EXPERIENCING INFERTILITY AND FACTORS OF LIFE QUALITY OF WOMEN : A LITERATURE STUDY

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Abstract
Greil released a review and analysis of the research on the sociopsychological effects of infertility around ten years ago. At the time, he discovered that most academics approached infertility more like a psychiatric disorder than as a social reality. Since the previous review, new research has been examined in this article. Despite continued clinical emphasis, many investigations are increasingly situating infertility within broader societal circumstances and social scientific frameworks. Methodological issues persist, although there have also been significant advances. In the social scientific study of infertility, there are two active research traditions that we may distinguish. In one tradition, clinic patients are studied using largely quantitative tools to identify the need for psychological therapy and to enhance service delivery. In order to understand infertile people's experiences in a societal context, the other tradition generally employs qualitative research. We draw the conclusion that the social context's influence on the experience of infertility is now receiving increasing attention. We urge further development of a clearly social perspective on infertility as well as continuing fusion of the two research traditions mentioned here.
Keywords:*infertility; literature review; treatment;*

Introduction
The majority of medical sociologists agree that socially created categories negotiated by medical professionals, patients, and others in a sociocultural context are the best way to understand health and sickness rather than as objectively measured states. A social context is used to determine what constitutes abnormality, how to describe it, and if any action should be done to address its symptoms. Both how sufferers see themselves and how others perceive them are outcomes of social definition processes. The word "medicalization" was used by Conrad and Schneider (1980) to describe the process by which a particular conduct comes to be seen as a matter of health and sickness, subject to the control of medical organizations. Infertility, which is often described in the scientific setting as the failure to conceive after 12 months of frequent unprotected intercourse, is one phenomena that has becoming more and more recognized as a medical issue. The introduction of fertility medications in the USA in the 1950s marked the beginning of the medicalization of infertility, but it has advanced much more quickly with the advent of assisted reproductive technologies (ART) including intracytoplasmic sperm injection and in vitro fertilization (IVF). Thompson (2005) recently described the intricate ontological choreography that takes place in the modern ART clinic, involving precisely timed actions (such as hormone injections, sperm ejaculation, and gamete cryopreservation) among an interrelated cast of actors (such as doctors, nurses, and patients).

Compared to other disorders, the social construction of health and sickness is possibly even more evident in the case of infertility. First off, couples do not identify

as infertile or seek therapy unless they see motherhood as a desirable societal duty, regardless of how medical professionals may characterize infertility. Second, whereas the biological paradigm views illnesses as a phenomena that affects the individual, infertility is often seen as a disorder that affects a couple, particularly in industrialized nations, regardless of which partner may have a functional disability. As a result, describing oneself as infertile entails discussions between the couple as well as maybe discussions with wider social networks in addition to discussions between the person and medical specialists. Thirdly, the lack of a desirable condition rather than the existence of clinical symptoms serves as a signal for infertility. It is a "non-event transition," according to Koropatnick et al. (1993: 163). Fourth, the existence of alternatives to seeking a "treatment" is more apparent in the case of infertility than it is for other medical disorders. Self-definition as a childfree person deliberately, adoption, fostering, or changing partners are all potential alternatives to therapy. The best way to understand infertility is as a socially created process wherein people come to see their inability to conceive as a problem, identify the kind of issue it is, and create a solution. The sociology of health and illness can benefit greatly from the study of infertility because it offers researchers a unique vantage point from which to examine aspects of medicalized healthcare like the conflict between the voice of medicine and the voice of the lifeworld (Mishler 1984), the gendered nature of health and healthcare, and the interaction between structure and agency.

