Exploring "His and Hers": Links between Infertility Diagnosis and Response

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Abstract

Over two decades ago, Greil and colleagues (1988) discussed the "his" and "hers" of infertility. In particular, women are often distressed whether or not they have a medical problem. In this paper, we use data from the National Study of Fertility Barriers to address the gendered relationship between medical diagnosis and response to infertility. We found that women were less likely to self-identify as infertile if the diagnosis was discrete male factor or 'no problem' compared to discrete female factor. Self-identification was related to greater distress, however, women reported greater distress if the diagnosis was discrete male factor compared to female factor. This suggests that the impact of infertility is not directly linked to diagnosis; rather, diagnosis has different relationships with different psychosocial outcomes. Additionally, we found evidence that these relationships may differ across time, affected by social, cultural, and technological changes that impact the diagnosis and treatment of infertility.

Introduction

Over two decades ago, Greil and colleagues (1988) discussed the "his" and "hers" of infertility, detailing how women and men in infertile couples have distinctly gendered experiences. Research on heterosexual couples' experiences of infertility since then has generally shown that women are more directly affected than men in a variety of ways. In particular, women are generally found to be distressed whether or not they are medically diagnosed as the infertile partner (Greil 1991; Greil 1997; Wright et al. 1991).

Infertility is often approached theoretically as a medical problem located within a reproductive partnership (i.e., the heterosexual couple) (Sandelowski 1993: 16), but in practice, an infertility work-up attempts to the identify whether the problem is male factor, female factor, or some combination of couple factors that contribute. Regardless

of the diagnosis, the majority of tests and treatments are typically conducted on the female partner's body. Scholars have linked this to the historic lack of research on male contributions to infertility, either because men were not willing to be seen by physicians, or because male infertility has often been associated with impotence and, as such, is a sensitive or taboo topic (Marsh and Ronner 1996; Sandelowski 1993; Greil 1991). More recently, however, male infertility has become more openly addressed as new techniques have been developed to surgically extract sperm from infertile men and to help egg and sperm join together outside the body (Palermo et al. 1992**;** Nicopoullos et al. 2004).

In this paper, we draw on data from the National Study of Fertility Barriers (NSFB), a national study of psychological and social aspects of fertility and infertility, to address the gendered relationship between medical diagnosis and self-identification as infertile. We ask if women feel responsible for a couple's infertility (i.e. identify as infertile) regardless of the diagnosis, and whether this relationship has changed over time given the more recent attention to male factor infertility. We further ask how this might relate to fertility-specific distress. By examining these different aspects of diagnosis and response to infertility, we seek to explore whether differences found in previous qualitative studies are also apparent on a larger scale. Moreover, we explore whether these particular, gendered aspects of the infertility experience have changed in the last few decades with greater awareness of and treatment for male factor infertility as well as changes in gender and family norms.

Diagnosis and Treatment: His, Hers, Theirs?

Though medical evaluation of infertility attempts to identify the cause as male, female, or couple factor, it is difficult to estimate the particular contributions of an individual or couple experiencing infertility. This also makes it difficult to estimate incidence and prevalence of male, female, and couple factor infertility at a more aggregate level. This is partially due to a lack of agreed upon, rigorously tested standards for sperm quality and function (Glatstein et al. 1997; Irvine 1998), which increases the likelihood of both false positives and false negatives in identifying male infertility. Additionally, though most clinics focus on semen analysis as the primary means of

identifying male infertility, such analyses may overlook other male factors (Sharlip et al. 2002).

In a joint report, the best practice committees of the American Society for Reproductive Medicine (ASRM) and the American Urological Association (AUA) cited estimates that male factors are solely responsible for 20% of all couple infertility, and at least contribute to the problem 30-40% of the time (The Male Infertility Best Practice Policy Committee 2006). While some literature agrees with these estimates (e.g., Sharlip, Jarow et al. 2002), other sources report rates as high as 33% for men's sole contributions and 50% for contributing male factors (American Pregnancy Association 2009). As a rough approximation, the ASRM suggests that a third of infertility is due to male factor and a third to female factor (ASRM 2009). The remaining third is generally attributed to some combination of couple factors, of which the majority (20- 30%) may be unexplained infertility (The Practice Committee 2006; ASRM 2009).

