

## Article 18

### **Multicultural Considerations in Infertility Counseling**

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#### **Abstract**

Infertility affects 15% of the world's population. It is a deeply intimate matter, often deemed as taboo to discuss publically, with pervasive social and psychological consequences. Over the last few decades, research has enlightened our understanding of the biomedical causes and treatment options of infertility and the psychological impact of the experience. However, less attention is given to counseling implications of these psychological studies, not to mention even less consideration of an infertile person or couple's social context, including the cultural and religious factors. In this article, we aim to impart a comprehensive overview of the multicultural implications in working with clients coping with infertility, including the roles culture and religion play in the etiological interpretations, the experience, and the possible resolutions to infertility. We conclude with tangible counseling implications for professional counselors.

*Keywords:* infertility, childlessness, multicultural counseling, religion

Infertility is characterized by either an inability to conceive after trying for 12 months, experiencing recurrent miscarriages, or an inability to carry a pregnancy to a live birth (RESOLVE, 2013). According to the Centers for Disease Control and Prevention, it affects over 7.3 million Americans, including 12% of women of childbearing age (RESOLVE, 2013). Worldwide, 48.5 million couples are experiencing infertility (World Health Organization, 2012). However, quantifying the prevalence of infertility can be

difficult. Greil, Slauson-Blevins, and McQuillan (2010) argued that Western biomedical definitions of infertility often exclude some people in developing countries, as well as minority groups in developed countries, where educational and cultural factors may prevent recognition or acknowledgement of infertility. Additionally, they point out that in the United States, for instance, only 50% of infertile women seek medical treatment. Therefore, it should be recognized that the actual prevalence of infertility is higher than some estimate and that there are many factors that may inhibit some individuals from seeking treatment.

Keeping these rates in mind, similar to the pervasive effects of chronic illnesses, infertility goes beyond statistics and facts: it is a life-changing experience with deep psychological repercussions. Anxiety, depression, and low self-esteem are the central psychological themes that run through the infertility experience, culminating into what some consider to be the most painful experience of their life (Miles, Keitel, Jackson, Harris, & Licciardi, 2009). Even though infertility is highly *medicalized*, the cultural and social constructs are what ultimately affect the psychological impact of the infertility experience; individuals and couples must embrace desired social roles in order to define themselves as infertile and seek treatment (Greil et al., 2010). With the expansion of globalization, significant immigration patterns, and the increase in inter-cultural relationships, taking a psychosocial context approach is essential to infertility counseling (Hynie & Burns, 2006). In this paper, we will explore how culture and religion influence the etiological interpretations of infertility, how they contextualize the infertility experience, and lastly we will discuss their influences in the potential resolutions. We will conclude with some counseling recommendations to serve as guidelines when working with individuals and couples coping with infertility.

### **Understanding Children Within a Cultural Context**

Although the importance of children is universal, the meaning of children, and thus of childlessness, varies across cultures (Hynie & Burns, 2006). Understanding collectivism and individualism provides great multicultural insight into a person's psychological experience through infertility. Collectivist cultures put tremendous importance on family, community, and kinship groups at the expense of personal goals. Furthermore, there is an important sense of interdependence under an umbrella of promoting and maintaining group harmony, thus frequently constricting choices and social mobility. This perspective results in one's family determining whom to marry and when to have children. In Vietnam, children are frequently believed to be the representation of personal happiness and marital satisfaction and are often the primary way for the wife to integrate into her husband's family (Pashigian, 2002). Sewpaul (1999) described how in South African culture, family is an ideological concept—for instance, marriage is viewed as a joining of two clans rather than two individuals. By extension, children are referred to as “generations”; hence, a child is primarily regarded as a way of propagating a species. This preoccupation with lineage is also observed in Ghanaian society (Donkor & Sandall, 2007), in Chinese culture (Loke, Yu, & Hayter, 2012), as well as in Middle Eastern cultures (van Rooij, van Balen, & Hermanns, 2004). Moreover, in most collectivist cultures, there is also a clear distinction between the meaning of a son versus a daughter. In their study of British-Pakistani Muslim families,

Hampshire, Blell, and Simpson (2012) noted that even though daughters fulfill important emotional roles, there is a preference attributed to sons, to the point where being “sonless” is sometimes equated with childlessness. For collectivist cultures, children mean security and wealth, both socially and economically (Sewpaul, 1999). Therefore, childlessness will not only be a crisis for the couple, who may stand to lose social standing and face being stigmatized, but also a tragedy for the whole community.