Infertility is often linked to psychological anguish since it entails the failure to fulfill a desired social function. Greil (1997) released a review and analysis of the research on the socio-psychological effects of infertility around ten years ago. While infertility was portrayed in the descriptive literature on the psychological effects as a tragic experience, he highlighted that efforts to test the psychological repercussions hypothesis had shown more conflicting findings. Those that used measures of stress and self-esteem did discover significant differences between infertile people and others, while studies that examined for psychopathology did not uncover any significant differences between infertile people and others. He discovered evidence to support the idea that infertility is fundamentally different for men and women. Greil also pointed out a number of flaws in the psychological distress literature, such as the use of cross-sectional designs, non-representative samples, failure to study those who have not sought treatment, failure to study economically disadvantaged and culturally distinct populations, and failure to find a satisfactory solution to the "controls" problem. However, Greil emphasized that the psychological distress literature treated psychological effects of infertility as a medical illness, paying little attention to the social construction of infertility.

It is our intention to analyze generalizations about infertile experiences, evaluate recurring constraints and advancements in the methodological and theoretical elements of infertility research, and assess how research released since the previous review article has evolved. We come to the conclusion that while the clinical emphasis of much older work still predominates, researchers are leaning toward placing infertility in social factors.

We also discover that, despite the fact that there are still numerous methodological issues, significant efforts are being made to address these issues. We also see that specific research areas, such as cross-cultural studies of infertility, potential long-term effects of childlessness, the connection between stress and infertility, and the significance of infertility in men's life, have made progress. We make an effort to show throughout why using non-clinic based samples is crucial if we are to advance in our knowledge of the experience of infertility.

We distinguish between two different research strands when it comes to the social and psychological effects of infertility. A particular tradition is the quantitative study of patient groups, often with a focus on those receiving ART, with the aim of enhancing service delivery and determining the need of psychological counseling treatments. Usually, the quantitative analysis of standardized psychological evaluation tools is used in these therapeutically focused investigations. The second tradition is focused on qualitative research of infertile men and women outside of clinic settings in both industrialized and developing nations. People being researched may or may not be patients in biological settings, but the goal of this study is to understand infertility and the social environment that influences it rather than to improve therapy. This second tradition has benefited more from advancements in social science research on stigma, gender, the body, and disease experience.

The works in one tradition seldom quote the works in the other, therefore there is little indication that these two traditions "talk" to one another. In the review that follows, we make an effort to combine these two study traditions in a preliminary way. We concentrate on research over the last ten years that examine how women, men, and couples react to infertility since our focus here is on the experience of infertility and infertility treatment. Studies that just address the institution of reproductive technology and its sociological and cultural context are not included. Inhorn and Birenbaum-Carmeli recently reviewed these issues (2008). Additionally, we don't include research whose main objectives are the prevalence and incidence of infertility.

Methodological Issues

There are still several methodological issues with infertility studies that Greil (1997) pointed out. Small sample sizes, poor sampling techniques, the use of non-standardized measures, a lack of adequate control groups, and studies being carried out in infertility treatment facilities with which the researcher is affiliated were all listed as problems with social-scientific research on infertility by Pasch and Christensen in 2000. Henning et al. (2002) criticize the many studies that heavily depend on self-report data, those that do not allow for the distinction between the psychological effects of infertility and the psychological effects of infertility therapy, and those that heavily rely on cross-sectional data.

Research on the effects of infertility is still dominated by studies of treatment seekers conducted in clinics (Henning et al. 2002). It is difficult to generalize because of the emphasis on individuals who are undergoing therapy (Greil 1997). Less than half of infertile women in the USA, for instance, seek therapy (Greil and McQuillan 2004, Stephen and Chandra 2000). Therefore, clinic-based research

don't reveal anything regarding 50 percent of infertile females. There are still many couples who choose not to seek treatment, even in countries where access to infertility therapy is legally guaranteed (Boivin et al. 2007). It is hard to ascertain what characteristics distinguish people who seek treatment from those who do not, or why those who might benefit from infertility therapy do not have access to it, without research of non-treatment seekers. Our capacity to comprehend people who discontinue therapies after early efforts has been hampered by the focus on the most cutting-edge treatments, even among those seeking therapy. It is hard to separate the effects of infertility from the effects of infertility therapy on psychological consequences without a non-clinical reference group.