Historically, the main treatment for male factor infertility has been artificial insemination either using the male partner's sperm or donor sperm (Marsh and Ronner 1996). In 1978, in vitro fertilization (IVF) proved to be a successful technique to bypass certain types of female infertility (Sandelowski and de Lacey 2002). Physicians began using IVF for male factor infertility because pregnancy could be achieved with a lower sperm count relative to artificial insemination (Van Voorhis et al. 2001). In 1992, Palermo and colleagues described intra-cytoplasmic sperm injection (ICSI) – a micro-manipulation technique where a single sperm could be inserted into an egg --as a promising technique for male factor infertility in combination with IVF. Later developments have included capabilities to extract sperm cells from men who have no sperm in their ejaculate by removing cells directly from the testicles through various means, such as testicular sperm extraction (TESE), microsurgical epididymal sperm aspiration (MESA), and percutaneous sperm aspiration (PESA) (Nicopoullos et al. 2004). Although newer techniques to address male factor infertility call for increasing involvement of men's bodies, most treatments still occur primarily on the female partner's body or require involvement of both partners to some extent (Greil 1997; Throsby and Gill 2004).

The Social and Psychological Impacts of Infertility

From a social science perspective, scholars have pointed to the gendered experiences within heterosexual couples, generally showing that women are more directly affected by infertility than men. Sandelowski (1993, especially Chapter 3) notes that, historically, women have been blamed for fertility problems; this blame was often framed either in terms of women stepping outside the boundaries of their traditional role (e.g., by attending higher education or joining the workforce) and subsequently compromising their reproductive capacities, or because they were not psychologically ready to accept their social destiny as a wife and mother. Contemporary studies of gender differences have focused on the transition to non-parenthood (Ulbrich, Coyle, & Llabre, 1990), infertility-related stress (Greil 1991), and the experience of infertility as a unique life problem (Andrews, Abbey, & Halman, 1992).

Scholars have also acknowledged asymmetries in who receives treatment as a major factor in stress and responsibility for infertility (Greil 1991; Becker and Nachtigall 1994). The process of seeking infertility services may reinforce traditional ideas about women and men's reproductive roles by assuming that women are more interested and involved in childbearing and childrearing. This places the brunt of the focus and responsibility for infertility on women. For example, Carmeli and Carmeli (1994) showed how husbands were actively excluded from being more involved in fertility treatments, both through medical professionals' actions and by the need to keep supporting the household if the wife was not employed or took leave from her work to focus on treatment. More recently, Throsby and Gill (2004) examined men and women's differential experiences of IVF, noting that it is not necessarily men's desire to place the major responsibility for the couple's infertility on their partners; rather, cultural norms about gender and reproduction, and stigma associated with male infertility, have often precluded men from being able to talk openly about infertility problems. They also noted that the protocol of infertility work-ups often places men in passive and supportive roles that they may not know how to engage with.

Other research has shown that, even though women may bear the brunt of the social, psychological, and physical responsibility for a couple's infertility, women in couples diagnosed with discrete male factor infertility may not feel the same as women

who personally have a medical problem. Miall (1986) described the dynamics of these women's indirect relationship to infertility as *courtesy stigma***:** the women had similar responses to the initial discovery of infertility, but those with a courtesy stigma were more concerned with information management to protect their husbands and did not identify themselves as being in the same situation as women who personally had medical problems. A recent study by Peronace et al. (2007) evaluated a similar phenomenon among a sample of men with male factor infertility and men in couples with unexplained, mixed, or female factor infertility. In contrast to Miall's study, Peronace et al. found that men were equally distressed independent of the diagnosis; distress was more a factor of unsuccessful treatment resulting in involuntary childlessness. They also concluded that women did not appear to take on the blame in situations of male-only infertility.

As is evident from the discussion above, the social science literature on infertility has long investigated gendered aspects of the infertility experience--particularly the links between gender, medical evaluation and treatment, and distress. While the literature conveys that women are more directly affected than men by infertility, there is some evidence that this is contingent on the diagnosis. Women with more recent episodes may have very different experiences than women women with more distant episodes, especially if analysis of men is becoming more routine as ASRM and AUA guidelines suggest (The Male Infertility Best Practice Policy Committee 2006). The last few decades have seen some major changes in gender and family norms (Stacey 2002; Weston 1992). New research developments in treating male infertility have broadened awareness that male factors contribute to infertility at a rate roughly equivalent to female factors (ASRM 2009; Nicopoullos et al. 2004; Palermo 1992). As such, we suggest that there is an impetus to more fully explore the relationship between diagnosis and response to infertility and whether these relationships change over time. We aim to situate this discussion within the broader question of whether social, cultural, and technological changes have impacted these more micro-level processes of the infertility experience.