By contrast, as described by Hynie and Burns (2006), individualist cultures prioritize the individual’s goals over those of the group. On an individual-level psychology, people tend to have an independent sense of self (i.e., idiocentrism), emphasizing individual traits, abilities, and a fluidity in social movement. Behaviors are influenced mainly by personal attitudes rather than social norms. Thus, children are primarily viewed as an extension of a couple’s desire to have their own ideal family, irrespective of societal expectations, social status, or wealth, as in the case of collectivist cultures. However, despite changes to our understanding and definitions of family and children, van den Akker (2001) noted that consanguinity (i.e., blood lineage) and traditional concepts of family still prevail in Western cultures; she concluded, “we are socialized to have a biological child” (p. 141). The degree of internalization of social norms and roles will therefore create variations in the experience of infertility on a personal level, despite the individualist cultural traits of a society. For instance, in the quintessential individualist country of the United States, depression levels of individuals going through infertility are similar to those with chronic illness such as cancer and HIV-positive status (Miles et al., 2009). Hence, cultural differences can impact how infertility is interpreted and experienced and, as a result, should guide mental health practitioners when providing counseling, while keeping in mind the variations in the degrees of internalization of social roles. Clients’ sense of self vis-à-vis their community (in broad terms) will determine if they feel an obligation to have children or whether having children is more of a personal desire. From this cultural perspective, children represent a continuity of lineage and their absence can create a sense of loss.

### **Etiological Interpretations of Infertility**

Cultural mores influence the perceived etiologies of infertility (van Rooij et al., 2004). This section will review how cultures influence the etiological interpretations of infertility: biological causes are predominantly recognized in individualist cultures, where as collectivist cultures tend to emphasize social reasons for infertility. As we will note, the lines between biological and social reasoning are frequently blurred regardless of dominant cultural assumptions about procreation.

During the early stages of infertility research, the literature primarily postulated that psychological factors, such as stress and distress, caused infertility (Miles et al., 2009; van Balen et al., 2002). According to this psychodynamic approach, a woman’s resentment or fear of a feminine role was a causative factor for the onset of infertility (Burns & Covington, 2006; Kikendall, 1994). Although the available research has not been enough to assuage all doubts and questions around infertility—especially when it comes to unexplained infertility, as well as the exact relationship between the psychological and biological workings of infertility—medical studies have helped address a lot of the questions around reproduction (Miles et al., 2009). In fact biological,

hormonal, and physiological factors account for the overwhelming majority of infertility cases (Burns & Covington, 2006; Miles et al., 2009). For instance, according to the American Society for Reproductive Medicine (ASRM; 2015), approximately one-third of infertility cases are due to male factors, one-third are due to female factors, and approximately 20% of cases are designated as “unexplained.”

As indicated earlier, the biomedical models that prevail in Western/individualist cultures belie themes of volition. With one in five infertile couple in the United States diagnosed with unexplained infertility (RESOLVE, 2013), Sandelowski (1990) elucidated the etiological and pathological ambiguities of infertility: is infertility a disease in and of itself or a consequence of a disease and past choices? Delayed childbearing, abortions, and exposure to sexually transmitted diseases can all be the original explanations for infertility. Consequently, even in individualist cultural settings, the burden is overwhelmingly placed on the couple, and especially on women (van Balen & Inhorn, 2002). In fact, in their study on gender differences in response to infertility (among American couples), Abbey, Andrews, and Halman (1991) noted that “attributions of responsibility were sensitive to physiological causes, but also to gender stereotypes that presume that women are responsible for fertility problems” regardless of the diagnosis (p. 305). It is therefore not surprising that while both men and women across cultures display symptoms of depression, anxiety, and low self-esteem, there is evidence that women experience more infertility-related stress symptoms than men (Abbey et al., 1991; Greil et al., 2010; McEwan, Costello, & Taylor, 1987).

The Western biomedical explanation for infertility is not as prevalent in most collectivist cultures (van Rooij et al., 2004). Middle Eastern migrant population studies on infertility highlight the minimal knowledge of reproductive health, often opting for seed and soil doctrines (Gacinski, Yüksel, & Kentenich, 2002; van Rooij et al., 2004). As such, men are seen as creating the child while women conceive it, thus marginalizing women from the reproductive experience (Inhorn, 2002). Additionally, similar interpretations for the causes of infertility can be observed in Chinese culture (Loke et al., 2012). From a South African perspective, Sewpaul (1999) described in great detail how infertility is interpreted as a lack of fulfillment of prior ritualistic obligations, such as not informing ancestors (through sacrificial rituals) that a child has come of age to reproduce. Infertility is therefore often perceived as punishment for past wrongdoings. Such karmic interpretations are also common in India, where Hindu religious traditions explain infertility as a consequence for past sins and misdeeds, child abuse, or abortions in previous lives, forcing couples to a life of childlessness (Sewpaul, 1999).

