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Revisiting “her” infertility: Medicalized embodiment, self-identification and distress

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A R T I C L E I N F O

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A B S T R A C T

Prior research emphasizes women’s distress and responsibility for a couple’s infertility because of gendered, pronatalist norms. Yet some studies suggest that being personally diagnosed and/or undergoing treatment differentially shapes reactions. We focused on differences in women’s experiences with diagnosis and treatment, conceptualized as the *medicalized embodiment of infertility*. Using regression analysis, we examined two psychosocial outcomes (self-identification as infertile and fertility-specific distress) in a sample of 496 heterosexual, U.S. women from the National Survey of Fertility Barriers. Medicalized embodiment was salient to women’s reactions, but had different relationships to self-identification versus distress. Although women experienced distress regardless of type of diagnosis, they were generally less likely to self-identify as infertile unless personally diagnosed. As such, we cannot assume that all women universally experience infertility. Future research should also address self-identification and distress as separate as opposed to simultaneous psychosocial outcomes.

Introduction

Over two decades ago, Greil, Leitko, and Potter (1988) discussed the “his” and “hers” of infertility, detailing how partners in U.S. couples have distinctly gendered experiences. Women are often more directly affected by infertility than men (Greil, 1997; Nachtigall, Becker, & Wozny, 1992; Throsby & Gill, 2004). This is typically explained by the gendered, socio-cultural context of infertility: women’s identity and social status are more closely tied to childbearing and parenthood (Exley & Letherby, 2001; Greil, 1991; Parry, 2005). Infertility, though, is not a universal experience because women are situated in different medical, social and lifecourse contexts. In this study, we focus on two potentially key medical differences: diagnosis and treatment.

In the U.S., as in most Western countries, infertility is generally considered a biomedical problem (Greil, 1991; van Balen & Inhorn, 2002), although less than half of infertile women seek any type of medical help (Stephen & Chandra, 2000). Among those who do, two basic aspects of the medical experience are diagnosis and treatment. Qualitative accounts from U.S. and Canadian women and men suggest that being personally diagnosed as infertile may produce a different psychosocial response than being fertile with an infertile partner (Clarke, Martin-Matthews, & Matthews, 2006; Miall, 1986; Nachtigall et al., 1992). Yet, women usually appear distressed regardless of who is diagnosed (Greil, Slauson-Blevins, & McQuillan, 2010), likely because treatment asymmetrically focuses on women’s bodies (Greil, 1991; Throsby & Gill, 2004). Other research, addressing infertile identities (Blenner, 1990; Miall, 1986; Olshansky, 1987), suggests that medical diagnosis does factor into the experience. Although previous work suggests the importance of these medical encounters for psychosocial responses, diagnosis and treatment have not been simultaneously considered in relation to both infertile identities and infertility distress.

We conceptualize having a personal medical diagnosis and/or undergoing treatment as women’s *medicalized embodiment of infertility*: the process through which women’s bodies are medically labeled as infertile or become medically involved in a couple’s reproductive problem (e.g., through treatment even when their body is not the source of the problem). Using data from the National Survey of Fertility Barriers (NSFB), we analyzed a sample of 496 heterosexual, U.S. women (ages 25–45) who had medical testing and reported a diagnosis. Through regression analysis, we addressed two major questions: 1) Does experiencing medicalized embodiment increase women’s propensity to self-identify as infertile? 2) How does medicalized embodiment relate to fertility-specific distress (i.e., are women more distressed if they are personally diagnosed and/or undergo treatment)? We view women who have experienced the medicalized embodiment of infertility as distinct from women who have not, with implications for their psychosocial responses.

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Conceptual framework

We draw from the literature on chronic illness addressing the impaired body, self, and identity (Charmaz, 1995; Kelly & Field, 1996) and from research on infertility and medicalization. The connections between the body, self, and identity become apparent when “bodily demands conflict with desired self-presentation” (Kelly & Field, 1996, p. 245) and inhibit an individual’s ability to fulfill certain social roles. Once the body malfunctions, it is no longer an aspect of the self that can be taken for granted. Similarly, once the reproductive body malfunctions, women may be blocked from achieving (biological) motherhood (Exley & Letherby, 2001). Bodily aspects of infertility are also intrinsically gendered, as bodily/reproductive failures may be interpreted as failures at being a woman or a man (Becker, 2000; Clarke et al., 2006).

All women potentially embody infertility because success or failure to conceive plays out through women’s bodies (Clarke et al., 2006; Greil et al., 1988), but not all women experience *medicalized embodiment*. We define the latter as the process through which women’s bodies are medically labeled as infertile or otherwise medically involved in a couple’s reproductive problem (e.g., through treatment). In Western countries, the social problem of involuntary childlessness (or unmet childbearing desires) has been transformed into the biomedical problem of infertility (Becker & Nachtigall, 1992). Seeking medical help is viewed as an appropriate solution. Yet, acquiring a medical diagnosis and seeking treatment can also reinforce a sense of self as abnormal (Becker & Nachtigall, 1992; Jutel, 2009). We argue that women’s reproductive failure becomes solidified, and may be more distressing and detrimental to the sense of self, when legitimized through a personal medical diagnosis and/or treatment.