Method

Data

We used data from the first wave of the National Study of Fertility Barriers (NSFB). The NSFB is a random digit dialing telephone survey that explores social and psychological aspects of childbearing and infertility among a nationally representative sample of women and a subset of their partners. Our sample consisted of 389 partnered women who reported seeking tests and receiving a medical diagnosis for a fertility problem. Women were asked about testing and diagnoses for both themselves and their partners. We also intend to analyze a sub-sample of 128 male partners that were interviewed for this group of women.

Analytic Strategy

The two outcomes in this analysis were *self identification* as infertile and *fertility-specific distress*. These measures are discussed in more detail below. *Self-identification* was a dichotomous variable, so we used logistic regression. *Fertility-specific distress* was an additive index with a range between 0 and 6. Since it was a limited dependent variable, we examined both linear and ordinal regression models after testing for the proportional odds assumption. The results were substantively similar, so we present the findings from the linear regression model. All analyses were weighted by the NSFB sampling design and population weights.

Measures

We coded a respondent as *self identifying as infertile* (yes/no) if they answered "yes" or "maybe" to either of the following questions: 1) Do you think you have/have had/might have trouble getting pregnant? 2) Do you think you have/have had a fertility problem? *Fertility-specific distress* evaluated reactions to experiencing a fertility problem. The following yes/no items were asked as: 1) I felt cheated by life, 2) I felt I was being punished, 3) I felt angry at God, 4) I felt inadequate, 5) I felt seriously depressed, and 6) I felt like a failure as a woman/man. A higher score indicated greater distress ($\alpha = .72$). This set of questions was asked using a planned missing design: each respondent was randomly given two-thirds of the items to answer to reduce overall

respondent burden without compromising the validity of the scale (Johnson et al. 2006). We created an overall score for each respondent by taking the mean of all available items.

The main independent variables were *medical diagnosis* from fertility testing and *timing of the infertility episode*. Women were asked whether they or their partner had gone for medical testing to determine the nature of their fertility problem. A follow-up question was asked about the resulting diagnosis. We coded these responses into five categories: *female factor only*, *male factor only*, *couple factor*, *unexplained infertility*, and *no problem*. These reflect conventionally used categories in the medical literature (ASRM 2009**;** The Male Infertility Best Practice Policy Committee 2006**).** We created a variable for *years since infertility episode* by subtracting the episode year from the interview year[1]. This is meant to be a proxy for when the medical diagnosis may have occurred because the NSFB does not include timing variables specifically for medical tests.

We controlled for several background characteristics: being either a biological *parent* or social parent through remarriage, adoption, or fostering (yes/no), *age* (years), *race* (white/non-white), *marital status* (married/all else), *family income* (less than/more than $40,000), and *health insurance* (private insurance/all else).

We also included attitudinal variables to assess *importance of parenthood* and *traditional gender attitudes* as these are likely related to the salience of infertility in terms of life-course goals (White et al. 2006; McQuillan et al. 2003) and may further impact the gendered experience of infertility. *Importance of parenthood* was a scale composed of the following items: 1) Having children is important to feeling complete as a woman/man, 2) I always thought I would be a parent, 3) Life will be or is more fulfilling with children, 4) It is important for me to have children. Items had four response categories ranging from "strongly disagree" to "strongly agree." All items were coded so that a high score reflects a greater value placed on parenthood ($\alpha = .84$).

Traditional gender attitudes were assessed by two questions in the NSFB: 1) It is better if the man earns the main living and the woman takes care of the home and family,

[1] We tested several timing variables, including a measure based on 5 year intervals and a measure based on several distinct cutoffs corresponding to advances in gendered technologies. Because these categorical measures did not have any meaningful relationships with self-identification or fertility-specific distress, we went with the simple continuous version.

and 2) If both partners work full-time, both should share household tasks equally. Each item had four response categories ranging from "strongly disagree" to "strongly agree." Items were coded so that a higher score indicated more traditional attitudes.