### **Cultural and Religious Impact on the Infertility Experience**

For most, parenthood is an important life goal, and as infertility is often unanticipated, it can be experienced as a life crisis (Kikendall, 1994; Yağmur & Oltuluoğlu, 2012). Greil et al. (2010) explained that infertility is not merely evidenced by pathological symptoms, but instead “by the absence of a desired state. It is ... a ‘non-event transition’” (p.141). In fact, Loftus and Andriot (2012) posited that women’s socialization revolve around the belief, from a very young age, that parenthood is intrinsic to adulthood. As a result, infertility is deemed as a “*failed life course transition*” (p. 227). The inability to achieve a desired social role, thus living in perpetual limbo, is

paramount in understanding the psychological repercussions of infertility.

Women experience infertility as a direct affront to their self-identity (Greil et al., 2010). E. Tory Higgins's self-discrepancy theory (1987) provides a valuable framework by which we can conceptualize the psychological distress that develops from the infertility experience (Kikendall, 1994). One of the many discrepancies presented is between the actual/own self-state and ought self-state. This discrepancy signifies the presence of negative outcomes, which correlates with agitation-related emotions, such as anxiety, fear, threat, and edginess (Higgins, 1987). In other words, women who have internalized their desire to have children also see their future role of motherhood as part of their social duties; consequently, a failure to meet these expectations can lead to anxiety (Kikendall, 1994). Women who engage in multiple social roles tend to experience less distress than those for whom womanhood and motherhood are indivisible. Studies of infertile women in collectivist cultures, where social roles are rigid, describe the stigma placed on them: women may be expelled from their marital homes (Donkor & Sandall, 2007; Hampshire et al., 2012), labeled as barren (Sewpaul, 1999), replaced by another woman (Hampshire et al., 2012; Pashigian, 2002; Sewpaul, 1999), ostracized (Donkor & Sandall, 2007; Hampshire et al., 2012), debased within the family structure to become the family servant (Hynie & Burns, 2006), and subjected to physical and psychological abuse (Behboodi-Moghadam, Salsali, Eftekhar-Ardabily, Vaismoradi, & Ramezanzadeh, 2013). In fact, some have identified the fear of such negative consequences (rather than the infertility experience) as the primary source of clients' stress, anxiety, social isolation, perceived stigma, and depressive symptoms (Naab, Brown, & Heidrich, 2013). While Higgins's self-discrepancy theory can also be applied to infertile women in individualist cultures, the impact of childlessness is not typically as acute because more women in individualist cultures tend to take on different social roles.

Generally speaking, children are viewed as a personal joy, and parenthood as a life satisfaction goal, rather than a social and gender role requirement (Hynie & Burns, 2006). For instance, comparing Ghanaian infertile women's stress to Canadian women, Donkor and Sandall (2007) noted that stress levels were lower in Canadian women. Canadian women, following individualist and idiocentric models, are engaged in multiple roles leading to more life satisfaction, higher self-esteem, more marital consensus, and less anxiety despite the infertility (Miles et al., 2009). Similar observations were noted when comparing Turkish and German infertile women's experiences (Gacinski et al., 2002). However, it is important to remember that many women from individualist cultures are willing to put their careers on-hold to pursue family building options, thus in part conforming to social and gender roles (Jennings, 2010). With this in mind, clients' internalization of social and gender roles rather than the generalizing cultural influences provide an unequivocal window into their infertility experience.

Religion and spirituality not only play an important function in influencing the etiological interpretations of infertility, they also have a significant impact on the infertility experience. Despite many differences across world religions, respective rituals, beliefs, and practices are often regarded as a source of strength and meaning for individuals coping through hardships such as infertility (Hynie & Burns, 2006). A British study found that Iranian infertile women reported less emotional distress than their more secular British counterparts in the face of failed infertility treatments (Baruch & Anderson 1994 as cited in Hynie & Burns, 2006). Iranian women, who were more devout

than the British women in the study, were better able to cope with the disappointment, framing the infertility as “God’s will.” For Indian women following Hindu religious values, infertility was eventually interpreted as part of one’s destiny in preparation for a higher purpose, such as greater involvement with their temples and helping children in need (although not usually considering adoption) or greater involvement in the lives of their nieces and nephews (Sewpaul, 1999). Explaining suffering beyond human comprehension can provide meaning, understanding, and an opportunity for regeneration for infertile couples (Loke et al., 2012; Sewpaul, 1999).