Since 1997, many significant research using non-clinic based samples have been conducted. King (2003) examined whether treatment seekers and non-treatment seekers are more likely to fulfill the criteria for anxiety by using the National Survey of Family Growth, a nationally representative sample that included infertility status data for women in the USA. Malin et al. (2001) used a Finnish random sample to gauge how satisfied patients were with their care. Redshaw et al. (2007) evaluated how recently delivered British women responded to infertility therapy using a nationally representative sample of these women. In order to provide a picture of the experience of infertility in those countries, Sundby et al. (1998) and Leonard (2002a, 2002b) used systematic sampling approaches to choose infertile respondents in The Gambia and southern Chad. McQuillan et al. (2003) investigated the association between general distress and infertility using a random sample of 580 women from the mid-western USA, including an oversample of minority women. The National Research of Fertility Barriers (NSFB), a prospective panel study based on a random sample of US women with an oversample of minorities and women who have not finished their childbearing, is currently gathering data. Greil, McQuillan, and their colleagues are involved.

Other research have taken measures to increase the generalizability of their results without conducting a population survey. Internet surveys were utilized by Epstein et al. (2002) and Bunting and Boivin (2007) to recruit participants for studies on the use of the internet for treatment research and support for infertility, respectively. Using the Ways of Coping Checklist, Jordan and Revenson (1999) performed a meta-analysis of six research. At family practice clinics, Jordan and Ferguson (2006) identified respondents, of whom 11.4% experienced reproductive issues.

Ethnographic methodologies have increased in popularity as research on infertility in emerging nations has multiplied. These studies unavoidably have representativeness concerns, but unlike those on infertility in developed nations, they haven't always been restricted to looking at patients in facilities with a western aesthetic. Although causation cannot actually be addressed in these research in a conclusive manner, that is not their main objective. Instead, ethnographic investigations provide extensive information and insight into what infertility means to local people in their own words (Inhorn and Birenbaum-Carmeli 2008). We are starting to get an understanding of the experience of infertility in developing nations since there

have now been qualitative community-based studies carried out in a variety of cultural contexts.

It is hard to distinguish between cause and effect when using cross-sectional analysis, which is still the most popular approach in research of the social and psychological effects of infertility. In recent years, longitudinal designs have increased, however the majority have a very short time horizon. Multiple studies have examined changes in stress levels during a reproductive cycle (for example, Edelmann and Connolly 1998, Verhaak et al. 2005). Some research have used a little bit longer time frames (Anderson et al. 2003, Hjelmstedt et al. 2004, Holter et al. 2006). From longitudinal research with longer time horizons, much may be learnt. The Copenhagen Multi-Centre Psychosocial Infertility (COMPI) research examined Danish women during their first visit to an infertility clinic and evaluated treatment results one year later (Boivin and Schmidt 2005, Peronace et al. 2007, Schmidt et al. 2005a). Data from the 1988, 1989, and 1990 waves of the USA-based Study of Marriage, Family, and Life Quality were utilized by Schneider and Forthofer (2005). Three years following the first interview, a nationally representative sample of US women will be re-interviewed as part of the NSFB, which is now in progress.

Another methodological question is more about conceiving infertile people than it is about creating research. The notion of who should be declared infertile looks simple as long as the research of infertility is restricted to clinic patients. The majority of research implicitly and unintentionally define operationally infertile patients as "those who present themselves for infertility therapy." The distinction between infertile and non-infertile persons blurs after we get beyond treatment seekers (Greil and McQuillan forthcoming), and it becomes clear that infertile people are a far more heterogeneous population than was previously thought. How should a woman be classified if she meets the medical criteria of infertility but does not believe she has attempted to conceive and does not believe she is infertile? Given how often such people are, this is a crucial issue. Infertile women are divided into two groups: "sub-fecund with intent" (women who claim they tried to conceive for at least 12 months without conception) and "sub-fecund without intent" (women who report having had unprotected intercourse without conception but who do not say that they were consciously trying to conceive at the time). Greil and McQuillan (2004) and Jacob et al. (2007) have found that the two groups differ with regard to Western biological criteria of infertility exclude a significant part of women in emerging civilizations who believe themselves to be infertile, according to research on infertility in developing nations (Gerrits 1997). Infertility is seen in The Gambia and Zimbabwe, according to Sundby (2002), as anything that stops women from achieving their reproductive goals. Leonard (2002b) tells the story of Solkem, a Chadian lady who may not be considered infertile by western biological standards since her husband left her and she no longer had frequent sex but who is still concerned with the idea of becoming pregnant.