Unlike other medical conditions, infertility is identified as a problem arising from two bodies (Sandelowski, 1993): it is medically defined as no conception after twelve months of regular sex without contraception (ASRM, 2009). Women can belong to an “infertile couple”, and are likely to undergo treatment without personally having a medical problem (Greil, 2002). This has important implications for how women’s bodies are defined in relation to reproductive failure, because it is not only through personally having a medical problem; one’s partner’s medical problem may also lead to association of one’s body with a reproductive failure. Below, we address two aspects of the medicalized embodiment of infertility—diagnosis and treatment—and discuss how these relate to psychosocial aspects of infertility.

The infertility diagnosis

Physicians typically identify root causes of infertility as male, female, or couple factor (Sandelowski, 1993). In the U.S., roughly one-third of infertility is due to male factor, one-third to female factor, and one-third to couple factors (ASRM, 2009; The Practice Committee, 2006). Although physicians typically sort causes into these three categories, up to 30% of infertility is described as having an ‘unexplained’ etiology (The Practice Committee, 2006). Furthermore, some who go in for medical testing are found to have no physiological problems (van Balen, 2002).

Research on the relationship between type of diagnosis and psychosocial outcomes has not found clear linkages. U.S., Canadian, and Western European women appear to be distressed regardless of whether they are personally diagnosed with infertility, their partner is diagnosed, or the infertility factor was unknown (Greil, 1997; Greil et al., 2010). In their U.S.-based study, Greil et al. (1988) found that even in couples with male-only infertility, women viewed infertility as *their* problem, harboring “suspicion that their bodies must also be working imperfectly” (p. 184). These women also saw themselves as having *spoiled identities* regardless of the diagnosis (Greil, 1991). Nachtigall et al. (1992) likewise found that women experienced negative psychosocial responses to infertility regardless of whether they or their partner was diagnosed with the problem.

Some studies, however, suggest that type of diagnosis does affect responses to infertility (Blenner, 1990; Miall, 1986; Olshansky, 1987). Interviewing involuntarily childless Canadian women, Miall (1986) found that women who were not personally diagnosed as infertile “strongly distinguished themselves” (p. 274) from those who were. Interviewing infertile persons in the U.S., Olshansky (1987) described how clinical confirmation of infertility led couples to “take on a more formal identity of self as infertile” (p. 60). This assessment, however, assumes a couple-level response that potentially obscures individual, gendered variations, suggesting more individual-level analyses are needed.

Although type of diagnosis may not differentiate women’s distress over infertility, it may affect their self-identification as an infertile person. For instance, previous U.S.-based research has shown that women who self-identified as infertile were more distressed than those who did not (Jacob, McQuillan, & Greil, 2007). This suggests there may be an indirect relationship between diagnosis and distress through self-identification. We expect that women who are personally diagnosed (female-only, couple factor) will be more likely to self-identify as infertile compared to women who are not personally diagnosed (male-only, unexplained, no problem) because they experience a more immediate, intimate sense of bodily failure, which is legitimated by medical authority (Jutel, 2009). However, we expect that the relationship between diagnosis and fertility-specific distress may be mediated by self-identification.

The treatment factor

One major factor complicating feelings of stress and responsibility for infertility is that women’s bodies more frequently come under the “medical gaze” (Greil, 2002), even for male factor infertility. Historically, there has been a greater emphasis on infertility as a women’s issue, with less attention to understanding and treating male infertility (Marsh & Ronner, 1996; Sandelowski, 1993). Women’s greater bodily engagement with treatment may contribute to distress and responsibility even in the absence of a personal diagnosis. Though not considering diagnosis, White, McQuillan, Greil, and Johnson (2006) found that, in a sample of 580 Midwestern U.S. women, those who self-identified as infertile were much more likely to have sought treatment. We expect that, regardless of diagnosis, women who undergo treatment will be more likely to self-identify, and will report greater distress because of the medical focus on their bodies.

Although undergoing treatment can be stressful, treatment can also be empowering because couples are finally seeking a solution (Blenner, 1990). This suggests that treatment may help resolve earlier distress. Yet, based on other prior research using more systematic data (e.g., Jacob et al., 2007), we expect that having undergone treatment will be positively associated with distress because of the intense focus on women’s bodies. However, this may also depend on where women are in their infertility journey (Blenner, 1990; Lorber & Bandlamudi, 1993) as well as the outcome of the treatment.

Diverse contexts of infertility

Although we focus on diagnosis and treatment, interpreting and responding to symptoms is influenced by individual, interpersonal and social contexts (White et al., 2006; Zola, 1973). Therefore, it is