reproduce interfered with achieving generativity, a primary concern of maturation in adulthood according to Erikson (Berk & Shapiro, 1984; Bernstein & Mattox, 1982).

The decision to have children was a crucial aspect of the female and male identity (Frank, 1984). Crisis resulted when this choice was lost. Both had a universal fear of failing to conceive

and becoming parents (Frank, 1984; West, 1983). "Not being a mother indicates lack of femininity and sexual incompetence as a woman; not being a father indicates lack of masculinity and sexual incompetence as a man" (Veevers, 1973, p.293).

Goodman and Rothman (1984) stated, "The concept 'infertility crisis' is employed to highlight characteristic manifestations of infertility that parallel other types of crises" (p.81). Shapiro (1982), as cited by Goodman and Rothman (1984), referred to the "infertility crisis" as the crisis of loss. A crisis was a disruption in the steady state, or a state of disequilibrium (D.R. Carp & H.J. Carp, 1984). Menning (1980) suggested four common elements to any crisis state: (1) a stressful event poses a threat which can't be solved in the near future, (2) the problem overwhelms the existing problem-solving methods of the person involved, (3) the problem may threaten an important life goal, and (4) the crisis may reactivate any prior unsolved problems from the immediate or distant past.

A crisis state is time-limited, and is usually resolved in six weeks or less (Menning, 1980). Since a person can't tolerate an indefinite period of crisis, three potential outcomes exist. The involved person will emerge from the crisis (1) at the same level of functioning prior to the stressor, (2) with increased strength and insight, or (3) at a less stable level of functioning prior to the stressor (Griffin, 1983).

The most important goal of crisis intervention is to assist the person through the state of vulnerability and disequilibrium to effect change, growth, and increased insight. Persons experiencing crises are in a vulnerable and anxious state. An effective counselor can channel this high level of energy to effect change and resolution of the crisis (Griffin, 1983).

As couples experienced the "infertility crisis," they were forced to resolve their feelings in response to the social meanings of parenthood (West, 1983). Veivers (1973) described nonparenthood as "being immoral...irresponsible...unnatural...hinders marital adjustment and increases divorce proneness" (p. 293). "Not being a parent is associated with immaturity and emotional maladjustment" (p. 293). These social meanings of nonparenthood created a state of crisis as the childless couple struggled to resolve such accusations presented by society.

#### Emotional Responses To Infertility

The emotional symptoms of anger, frustration, and depression were often mistaken as the cause instead of the effect of infertility (Leader, Taylor & Daniluk, 1984). Frank (1984) noted that professionals were as guilty as the general public in suggesting that infertility is psychogenic, caused by the mind. Bresnick and Taymor (1979) depicted a wide acceptance that emotional factors were a contributing cause of infertility. Sandler (1968) related stress as a cause of infertility. However, others refuted the potential of psychogenic infertility, mainly due

to unsubstantiated evidence (Leader et al., 1984; Mudd, 1980; Seibel & Taymor, 1982). An increase of empirical evidence may reverse these theories as the science of infertility moves out of its infancy stages.

Couples experiencing the "crisis of infertility" rode an emotional roller coaster that coincided with phases of their diagnostic work-up and treatment over an extended time (Frank, 1984). Women were subjected to the highs and lows of this roller coaster effect with the hope for pregnancy each month and the devastating disappointment of each menstruation (Mazor, 1979). Reoccurring crises became a way of life for infertile couples. These crisis periods also had the potential for reactivating unresolved past problems that compounded the depth of the crisis and depleted the couple's coping abilities (Leader et al., 1984; Mazor, 1979).

Male and female partners of each infertile couple often presented varied intensities of emotional responses (Bresnick & Taymor, 1979). The exact nature of the differences was unclear, since limited available data revealed more about infertile women than infertile men (Bell, 1981). Male partners often had trouble coping with their feelings, which often adversely affected work, social situations, and other parts of the marital relationships. One of the greatest difficulties men related was in the area of communication with their spouse. Sexual difficulties; embarrassment with diagnostic procedures; and threatened

self-esteem, masculinity, and virility were also major sources of male emotional problems (Leader et al., 1984). Bresnick and Taymor (1979) suggested that females experienced more overt and intense emotional reactions than males. Women exhibited a heightened fear of failure which led to a sense of helplessness, despair and intense depression (Leader et al., 1984).

Members of the infertile couple were rarely in the crisis state at the same time, according to available data (Menning, 1980). Some couples developed stronger marital bonds, but the majority of couples endured great strains in their marriages. Many marriages did not survive the infertility crisis due to intense emotional reactions and the failure to make it a "couple's issue" (Berk & Shapiro, 1984). Partners became alienated, particularly if one of the partners denied negative feelings of pain, disappointment, blame, or anger (D.R. Carp & H.J. Carp, 1984). The greatest source of marital frustration occurred if fertile partners tried to maintain a front of complete loyalty (Berk & Shapiro, 1984).

According to Berk and Shapiro (1984), infertility threatened injury to the self-esteem of each partner. "Infertile men may describe themselves as 'neuter,' a 'gelding,' or 'no man at all;' and infertile women may see themselves as 'incompetent in the one thing women can really do,' 'hollow,' or 'barren'" (p. 42). No aspect of a couple's functioning was more affected than their sexuality. Some partners tried to restore their feelings of sexual

adequacy by having extramarital affairs or becoming inappropriately seductive. There often was a loss of sexual desire and the capacity for orgasm often diminished sometime during the infertility work-up (Mazor, 1979).