Descriptive literature on the experience of infertility

Recent descriptions of infertile people (such as those in Becker 2000, Clarke et al. (2006), Earle and Letherby (2007),

Johansson and Berg (2005), and Redshaw et al. (2007) tend to support and expand on earlier descriptions. From qualitative study, a number of descriptions of infertile women or couples have been developed. Williams (1997), for instance, identified 11 themes from interviews with infertile women, including negative identity, a sense of worthlessness and inadequacy, a lack of personal control, anger and resentment, grief and depression, anxiety and stress, lower life satisfaction, mother envy, the loss of the dream of co-creation, the "emotional roller coaster," and a sense of isolation. According to Ulrich and Weatherall (2000), women who are infertile see infertility as an unexpected interruption to their life plans. Martin-Matthews and Matthews (2001) examine the relationship between family and social timelines, body timetables, and treatment timetables with an emphasis on the feeling that time is passing quickly among infertile women (see also Earle and Letherby 2007). According to Parry and Shinew (2004), the process of seeking therapy and feelings of social isolation reduce leisure happiness. However, evidence indicates that the description of infertile women as wholly preoccupied with attempting to conceive only applies to treatment seekers (Greil and Mc-Quillan 2004 and forthcoming, Jacob et al. 2007, White et al. 2006).

The importance of sociocultural context

The role of the sociocultural environment in influencing the lived experience of infertility is being emphasized more and more in the social-scientific literature on infertility. According to Kirkman and Rosenthal (1999), the availability of reproductive technologies has a significant impact on how people see and react to infertility. Letherby (2002) contends that prior to the development of assisted reproductive technology, ambivalence regarding parenthood may have been more socially acceptable (ART). Sewpaul (1999) demonstrates how different religious traditions might affect how infertile people view the condition in a qualitative study of infertile people in South Africa. Despite the shame associated with infertility in The Gambia, Sundby (1997) claims that 43% of infertile couples there have a foster kid, a situation that undoubtedly has an effect on the experience of infertility. According to Feldman-Savelsberg (2002), the political climate in Cameroon has a profound impact on infertile women's perceptions of their state's ability to protect them from witches.

Pro-natalism is one aspect of the social setting that affects infertility (Parry 2005, Ulrich and Weatherall 2000). All communities are pro-natalist, although some place a greater emphasis on the significance of motherhood to a woman's identity than others. For instance, Israel has a very pro-natalist culture and provides governmental funding for IVF and surrogacy (Birenbaum-Carmeli 2004, Kahn 2000). Remennick (2000) conducted research on a small sample of Israeli women and came to the conclusion that none of the women she talked to even acknowledged the existence of deliberate childlessness. Having children may be crucial for women in developing nations in particular to obtaining adult status and getting respect in the society (Hollos 2003). The significance of reproduction to the status of women in Pakistani squatter communities is discussed by Bhatti et al. in 1999. Sundby and Jacobus (2001) claim that in southern Africa, having children entitles a woman to a portion of her

husband's money and property.

In the Yoruba culture, parenting is crucial to an adult woman's position since lineages cannot survive without offspring (Pearce 1999). According to Pashigian (2002: 135), motherhood and femininity are synonymous in northern Vietnam, and trying for a child is an effort "to participate in normative identity development." Infertility might cause women to live in poverty in Cameroon (Feldman-Savelsberg 2002). Women and men with reproductive issues may avoid categorizing themselves as infertile since reproduction is such a crucial component of women's identities in developing nations (Barden-O'Fallon, 2005).

