The Effect of Infertility on Female Sexuality

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Full Text: Headnote ABSTRACT: Infertility affects one in six couples in America. Only half, or five million of them will be helped by medical means. For the others, the problem is long term. Women who are infertile may not only grieve the childless state, but must also incorporate the inability to have a child into their sexual identity. The emotional turmoil of infertility can have far reaching effects. The woman's self identity is called into question, as are her role expectations. The quest to become pregnant overshadows daily living, which can affect the couples relationship. Professionals who work with infertile women need to be aware of these aspects of the problem as well as provide support to their clients. In this era of choice, the idea that anatomy is destiny seems ludicrous at least and sexist at best. Women today believe they have more control over their lives-from when or if to marry-to whether or not to have children. If children are desired, women are choosing to have them after they have established themselves in a career. Only then do they try to conceive. Few women ever really consider that they may not be able to have a child. For a majority, the effort has been focused on preventing pregnancy from occurring. The issue associated with concern is what to do when faced with an unwanted pregnancy. However, infertility is not as rare a phenomenon as some would think. "Infertility, the inability to achieve pregnancy after one year of regular sexual relations, or the inability to carry pregnancy to a live birth, is experienced by 15% of the population of childbearing age" (Menning, 1982, p. 155). In the U.S., this translates into ten million people, or one in six couples of childbearing age. Of the ten million, half will be helped by medical or surgical means. For the other five million Americans, conceiving and carrying a pregnancy will prove to be impossible. This group does not have a physical or mental illness. They have a social condition-involuntary childlessness-and it can play havoc with their emotional, physical and social lives. There is some concern that the infertility rate is growing in the U.S. This is due to a number of sociological and medical factors (Albino and Tedesco, 1983). Menning (1982) states: there is growing proof that the infertility rate is on the rise in the U.S. and around the world. One of the most important is the trend toward delaying marriage and childbearing into the fourth decade. While this can be a sound economic and emotional decision, both women and men are maximally fertile in their mid twenties, and fertility in women falls off rapidly in the years after 30. Also, some major causes of infertility in women, such as endometriosis, are more prevalent in the older woman. Other factors increasing the infertility rate are the recent rise in venereal disease, prolonged use or misuse of certain birth control methods (notably the pill and intrauterine devices), and exposure of both men and women to toxins, drugs, and environmental conditions which may put them at risk for future fertility (p. 156). Throughout the ages, art and literature describe the very essence of woman as being linked to the ability to conceive and bear children. Fertility and femininity are intertwined. One of the most far reaching effects of the women's movement has been the facilitation of the idea that women can feel good about their sexual selves and expect fulfillment in their relationships without the experience of pregnancy (Savage, 1981). The choices surrounding motherhood have received great attention and women's ideas about how, when and if motherhood is to occur have changed. Yet, most women still regard childbearing as an integral part of their self identity. What factors support motherhood as a central role in the definition of women? The literature suggest that education and religious traditionalism are the "key antecedents that account for why some persons are traditional in their sex role orientation and others are not. Education, age, and exposure to metropolitan living are related to sex role orientation insofar as experience associated with these variables tend to develop and enhance the feasibility of alternative roles to women" (Scott and Morgan, 1983, p. 903). Yet when women desire

and are not able to fulfill the mother role, there is a sense of loss. If a woman has chosen to become pregnant, she equates her value as a member of society with her ability to produce a normal, healthy baby. Spontaneous abortions, ectopic pregnancies, or stillbirths are evidence that the woman cannot fulfill her role. Feelings of guilt and loss of self-esteem can occur. As Quirk (1979) states: "Giving birth to a normal child may reaffirm one's femininity or masculinity and one's image of a good self; a perinatal death may destroy this image" (p. 15). If the woman already has poor self-esteem she may be particularly vulnerable to guilt. Belief that it is punishment for past sins or that she does not deserve a pregnancy or a child may keep her from sharing her thoughts about the loss (Menning, 1982). Women who lose an early pregnancy may already be in a state of crisis from the diagnosis of pregnancy itself. Often, the spouse is not in a position to be helpful in the time of crisis. Helmrath and Steinitz (1978) found that men and women react differently to the loss of a pregnancy or the diagnosis of infertility. Men tend to not talk about the loss, seldom cry, and have a shorter grief process than women. Women tend to grieve longer, are more verbal and express their emotions more readily. Such differences in the reaction to the loss can cause difficulty in the couple's relationship. Once a diagnosis of infertility is confirmed, the woman must make a choice. She must decide whether or not to continue to try to conceive or to give up on the idea of becoming pregnant. Such a choice has an impact on the woman's sexuality. Surgery may be required to alleviate the problem, creating scars and a change in body image. What she thought was a normal, functioning body now has scars to remind the woman that she is "damaged and malfunctioning." Changes in sexual contact-"by the calendar sex"-is often unromantic and sometimes unsatisfactory to both partners. The need to become pregnant supercedes all other functions in life. As one woman states: "Again, months went by, and again we became discouraged. I sensed myself getting older. My husband and I argued about whether to change course and try to adopt a baby. Both of us were exhausted by the years of tests, by the recordkeeping and the intrusion into our sex life" (Berezin, 1982, p. 120). In most cases, the common advice given to couples is to go home and relax. This however, is not as easy to do as it seems. As Marion Cohen states in the Trying-to-Conceive Poem #4: Anything, I'll do anything Temperature charts, Tes-Tape, litmus paper, Vitamin A, Vitamin E, zinc, manganese, Abstinence to maximize sperm count. Lying on my back with a pillow under my behind and my legs up like a beetle. Anything, I'll do anything-But please-please-don't ask me just to relax (Berezin, 1982). The underlying issue here is that women who are infertile tend to become obsessed with the idea of becoming pregnant. This overriding desire colors every aspect of their lives to the exclusion of all other activities. Marital relationships become strained, communications break down and the individuals are left with a sense of isolation, low self-esteem and incompetence. After all, what's so difficult about making a baby? If a woman becomes pregnant after a loss, there may be difficulty in attaching to the new pregnancy. The thrill, excitement and anticipation is not apparent. Couples face the pregnancy with fear and trepidation. Often, they do not announce the pregnancy until after it has progressed past the point where the previous pregnancy was lost. The mother may feel ambivalent toward the child growing inside her, which may inhibit the feeling of maternal adequacy. "While most pregnant women wonder at this time what kind of mothers they will be and whether or not they will enjoy motherhood, the high-risk gravida often wonders whether she will be a mother at all" (Penticuff, 1982, p. 70). Such an inability to adapt to pregnancy can cause later problems such as a lack of adherence to the regimen prescribed by the physician, problems with a reality based perception of the infant and problems with initiating the attachment process to the child (Penticuff, 1982). The couples relationship and how their affection is expressed can suffer during this time. Again, the focus remains on the retention of the pregnancy. This is paramount above all other aspects of marital life. There is research which show that high risk mothers should not engage in sexual activity which leads to orgasm (Goodlin, Keller, &Raffin, 1971; Goodlin, Schmidt, &Creevy, 1972; Grudzinkas, Watson, &Chard, 1979). During the first trimester, a diagnosis of threatened or inevitable abortion precludes any vaginal penetration in order to avoid infection (Cohn, 1982). So what has been a normal way of expressing affections now can become a threat to the pregnancy. For those women who choose not to try again, there is the grieving over the loss of body functioning, the loss of the