Menning (1979) described a predictable and nearly universal syndrome of feelings which accompanied the infertility crisis even if pregnancy was achieved. Feelings frequently varied in order and intensity. The ideal process of the stages of resolution of infertility was modeled after Elisabeth Kubler-Ross' stages of death and dying (Draye, 1985; West, 1983). The stages of infertility resolution included: (1) surprise or shock, (2) denial, (3) anger, (4) isolation, (5) guilt, (6) grief, and (7) resolution (Menning, 1982).

Surprise and shock occurred temporarily as couples discovered that infertility existed (Menning, 1979). This stage was especially difficult for persons who were highly achievement oriented, and who felt capable of overcoming any obstacle. Some couples practiced birth control for years and then discovered that they were infertile all along (Griffin, 1983; Menning, 1982).

Denial was a coping mechanism that allowed individuals to protect themselves from something which was too overwhelming for them. Caplan (1981) respected this capacity of individuals to monitor their own level of emotional tolerance and consequent need for denial. Prolonged use of denial required long-term psychotherapy (D.R. Carp & H.J. Carp, 1984).

Anger resulted due to the couple's surrender of their sense of control over their bodies and the outcome of infertility (Menning, 1979). This anger was rational, focused at real insults; or irrational, projected onto targets having control over them, such as the doctor, a relative, or the adoption worker. If this anger wasn't acknowledged or released, it often was repressed and led to chronic depression (Menning, 1977). Inadequate decision-making tormented the couple during this stage. Short-term plans were delayed for diagnostic measures or scheduled intercourse while couples hesitated to make long-term commitments in their careers or finances. This further increased their frustration at being at a standstill in life (Frank, 1984).

Isolation often cut an infertile couple off from potential sources of comfort and support when it was most critical (Menning, 1980). Marital tension increased if partners disagreed in their need for keeping their infertility a secret. If one partner related their problem openly, the other often felt betrayed (Goodman & Rothman, 1984). Secrecy and isolation subjected couples to needling and pressure to start a family as well as forcing partners to rely solely on each other for support. Male and female partners differed in their infertility experiences and could not easily empathize with each other (Menning, 1982). Another form of isolation was avoidance of painful social gatherings and events such as baptisms, christenings, and baby showers where babies were the center of attention.

Guilt and feelings of unworthiness frequently contributed to the secrecy surrounding infertility (Menning, 1980). Individuals with low self-esteem seemed more vulnerable to guilty thoughts. Many people sought a cause-and-effect relationship for their infertility. They searched for a guilty deed for which they were being punished which could include the use of birth control, premarital sex, a history of abortion, venereal disease, extramarital affairs, homosexual thoughts or acts, and sexual pleasure (Griffin, 1983). After the source of guilt was identified, individuals sought atonement and forgiveness through the performance of religious acts, through requesting painful diagnostic or treatment procedures, or through working in painful areas such as counseling unwed mothers. These guilt feelings frequently transferred to all areas of their lives rendering them ineffective in their work, friendships, and marriages. Resolution of this guilt and unworthiness occurred as individuals recognized that fertility and worthiness shared no relationship (Menning, 1980).

The crisis of infertility represented many losses: the loss of children, the potential loss of being a parent, the loss of genetic continuity, the loss of a perceived self-image, the loss of fertility, and the loss of the pregnancy experience (Menning, 1982; Sawatzky, 1981). Grief is the natural response to a clearly perceived loss. Yet, the inability to grieve was one of the most common presenting problems of the infertile person. Grief failed

to appear because there was no recognized loss; it was unfocused. It was the loss of a potential, not an actual person. Some persons compared this grief to "that of a loved one missing in action in war" (Menning, 1979, p. 105). There were no elaborate rituals, no funeral, no wake, no grave, and little outside social support to comfort the bereaved infertile parent (Frank, 1984; West, 1983). Counselors assured persons who were afraid to grieve that it ran a predictable course and it did end (Menning, 1980).

### Resolution

Resolution is the ultimate goal of any crisis. A successful resolution for infertility was not considered in terms of an achieved pregnancy; a child was not the cure for infertility (Bresnick, 1981). Rather, a successful outcome was achieved if the infertile couple emerged from the crisis at the same level of functioning prior to the infertility, or with increased strength and insight (Menning, 1980). Behavioral symptoms which frequently accompanied resolution included a return of energy, a zest for living, a renewed optimism, a sense of humor, and plans for the future (Griffin, 1983). Tasks of resolution included redefining sexuality around the loss of childbearing, regaining a healthy self-image and a positive self-esteem, and working through each of these stages of feelings. These feelings resurfaced with different events or crises, but they were never as powerful or overwhelming as before. Alternative life plans were sought (such as adoption, artificial insemination by husband or donor, and surgery) to build

a way around the obstacles of infertility and return to normal (Menning, 1982).

#### Summary

Infertility is a complex developmental crisis related to parenting. Infertile couples are haunted by the myths that all they need to do to achieve pregnancy is relax, adopt, or take a vacation (Griffin, 1983). Professional counselors can offer accurate empathy, compassion, and support if they are knowledgeable and aware of what helps and what hurts the infertile couple. More empirical evidence is needed since the science of infertility remains in the infancy stages. There is a need for sensitivity, education, and training for professional counselors in this area, especially in handling content and feelings in the discussion of infertility. This could have an overwhelming impact on the quality of life for the infertile couple in their quest for parenthood.

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