Patriarchy shapes the experience of infertility, although the extent of male domination and the variety of responsibilities available to women outside of parenting differ from civilization to society. Even if they are aware that there is a male cause of infertility in Egypt, women still carry the burden (Inhorn 2003). Remarriage is the "therapy" for males in Bangladeshi slums, according to Nahar et al. (2000), since women are blamed for infertility. Jenkins (2002) describes a situation in Costa Rica where a lady named Silvia was forced to accept childlessness because her husband would not submit to a pregnancy test. According to many research, infertile women who suffer pressure or rejection from their spouses and families are more distressed (Gulseren et al. 2006, Guz et al. 2003). According to Gerrits (1997), matrilineal communities may have a distinct experience with infertility. In modern civilizations, patriarchy may be less obvious, but that doesn't imply it has no impact on the experience of infertility there. Throsby and Gill (2004) address what they regard as the impact of hegemonic masculine culture on marital relationships in a qualitative study of guys who are infertile and have stopped IVF. Infertility is seen by men as a challenge to their manhood; wives are sympathetic, while husbands are made fun of. Throsby and Gill (2004) claim that men react by blaming their spouses.

Two worlds of infertility

The experience of infertility differs noticeably between established and developing nations, as shown by the remarks above. Thinking about infertility in terms of two universes may be justified. Prevalent beliefs on childlessness vary across developed and developing countries. In modern nations, choosing not to have children is seen as a more feasible and acceptable choice, and women who are childless are often assumed to be doing so intentionally. However, deliberate childlessness is uncommon in Kerala, India, according to Riessman (2000: 113) because "carrying and raising children are crucial to women's power and well-being." According to Leonard (2002a), menstruation is seen as a "bad disease" and there is pressure in Chad to demonstrate one's fertility shortly after marriage. In many societies, motherhood and marriage are inextricably linked, therefore it is assumed that women remain childless solely if they are infertile. Therefore, in societies where choosing not to have children is accepted, many women perceive infertility as a "hidden stigma" (Greil 1991b: 22); in countries where choosing not to have children is not accepted, it is not feasible to conceal infertility. Because of this, underdeveloped nations are probably more prone to experience the shame and pain of infertility (Dyer et al. 2005).

In developing nations, overpopulation is frequently a greater concern for policymakers and academics than infertility (Bos et al. 2005, Inhorn and Birenbaum-Carmeli 2008, Nachtigall 2005, van Balen and Gerrits 2001), but the perspective of those who experience infertility is frequently very different from that of those who make policy. Although infertility and population reduction are seen as the biggest threats by women in the Cameroon grasslands, overcrowding is the biggest issue from the perspective of national and international policy (Feldman-Savelsberg 2002). Studies of infertility in affluent nations more often examine infertility as a medical, ethical, or psychological problem and pay less attention to the social environment; studies of infertility in underdeveloped societies are frequently extremely attentive to questions of sociocultural context (Bos et al. 2005).

The use of folk theories to explain infertility is another way that infertility differs across industrialized and developing countries. The biological paradigm is almost dominant in industrialized cultures, although in other communities, biomedical interpretations of infertility coexist and interact with traditional interpretations to a larger extent (Dyer et al. 2004, Feldman-Savelsberg 2002, Gerrits 1997, Nahar 2007). Egypt's explanation for male infertility centers on the idea that the sperm "worms" are not strong enough (Inhorn 2003). Infertility among the Macua people of Madagascar may be caused by a woman marrying a ghost, her blood not mixing with her husband's, or a witch digging up her pubic hair, which was buried during initiation ceremonies (Gerrits 1997). In both industrialized and developing civilizations, biomedical and traditional theories of infertility may coexist (Kahn 2000, Sewpaul 1999, Yebei 2000). Among the Sara of southern Chad, the choice between using conventional remedies (such as "going to the village") or western treatment (such as "going to the hospital") relies on how the issue is seen (Leonard 2002a, 2002b).