Findings

Table 1 displays the descriptive results. More than three-quarters of the women self-identified as infertile. Slightly more than half were diagnosed with discrete female factor infertility, while only 7% reported male factor as the couple's infertility diagnosis.It is important to note here that this does not reflect the overall estimates of male, female, and couple factors reported by the ASRM and AUA (ASRM 2009; The Male Infertility Best Practice Policy Committee 2006): discrete female factor is over-represented within this sample of women, and discrete male factor is grossly under-represented. We ran a chi-squared test to examine possible differences in diagnoses based on when the infertility epsiode occurred. This showed no significant differences when comparing the distribution of infertility diagnoses for women before versus after the development of ICSI (and presumed increased public awareness of male infertility). On average, most respondents had experienced an infertility episode about 11 years prior to their NSFB interview, which would place the experience roughly between 1994-6.

Infertility should not be equated with childlessness; the majority of the women in our sample have children either biologically or through social relationships such as adoption, step-parenting, or fostering. Average respondent age was about 37 years. Most women were white (75.6%) and married (95.8%). More than three-quarters reported a family income greater than $40,000 per year, and 81.5% reported having private insurance coverage. This sample is typical of the relatively select group of women who seek help for infertility, but it does not reflect the general population of infertile women (Stephen and Chandra 2000). As such, our results can at best be generalized to the former group, but not the latter.

[Table 1 about here]

The first model in Table 2 shows the logistic regression results for *self-identification as infertile*. Medical diagnosis was a significant predictor for women's self-identification; women were much less likely to identify as infertile if the couple's diagnosis was solely male factor as opposed to female factor (OR = .14). Similarly, if the medical testing revealed 'no problem,' women were less likely to identify compared to women with female factor diagnosis (OR = .26). Women who reported couple factor or unexplained infertility were not significantly different from women with discrete female factor in terms of their propensity to self-identify. Years since the infertility episode was also significantly associated with self-identification: women with episodes in the more distant past were more likely to self-identify compared to women experiencing infertility more recently (OR = 1.06).

[Table 2 about Here]

Model 2 shows the linear regression results for *fertility-specific distress*. Women who self-identified as infertile reported greater fertility-specific distress scores on average than women who did not self-identify (b=.27). Medical diagnosis was also significant: women in couples with discrete male factor reported greater fertility-specific distress on average compared to women with a female factor diagnosis. This finding seems counterintuitive because it suggests that women are more distressed when their husbands are medically infertile than when they themselves are medically infertile. The results here support the conclusion by Peronace et al. (2007) that women do not necessarily identify as infertile when the diagnosis is male factor, but our results suggest that for those women who do self-identify in this sutuation, they may be more personally impacted by infertility. Although our second focal variable, *years since infertility episode*, was significantly associated with self-identification as infertile, it had no effect on fertility-specific distress.

In contrast to the findings in the first model, several demographic and attitudinal variables were significantly associated with fertility-specific distress. Married women reported lower distress (b=.-.17) than unmarried women. Likewise, women in households with a family income greater than $40,000 per year reported lower distress

(b=-.17) than women in lower income households. Women who rated a greater importance of parenthood had higher fertility distress scores on average (b = .09). Women with more traditional responses to the statement 'women should care for the home and family while men work' reported greater distress. Meanwhile, women who agreed with the statement that 'men and women should share housework responsibilities if both work' reported lower distress (b=-.07). These finding suggest that women who hold more gender-equitable attitudes were less likely to internalize distress due to an episode of infertility.

Discussion and Conclusion

In the analyses above**,** we revisited the link between diagnosis of and response to infertility to more fully explore the gendered dynamics of the infertility experience. In the medical literature, there has been increasing discussion of male factor infertility alongside new technological developments to treat or bypass these problems (ASRM 2009; Palermo et al. 1992; Nicopoullos 2004). In the social science literature, scholars have long conveyed the gendered asymmetries of the infertility experience, but studies point to different mechanisms for the impact of infertility. Most research suggests that women are more directly affected by infertility than men (Greil 1991; Greil 1997; Wright et al. 1991; Becker and Nachtigall 1994; Throsby and Gill 2004), but there is some evidence that this is contingent on the diagnosis (Miall 1986; Peronace et al. 2007)**.**

Our study shows that the relationship between diagnosis and response is indeed quite complex. Women in couples with a male factor or 'no problem' diagnosis were much less likely to self-identify as infertile compared to women personally diagnosed with a medical problem. Women who self-identified also experienced much greater fertility-specific distress. The relationship between diagnosis and fertility-specific distress, however, showed that women in couples with male factor infertility were more distressed than women with a female factor diagnosis. This suggests that self-identification as infertile and fertility-specific distress are very different psychosocial processes: An infertility diagnosis pinpointed to a specific partner does not automatically dictate who accepts responsibility for the infertility episode and feels distress about the outcome. One possible explanation is the different type of stress related to information management for women experiencing a courtesy stigma (Miall 1986).