fantasy child and the loss of role fulfillment. There is a great deal of adjustment necessary as the woman lets go of the idea that she will be a mother. Most infertile women report a lengthy time of adjustment to the idea of childlessness (Berezin, 1982). Many couples who choose not to continue with infertility tests and procedures state the reason as being a longing to return to a normal way of life. The stress of pregnancy loss becomes too much to continue. As one woman states: "the years of ups and downs of trying and hoping were taking a toll. I was edgy, easily depressed, and Steve, who had always been very patient and calm was irritable ... I started to cry at the thought of giving up, but I had to admit that I longed to return to our normal live. My life had become centered on getting pregnant" (Friedman &Gradstein, 1982, p. 173). With all of the attention focused on new ways of medically treating infertility, the health care professionals have seemed to ignore the psychological effects of the diagnosis. The emotional pain of infertility is very real. I stare at the ghost of the bassinet My ghost arises, Lifts you, holds you, feeds you, smiles at you. ... Do you know I have to get over you for the sake of my love and my life? Well, not exactly get over you. Just not dwell on you so much. Do you know there will soon come a time When we can't go on meeting like this? Marion Cohen "Goodbye" (Berezin, 1982). There is little in the research literature which focuses directly on the impact of infertility on the sexuality of women. Yet it is apparent that the diagnosis of infertility does have far reaching effects on every aspect of a woman's life. This raises some interesting research questions: What is the effect of infertility on both male and female self-concepts, on the marital relationship, and on family dynamics? What is involved in the decision making process related to the infertility diagnosis? What kinds of support are beneficial to infertility patients? And, if infertility treatment is successful, what is the relationship of the couple with their child? Such questions have yet to be addressed, but are pertinent to the age in which we live. As the technology advances to help the infertile patient, the psychological aspects associated with the diagnosis must be addressed. References REFERENCES Albino, J. &Tedesco, L. (1983). Women's health issues. Issues in Mental Health Nursing, 5(1-4), 157-72. Berezin, N. (1982). After a loss in pregnancy. New York: Simon &Schuster. Cohn, S. (1982). Sexuality in pregnancy: A review of the literature. Nursing Clinics of North America, 27(1), 91-8. Friedman, R. &Gradstein, B. (1982). Surviving pregnancy loss. Boston: Little, Brown and Co. Goodlin, R.C., Keller, D.W., &Raffin, M. (1971). Orgasm during late pregnancy. Obstetrics and Gynecology, 38, 916. Goodlin, R.C., Schmidt, W., &Creevy, D.C. (1972). Uterine tension and fetal heart rate during maternal orgasm. Obstetrics and Gynecology, 39, 125. Grudzinkas, J.C., Watson, C, &Chard, T. (1979). Does sexual intercourse cause fetal distress? Lancet, 2, 692. Helmrath, T. &Steinitz, E. (1979). Death of an infant: Parental grieving and the failure of social support. Journal of Family Practice, 6(4), 785-90. Menning, B. (1982). The psychosocial impact of infertility. Nursing Clinics of North America, 27(1), 155-63. Penticuff, J. (1982). Psychological implication in high-risk pregnancy. Nursing Clinics of North America, 17(1), 69-78. Quirk, T. (1979). Crisis theory, grief theory and related psychological factors: The framework for intervention. Journal of Nurse Midwifery, 24(5), 13-6. Savage, J. (1981). Effect of crises on female sexual identity. Issues in Health Care of Women, 3, 151-60. Scott, W. &Morgan, C. (1983). An analysis of factors affecting traditional family expectations and perceptions of ideal fertility. Sex Roles, 9(8), 901-14. AuthorAffiliation Karen Reed, M.N. AuthorAffiliation Karen Reed, M.N. is a lecturer, School of Nursing, University of North Carolina at Greensboro. Address requests for reprints to the author, University of North Carolina at Greensboro, School of Nursing, Greensboro, NC 27412.

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