Research on the psychology of infertility

A more statistically oriented body of work that focuses on evaluating theories concerning the psychological components of infertility coexists with the descriptive literature. Among British infertility patients, Edelmann and Connolly (1998) found no indication of psychopathology. They suggest that the discrepancies between the results of controlled research and those based on clinical perceptions are due to the fact that counselors visit the most troubled individuals. However, given that the majority of descriptive literature and reports based on clinical impressions assert that the experience of infertility is a source of psychological distress rather than that infertile patients are fundamentally different from others in their psychological functioning, it is possible that they are responding to older arguments rather than more recent accounts (Greil 1997). IVF couples are happy, according to Eugster and Vingerhoets (1999), who reviewed the literature on studies of patients who had the procedure. While the majority of couples do not exhibit psychopathology, Wischmann et al. (2001) contend that there is a fraction that need psychiatric assistance.

Although infertile women are more likely to suffer discomfort than comparable groups, they are not necessarily more likely to display psychopathology (Beutel

et al. 1998, Fekkes et al. 2003, Monga et al. 2004, Oddens et al. 1999). According to Wischmann et al. (2001), women at a German clinic experienced slightly more stress than average and performed worse than average on a variety of life satisfaction sub-scales. In family practice clinics, infertile women score more distressed than other women on the Patient Health Questionnaire (Jordan and Ferguson 2006). Women who are presently having infertility issues exhibit higher levels of despair and anxiety than peers who finally became pregnant naturally (Oddens et al. 1999). However, according to many research (Holter et al. 2006; Verhaak et al. 2005), overall distress levels among IVF women are not considerably higher than average.

Studies on males have produced conflicting findings. Iranian males with infertility, particularly those with male-factor infertility, had higher scores for sadness and trait anxiety, according to Baluch et al. (1998). According to Folkvord et al. (2005), one-third of infertile males in Zimbabwe had moderate clinical depressive symptoms. On the other hand, males in infertile couples do not vary from controls on a measure of psychological wellness, according to Monga et al. (2004). Peronace et al. (2007) draw the conclusion that infertility is stressful for males regardless of the cause of infertility based on a longitudinal research conducted in Denmark. Dutch IVF guys who were younger than average but not older had greater emotional issues than expected (Fekkes et al. 2003).

Gender disparities in distress levels have been the subject of a lot of study, both on general distress and anguish related to reproduction. There is evidence, according to literature studies (Abbey 2000, Eugster and Vingerhoets 1999, Henning et al. 2002, Savitz-Smith 2003), that women are more stressed out about infertility than males. According to Edelmann and Connolly (1998), this result may simply be a result of women often having higher levels of discomfort than males. Despite this warning, the majority of current studies support prior research that found infertility to be more upsetting for women than for males (Anderson et al. 2003, Holter et al. 2006, Lee and Sun 2000, Monga et al. 2004, Schneider and Forthofer 2005, Slade et al. 2007).

Furthermore, White and McQuillan (2006) discovered that for women but not for males, giving up a strong desire to have a child is linked to increased suffering. Women spend more in having children and are more treatment-oriented than males, according to Pasch and Christensen's (2000) research. Stigmatization of women is more prevalent than that of males (Slade et al. 2007). On the other hand, Dyer et al. (2004) demonstrate that males in South Africa find forced childlessness to be a major source of distress.

Exploring the qualitative variations in how infertility affects men and women is equally crucial. According to Beutel et al. (1998), whereas infertile spouses perceive infertility to have a bigger effect on their everyday life and feel a higher need for assistance, their husbands perceive infertility to have a stronger sense of responsibility. Although both men and women express emotions of unfairness, Hjelmstedt et al. (1999) claim that women are more prone to confess to mood swings, envy of those who are not infertile, and a

sensation that their biological clocks are running out. Men worry about losing control and how their spouse will respond to infertility (Hjelmstedt et al. 1999). The majority of the above is reminiscent of Greil's (1991a) claim that spouses directly feel infertility as a blow to their sense of self, but husbands indirectly experience infertility via the impact it has on their wives.