However, professional counselors should not ignore the religious messages—primarily correlating worthiness with fertility—that may engender shame and guilt in clients coping with infertility (Connor, Sauer, & Doll, 2012; Flowers, 2002; Sewpaul, 1999). As many people across cultures rely on religion to define their social roles (e.g., womanhood as motherhood), being categorized as barren can exacerbate the infertility experience. In her qualitative research on the role of religion in the infertility experience, Jennings (2010) identified common themes of isolation and social pressures experienced by women with infertility. Lastly, while religion and spirituality can help couples maintain a sense of hope for a “miracle,” this belief may also potentially hinder their ability to work towards a resolution, thus living in chronic distress and even resentment towards their faith (Hynie & Burns, 2006; Sewpaul, 1999). Flowers (2002) encouraged counselors, and more specifically Christian counselors, not to offer false hope, knowing that approximately one-third of couples who seek medical treatment conceive successfully. Therefore, it is critical that professional counselors be attuned to the salience of religion and spirituality in the clients’ lives, as well as the messages that are conveyed vis-à-vis their infertility experience.

### **Multiculturally-Aware Explorations of Resolutions to Infertility**

The effects of culture and religion are also felt in the treatment approaches and ultimate resolutions to infertility, which typically fall into three categories: “(1) medical interventions; (2) prayer or spiritual interventions; and (3) realignment of social relationships (e.g., divorce, polygamy, and adoption).” (Hynie & Burns, 2006, p. 66). In collectivist cultures, as illustrated by Jenkins’s field study of infertile couples in Costa Rica (2002), people tend to see themselves as having less control over their environment, believing that having children must occur the “natural” way, and that it has to be part of “God’s will.” As a result, some infertile couples are more likely to find ways to adapt to undesirable situations rather than to change their environment, thus taking a fatalistic view of their experience. Furthermore, they are more likely to seek spiritual and holistic means (e.g., prayer, seeking a healer, experimenting with herbal remedies) to help resolve their infertility, before ever considering Western medical solutions. Interestingly, because the consequences of being childless are more severe than in individualist cultures—due of the ubiquitous interdependence of individuals with their communities and the strong expectations to meet social roles—some infertile couples may be more willing to defy their religious and cultural beliefs to seek various treatment avenues.

Religion oftentimes plays a pivotal role in providing the permissible guidelines for family building options (Roudsari, Allan, & Smith, 2007). For instance, even though Catholicism forbids the use of assisted reproductive technologies (ART), Protestant and

Anglican churches, Judaism, and Islam are accepting of these technologies, because they are often viewed as a helping hand towards parenthood (Hynie & Burns, 2006; Kahn, 2002). For instance, in pro-natalist Israel, every citizen is entitled to unlimited rounds of in-vitro fertilization as part of their national health care coverage to conceive at least two children (Kahn, 2002).

Despite cultural and religious nuances, biological connectedness appears to be paramount. Even in cultures and religions where the use of ART is acceptable, third-party reproduction (i.e., sperm, oocyte, embryo donation or surrogacy) is commonly frowned upon (Hynie & Burns, 2006; Inhorn, 2006). As discussed in the meaning of children in different cultures, direct blood lineage is not only the ideal family aesthetic, it is also a cultural and religious mandate. It is therefore not surprising that in the case of childless Indian and Middle Eastern couples, while devotion to helping children in need provides meaning in light of the infertility, adoption is usually not considered as a viable option nor is it acceptable to some (Gacinski et al., 2002; Sewpaul, 1999). Even in Western cultures, where there is greater acceptance of post-modern family models, there is still an unwillingness to disclose non-genetic means of family building (van den Akker, 2001; van Rooij, 2004). Van den Akker (2001) concluded, “considering the incongruence between the real and ideal family as defined by society, it is perhaps not surprising that research has demonstrated unease and cognitive dissonance between people opting for alternative reproductive choices and disclosing this to society” (p. 140).