We further explored whether there were any differences in identification and distress related to when women experienced infertility. We found that women who had episodes in the more distant past were more likely to self-identify as infertile, even controlling for who the diagnosed partner was. This relationship did not hold for fertility-specific distress, suggesting that epsiode timing may have been mediated through self-identification as infertile. We also examined gender attitudes because of the changes in gender and family norms over time and their salience to the infertility experience (White et al. 2006; McQuillan et al. 2003). Although there was no association between traditional gender attitudes and self-identification as infertile, gender attitudes did play a role in fertility-specific distress. Women with more traditional attitudes about 'separate spheres' reported greater distress, while women with more gender-equitable attitudes about the household division of labor appeared less distressed.

Taken together, these results suggest a more complicated association between infertility diagnosis and response. More specifically, the gendered impact of infertility is not a direct link to who is the diagnosed partner; rather, diagnosis has different relationships with different psychosocial outcomes. These women may be impacted by various processes including the experience of a *spoiled identity* (Greil 1991) in terms of barriers to motherhood, attitudes and expectations about men and women's responsibilities in childbearing and childrearing, as well having to manage a *courtesy stigma* if their partner is infertile (Miall 1986). Our results also suggest that these relationships differ across time, especially given social, cultural, and technological changes that may directly or indirectly affect the diagnosis and treatment of infertility.

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Table 1. Descriptives for Women Who Had Medical Testing and Reported a Diagnosis (n = 389)*

	Mean	***SD***	***Range***
Self-Identify as infertile	77.8%		
Fertility Specific Distress	0.38	0.36	0 to 1
Medical Diagnosis			
Female Factor	56.2%		
Male Factor	7.0%		
Couple Factor	5.0%		
Unexplained	20.2%		
No Problem	11.6%		
Years Since Infertility Episode	11 years prior to interview	6.75	0 (same year) to 40 years prior
Parent (biological or social)	85.6%		
Age (years)	37.12	5.3	25 to 45
White	75.6%		
Married	95.8%		
Family Income > $40,000	77.3%		
Private Insurance	81.5%		
Importance of Parenthood	3.47	0.59	1.33 to 4
Traditional Gender Attitudes			
Men work, women take care of home/family	2.76 (disagree/neutral)	1.33	1 to 5
Share housework if both work	1.39 (strongly agree)	0.57	1 to 5

*Weighted to adjust for sampling design and survey non-response.

Table 2. Logistic and Linear Regression Results for Women's Identification and Response to Infertility (n = 389)*

	Self-Identification			Fertility-specific Distress		
	OR		S.E.	b		S.E.
Self-Identify as Infertile	-		-	0.27	***	0.05
Medical Diagnosis						
Male Factor	0.14	***	0.07	0.23	**	0.09
Couple Factor	0.65		0.44	0.21		0.13
Unexplained	0.78		0.32	-0.06		0.05
No Problem	0.26	**	0.11	-0.12		0.07
Years Since Infertility Episode	1.06	*	0.03	-1.5E-03		2.8E-03
Parent (biological or social)	0.53		0.23	-0.08		0.06
Age (years)	1.02		0.03	0.01		4.0E-03
White	1.48		0.52	-0.02		0.06
Married	1.03		0.79	-0.30	**	0.11
Family Income > $40,000	1.09		0.53	-0.17	**	0.06
Private Insurance	1.01		0.50	0.10		0.07
Importance of Parenthood	1.59		0.42	0.09	**	0.04
Traditional Gender Attitudes						
Men work, women take care of home/family	0.86		0.10	0.04	*	0.02
Share housework if both work	1.08		0.23	-0.07	*	0.03
Constant				0.10		0.22
Wald Chi-square	34.13					
R^2/*Psuedo* R^2	0.11			0.28		

*Weighted to adjust for sampling design and survey non-response.