The majority of academics that have looked into the connection between infertility diagnosis and unhappiness have come to the conclusion that the diagnosis has no effect on how distressed people feel (Edelmann and Connolly 1998, Hjelmstedt et al. 1999, Holter et al. 2007, Verhaak et al. 2005, Wischmann et al. 2001: for an exception, see Dhaliwal et al. 2004). No research have determined the degree to which infertility therapy may be the cause of an individual's misery rather than infertility itself. King (2003) came to the conclusion that therapy does not mitigate the effects of sub-fecundity on general anxiety disorder based on a national probability sample of women in the USA. According to some studies (Anderson et al. 2003), the duration of therapy is unrelated to the degree of stress, while other researchers have observed conflicting results (Chiba et al. 1997, Nasseri 2000). If variations in distress over time are a reaction to therapy or if they are a function of the length of infertility, that is one unsolved issue. Male and female IVF studies (Ardenti et al.

According to research from 1999, Boivin et al. 1998), therapy stage affects how distressed patients are. Studies on IVF women have shown that greater degrees of discomfort are caused by the treatment's results rather than its length (Lok et al. 2002; Sydsjö et al. 2005; Verhaak et al. 2007). The majority of women ultimately got used to failed treatments, but a sizable minority displayed emotional issues (Beutel et al. 1998, Holter et al. 2006, Verhaak et al. 2001, 2005, 2007).

Abbey has studied the extensive research on the connection between infertile people's pain and coping mechanisms (for instance, Benyamini et al. 2008, Schmidt et al. 2005b, van den Akker 2004). (2000). According to Gibson and Myers (2002), women who experience infertility stress are less likely to experience it when they have access to social coping mechanisms, connections that encourage development, partner support, and family support. According to Hansell et al. (1998), women who saw their infertility as a "challenge" were less upset than those who perceived it as a "loss". According to Brothers and Maddux's research from 2003, women who believe having children would make them happier in the future are more likely to experience psychological anguish. Studies of coping mechanisms also show an emphasis on gender variations (Dhillon et al. 2000, Hjelmstedt et al. 1999). According to Jordan and Revenson (1999), who conducted a meta-analysis of six research using the Ways of Coping Checklist, women exhibit greater levels of seeking social support, evasion or avoidance, plan-oriented problem-solving, and positive reappraisal. According to some data, distress levels are correlated with both one's own and one's partner's coping mechanisms (Schmidt et al. 2005a). Pasch et al. (2002) made the intriguing conclusion that men exhibit greater negative impacts when wives desire to chat. Greil (1991a, 1997) asserts that

despite the stress and communication issues that might arise in marriages, many couples say that they believe their infertility has brought them closer. Infertility often does not result in interpersonal or sexual issues, according to a review of the research by Pasch and Christensen (2000) (see also Daniluk 2001, Hjelmstedt et al. 1999, Schmidt et al. 2005a, and Sydsjö et al. 2005). According to Webb and Daniluk (1999), when males admitted to genuinely starting to cope with their infertility, they began talking to their spouses. This eventually led to a feeling of infertility as a shared experience, which in turn boosted their bonds. However, there are many who assert that infertility does negatively affect marriages (Wirtberg et al. 2007). In The Gambia, where marital stability is already a problem, infertility is seen as a significant danger to marital stability, according to Sundby (1997).

These research demonstrate that the social setting affects how infertility affects marital relationships. For instance, in cultures where having children is more closely associated with women's roles, where having children for one's family is viewed as a major responsibility, and where marriage is defined in terms of having children and raising them, infertility is likely to have a more detrimental effect on couple relationships. This suggests that infertility will affect relationships more severely in the developing countries. Research demonstrating that infertility is more strongly linked to psychopathology in Nigeria, a polygamous culture, supports this conclusion (Aghanwa et al. 1999).

