NEWS AND VIEWS

CONTROVERSIES IN ASSISTED REPRODUCTION AND GENETICS

Does Assisted Reproduction Make an Impact on the Identity and Self-Image of Infertile Couples?

INTRODUCTION

When the doctor told me I was infertile it was like my whole life changed. I had had images of myself as pregnant, holding a baby in hospital and being a parent collecting my child from school. Now I had a new identity and such images were not to be a part of it.

This woman's very articulate description of her reaction to the diagnosis of infertility is not unusual. While it was a physical condition that led to the diagnosis, the reaction, as described, is essentially a psychological and social (psychosocial) one. Identity and self-image are psychosocial concepts that draw heavily on knowledge from the field of social psychology. Although the opening comments are those of a woman, it needs to be noted that both men and women face issues concerning identity when confronted with infertility.

IDENTITY AND SELF-IMAGE

Identity can be described as a set of labels that individuals attach to themselves—it is how they view their person. In the same way self-image and self-concept are the organization of the qualities that individuals attribute to themselves. However, each individ-

ual's conceptions/images/identities emerge from both internal and external factors. My self-image will be molded by how I view myself, as well as by how I perceive others viewing me—real or imagined. My social interactions are crucial in that they will serve to guide and influence my thoughts and behaviors.

Goffman (1) coined the phrase "spoiled identity" to describe those persons whose identity has been damaged in one way or another. It was also Goffman (1) who wrote about the notion of stigma, suggesting that those with spoiled identity are likely to feel stigmatized, or perhaps be stigmatized by others. Such persons differ from what is regarded as the "norm," or normal, and therefore have a marginalized status.

INFERTILITY, SELF-IMAGE, AND IDENTITY

Mazor (2) has said that

infertility patients often feel damaged, defective and "bad". This sense of badness may not remain confined to reproductive function alone, but may encompass sexual function and desirability, physical attractiveness, performance, and productivity in other spheres as well.

Many studies (3–6) have highlighted the impact of infertility on psychosocial functioning, and infertility consumer magazines and newsletters regularly include accounts of the personal and social impact of infertility. Many such accounts reflect the intrapsychic or internal thinking of the individual concerned. The social dimension and its impact cannot, however, be overlooked.

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Rowland (7) has described Australia as a pronatalist society—everything is geared toward the view that a “normal” family consists of parents/ parent and children. I would suggest that most countries could be described as pronatalist. Where the norm is to “have” children, there is likely to be a heavy burden experienced by those who cannot meet this norm. Given that social policies and social attitudes are directed toward the normal, the infertile are likely to feel alienated with a consequential impact on identity and self-image.

Infertility is not a condition that can be recognized by looking at a person. From a social point of view, not disclosing an infertility problem may be one way of avoiding some of the perceived social stigma, and therefore some of the resulting pain. The use of assisted reproduction may provide individuals or couples with the opportunity of avoiding the stigma, in that, if conception occurs, then others need not know the nature of the conception. In the case of the use of donated gametes, it may be possible to “pretend” that the pregnancy has resulted from the couple’s actions alone. This clearly has implications for identity as perceived by others, but it does not alter the identity as perceived by the individuals themselves.

ASSISTED REPRODUCTION AND IDENTITY

For the infertile couple seeking assistance from a clinic, the expectation is likely to be twofold: to have a baby and to become a parent. Part of being at a clinic means recognizing that they are not going to be able to achieve these goals on their own—they need assistance. Assisted reproduction, or, as it is sometimes described, assisted conception, offers the hope and promise that the couple’s goals may be achieved. The widespread publicity that has surrounded assisted reproduction—most of which has focused on the successful outcomes—may lead many couples to the belief that there is a technological fix that will be available to them. One of the concerns of those whose specialist area is the psychosocial domain is that the transition from (a) a couple seeking to have a child on their own, to (b) the couple being told that this is not possible because of infertility, to (c) their being offered an alternative means to parenthood that involves high technology and possibly the use of third-party gametes, is a dramatic one. This transition, which is sometimes handled at considerable speed by clinics, involves major psychosocial

adjustments to identity and self-image. Each stage in the transition process may involve enormous amounts of energy and time if it is to be successfully managed by those most concerned.

In a paper written almost 15 years ago, colleagues and I (8) discussed the issues and problems of infertile couples. The paper was written in response to our experiences in adoption and donor insemination (DI). We were seeing couples who had been told by their doctor that they were infertile and then immediately referred for either adoption or DI. As social workers and counselors, we found that couples coming to us in such circumstances were confused, often angry, and invariably unaccepting of their infertility status—of their spoiled identity. Attention needs to be given to ensuring that couples and individuals have appropriate time and assistance to manage the transitions. A headlong rush to “solve” the problem of infertility by creating a child makes no allowance for the psychosocial changes that are a necessary part of identity and self-image adjustment.

In 1981 a conference was held in Melbourne, Australia, to discuss issues associated with infertility and the publication that resulted from that conference was aptly entitled “A Child Is Not the Cure for Infertility” (9). The birth of a child as a result of third-party gametes does not change the infertile status of one or both of the partners in a relationship. This identity remains and is likely to continue to impact on self-image.

A very interesting study by Bernstein *et al.* (10) of 20 previously infertile women showed that only 2 of the 20 reported no longer feeling infertile—even though they were pregnant—and 75% were planning in the third trimester for a resumption of infertility treatments if the outcome of the pregnancy was not successful. The authors quote one woman as saying, “Maybe, when I have a baby in my arms, I won’t be infertile . . . maybe” (p. 130). The study also showed that “previously infertile women were much more likely to describe themselves as fat and bloated instead of pregnant. Nearly 80% of the adjectives used to describe themselves were negative” (p. 130). These results strongly suggest that identity and self-image are extremely powerful determinants of reactions, not only to infertility and assisted reproduction, but also to pregnancy and, potentially, to birth and parenthood. In her book Ellen Glazer (11) talks about how the swing from hope to despair that occurs during treatment can

leave couples unprepared for success. Jill Emery (12), in a personal account of her experience, says,

No one can ever prepare you for the feelings associated with pregnancy, birth and motherhood, even when conception is natural. These feelings are compounded when your children are born through assisted conception. There is an expectation that you will be a perfect mother, be happy every day and be thankful that the treatment has worked. No matter how hard you try, there are still times when it is difficult to cope with being a mother.

Given that identity and self-image are psychosocial concepts, factors arising from them should be responded to by those with expertise in this area. An effective infertility, assisted-conception team will have within its membership persons with such expertise. They should be available to meet with couples and individuals, to assist not only with the breaking of bad news, the preparation for treatment, and the support during treatment, but also in the follow-up, which requires further changes and adjustments to identity and self image.

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