### **Mental Health Counseling Implications**

In this article, we hope we were able to provide a cogent overview of the infertility experience through the prism of multiculturalism. Given all that we know from the available psychological, anthropological, and sociological research available (many of which were instrumental for this article), there still remains a dearth in research when it comes to pragmatic information for professional counselors who are or will be working with these clients. Below are some of the recommendations for professional counselors when working with individuals coping with infertility:

- First and foremost, as part of our professional counseling competencies, providers must be aware of their cultural and religious biases and assumptions and be cognizant not to distort clients' experiences through infertility because of their own beliefs (Sue, Arredondo, & McDavis, 1992).
- Although not within the scope of this article, professional counselors must consider the best modalities when working with individuals and couples coping with infertility (Burns & Covington, 2006).
- Professional counselors must ascertain clients' level of education, whether fertility and sexuality were openly discussed, and what those messages were. This information will help counselors determine the level of responsibility a woman may be unwittingly taking on.
- Ancillary to the above, cultural genograms provide invaluable information regarding clients' cultural backgrounds, education, family values and dynamics, levels of acculturations, and communication patterns (Hynie & Burns, 2006).
- Professional counselors must be knowledgeable of the biomedical model of reproduction. Clients who are experiencing infertility may have varying degrees

- of knowledge—and at times, misinformation—regarding human sexuality, reproduction, and fertility options.
- Despite relevant framework provided by the use of collectivist and individualist cultural paradigms, it is important to stay mindful of the individual self-psychology (i.e., idiocentrism/independence vs. allocentrism/interdependence). Professional counselors must allow clients to describe their cultural and religious perspectives to give meaning to the infertility experience (with the guidance of counselors).
  - By extension, professional counselors must assess clients' internalization of social and gender roles rather than the generalizing cultural influences. Similarly, providers should gather insights around clients' degrees of religiosity and spirituality, irrespective of their cultural affiliations.
  - Professional counselors should work with clients to externalize the infertility experience, thus moving away from pathological language to a more experiential one (Burnett, 2009).
  - Professional counselors must help clients gain control over their life decisions in light of their loss of control over their fertility (Watkins & Baldo, 2004).
  - Professional counselors must be comfortable exploring the possibility of non-resolution to infertility treatments, as well as available alternatives to a biologically-linked child.

### **Final Thoughts**

The realities of multiculturalism have had a momentous impact on therapeutic professions. When it comes to infertility counseling, cultural and religious norms not only influence the meaning of involuntary childlessness and its potential remedies, they shed light on the psychological implications of the experience. While collectivism and individualism, along with religious doctrines, create valuable prisms from which to interpret the stressors of clients' infertility experience, it is critical for professional counselors to be mindful of the variability of clients' self-psychology within these cultural and religious norms. These discussions and explorations will allow clients to find meaning in this harrowing time of their life and work towards resolutions. Even though it was not within the scope of this article, a multicultural approach to counseling clients with infertility must include a sincere understanding of the racial and ethnic, and socio-economic influences of the infertility experience—what has been called by anthropologists Ginsburg and Rapp, *stratified reproduction* (Greil, McQuillan, & Slauson-Blevins, 2011).

Research indicates that despite the need and desire for psychological care by infertile patients, there appears to be both a dissatisfaction with the care received and, more surprisingly, very few infertility patients actually seek mental health counseling (Ningel & Strauss, 2002). The dissatisfaction with psychological counseling can be in part attributed to the etic approach some therapeutic practitioners take to infertility counseling and also to the low acceptance of the psychological uniqueness of the infertility experience (Jennings, 2004). Additionally, it appears that infertile couples are often reluctant to report depressive symptoms to their medical physicians (eager to appear well adjusted) out of fear that their treatment will be denied or postponed (Vogsten,



Skoog Svanberg, Ekselius, Lundkvist, & Sundstruöm Poromaa, 2008). Many individuals and couples coping with infertility could greatly benefit from mental health counseling. However, many are not only reticent to seek treatment, they are often not referred to mental health professionals, unless third-party reproduction options are considered. The life crisis that results from infertility warrants more sensitivity from our society, as well as medical and therapeutic communities. There is a tremendous opportunity for professional counselors to participate in infertility advocacy to bring about greater awareness and acceptance of infertility. It is also essential that the mental health field furthers its understanding of the emotional complexities of the infertility experience to develop more tailored treatments.

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#### Footnotes

<sup>1</sup> *Medicalization* is a term used by Conrad and Schneider (1980) that denotes the process by which certain behaviors are conceptualized as matters of health and illness, subject to the supervision of medical institutions (Greil et al., 2010).