Information-sharing among couples considering multifetal pregnancy reduction

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Objective: To determine the information-sharing strategies of couples considering fetal reduction, and the impact of these strategies on the chances of encountering hostility in their social networks.
Design: Cross-sectional design of semistructured qualitative interviews, coded with respect to sharing strategies and level of personally directed hostility encountered.
Setting: Multiple Pregnancy Management Program, Comprehensive Genetics, New York, New York.
Patient(s) and Intervention(s): Fifty women and their partners who were making a first visit to our maternal-fetal management facility, in order to consider the possibility of multifetal reduction as a pregnancy-management strategy.
Main Outcome Measure(s): Development of information-sharing strategies, and the chances of encountering personally directed hostility regarding multifetal reduction associated with more and less selective strategies.
Result(s): Four information-sharing strategies emerged from the analysis. Two of these strategies were relatively open (extended network, and both parents). Two other strategies were relatively selective (qualified family and friends, and defended relationship). The selective strategies were significantly less likely to encounter to encounter personally directed hostility (odds ratio, 3.88; 95% confidence intervals, 0.87–17.30).
Conclusion(s): Selective sharing of information for couples considering multifetal prgnancy reduction is a potentially useful strategy for moderating potentially stressful relationships in their social networks. Clinics should find a way of integrating the discussion of selective sharing into their clinic's cultural repertoire of patient-support services. (Fertil Steril® 2007;87:490–5. ©2007 by American Society for Reproductive Medicine.)

Key Words: Stigma, coping, sharing, multifetal reduction, social support

It is well-established that couples going through fertility therapy are exposed to multiple sources of stress, some of which are social in nature (1–12). Stress, as a generic label for the many feelings and emotions that patients experience, has at least some social roots, owing to the controversial nature of fertility therapy and multifetal reduction (13, 14). For those who come out of fertility therapy carrying three or more fetuses, the prospect of fetal reduction is, for many, an emotional roller coaster. Just when they are able to celebrate having achieved a pregnancy, they discover that the mother is carrying sufficient fetuses to warrant concern over the escalating risks associated with higher-order pregnancies (15). In the course of going through fertility therapy and subsequently considering multifetal pregnancy reduction (MFPR), couples face a dilemma regarding with whom to share what they are going through and the options they face.

This dilemma is shaped by the double-edged nature of sharing such information with others. On the one hand, couples may garner social support (16), which has the potential to be useful (17–19). On the other hand, they may face criticism, hostility, and/or ostracism from the social worlds (composed of family, friends, and colleagues) they inhabit, so they may be reduced to spousal support (20, 21). The irony is that at the very time that social support is needed the most, the risk of nonsupport is also the greatest. Here, we ask how patients and their partners who have gone through fertility therapy, and have subsequently considered MFPR, have developed strategies for sharing information with others, and how successfully these strategies have been in avoiding hostility in their social worlds. We then consider the implications of our findings for MFPR and fertility clinics.

Our approach draws on basic work on the management of "spoiled identities" and the social construction of reality (22–24). Such a perspective is germane to the examination of situations in which the disclosure of discreditable or stigmatizable information about the self could result in hostility and/or conflict with others who inhabit one's social world. Our approach also draws from work on the social construction of reality (25–27), a body of work that assumes mutual influence among values and norms, behavior, and the like-mindedness of those with whom one interacts, especially

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TABLE 1

Examples of successful and unsuccessful sharing.

Type of sharing	Examples
Successful sharing	My parents know, but not John's. They are very "pro life" and it would complicate things. Publicly, we've told all our friends that we are having natural twins, and, of course, that we did not go through fertility therapy. We did it in order to reduce some of the stress: that's why we told most of our friends and family that we are pregnant with natural twins.
	We are close to both sets of parents and see them frequently— several times a week, either by phone or in person. My family knows about the procedure and is very supportive. We have not talked to Hal's family because they would not be supportive, and would not find the prospect of a reduction procedure, uhm, acceptable . . . But it's more personality than religious with them.
	We see my family all the time, including my sister. They know about the procedure and are supportive. What we have not shared with anyone is that we are using donor eggs. My sister has a child with cystic fibrosis, and I know that I am a carrier. We just thought it would be too hard on her to tell her what we were doing in terms of donor eggs.
Unsuccessful sharing	My husband is totally against this reduction on religious grounds. He did not even come . . . As a matter of fact, the night before my mother and I were supposed to come, he went to her house and tried to talk her out of coming.
	My dad's family is fully supportive, and so are our friends at the Methodist church we go to. The sole holdout is my sister. She would have preferred we keep all four embryos.
	Both of our parents know, and they are supportive, but some of our friends are against this. One thinks that this is "an offense against God," and the other thinks that two should be raised, and the other two put up for adoption!

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under conditions where what is being engaged in is controversial. We consider sharing as a strategy for realigning one's social environment to generate support, while minimizing hostility in response to what one is going through and the pregnancy-management options that are being considered or implemented.

In previous work, we examined how women considering multifetal reduction framed their dilemmas, in order to make sense of their positions for themselves and others (28). Framing is an attitudinal and normative-development exercise. The parallel strategy in reality construction is the development of a network of social support for the decisions that one has made. Here we examine this process through the lens of people with whom the couple has decided to share what they are going through and what they are contemplating.

We define and distinguish among four sharing strategies which differ one from another in the number of people with whom sharing takes place, and in the selectivity with which sharing takes place (Table 1). Two of these sharing strategies are relatively selective. The most selective of these is a *defended relationship* (DR) strategy, in which only the couple knows what they have been going through and what they are facing. Slightly broader is a *qualified family and friends* (QFF) strategy, in which parents, friends, and colleagues are let into the loop to the extent that they appear to be supportive and are considered trustworthy with respect to keeping privileged information private. Two other strategies are less selective. A *both parents* (BP) strategy has both sets of parents in the loop. An *extended network* (EN) strategy embraces a larger number of family, friends, and colleagues, and is the most open of the strategies. We hypothesize that the two selective strategies will be more successful in preventing hostile responses from family, friends, and colleagues.

MATERIALS AND METHODS

Sample

Over a 2-year period, at least one member of a three-member sociological research team sat in on multiple pregnancy and MFPR counseling in our Wayne State University Medical School (Detroit, MI) program, and subsequently interviewed patients who were considering going through MFPR. In total, 63 couples were interviewed, and analyses were conducted under the auspices of the Wayne State Institutional Review Board Committee. After the first 3 months of the project, the protocol was revised to ask semistructured ques-