Compared to the past, researchers are undertaking more thorough investigations on the use and efficacy of psychological therapies (Domar et al. 2000, McQueeney et al. 1997, Pook et al. 2001). According to a study of the literature on research examining the efficacy of psychological therapies, there is not yet enough data to conclusively prove the value of therapy (Boivin 2003). More patients with infertility indicate a need for therapy than subsequently do so (Boivin et al. 1999). According to research provided by Guerra et al. (1998), many infertile patients who might benefit from counseling are not forwarded.

Nowadays, a lot of couples turn to the internet for guidance and assistance (Kahlor and Mackert 2009, Porter and Bhattacharya 2008, Rawal and Haddad 2006). While Epstein et al. (2002) present evidence that suggests women who use the internet as their only outlet for infertility support are more depressed than those with multiple outlets, Wingert et al. (2005) argue that internet self-help in the form of online bulletin boards serves many of the same functions as support groups. A software created to provide patient assistance through the internet, according to Cousineau et al. (2008), was shown to have favorable outcomes.

Although the majority of researchers disagree with the idea that psychopathology has a significant causal role in infertility (Brkovich and Fischer 1998), there is evidence in favor of the cyclical argument (van Balen 2002) that stress limits fertility by causing infertility to occur (Henning et al. 2002, Pook et al. 2004). In a review of the literature on

psychological distress and infertility, Wischmann (2003) makes the case that stress and anxiety are frequently a contributing cause of infertility but not always the only one. She also claims that methodological advancements are required before it is possible to make firm conclusions about the causal roles of stress and anxiety. Eugster and Vingerhoets (1999) highlight some research suggesting that psychological issues may affect IVF success rates. Some researchers' work (Boivin and Schmidt 2005, Boivin et al. 2006, Gulseren et al. 2006) supports this, whereas other researchers' work (Anderheim et al. 2005, Salvatore et al. 2001) finds no support for it. According to Strauss et al. (1998), psychological factors only partially account for the variation in treatment results. There is evidence that sperm quality is affected by stress levels and coping mechanisms (Pook and Krause 2005; Pook et al.1999).

Sociocultural environment of treatment

There is a corpus of literature that complements the literature on the experience of infertility and focuses on the treatment of infertility in both developed and developing nations. Access to care is a significant issue that affects the experience of infertility, especially in sophisticated cultures (Beckman and Harvey 2005). Compared to non-Hispanic Whites, ethnic minorities in the USA, the UK, and The Netherlands have poorer access to healthcare (Becker et al. 2005, Bitler and Schmidt 2006, Culley and Hudson 2006, 2007, Henne and Bundorf 2008, Inhorn and Fakih 2005, Jain 2006, van Rooij et al. 2007, White et al. 2005). Latina women, women with lower levels of education, and impoverished women are underrepresented in ART clinics even in Massachusetts, a US state where ART coverage is required (Jain 2006). In a military reproductive clinic where everyone had equal access, Feinberg et al. (2006, 2007) discovered that Hispanics were underrepresented but that African Americans were not. Israeli women face infertility in the setting of governmental assistance for infertility treatment, in contrast to women in the US (Kahn 2000, Remennick 2000). Socioeconomic level (SES) and employment do not seem to influence the use of ART in France, where it is subsidized, however low SES women are disproportionately represented among the early adopters of ART (Tain 2003). This implies that use patterns and, in fact, the experience of infertility, may vary as new therapies become available. For instance, Miller (2004) notes that the desire to get pregnant has increased more quickly among sub-fecund women than in fecund women, and she hypothesizes that this tendency may be a reaction to the growing accessibility of ART.

Despite similar percentages of infertility treatment requests in developed and less developed nations (Boivin et al. 2007), access to care is much more restricted in underdeveloped societies (Kielman 1998, Nachtigall 2005, Ombelet et al. 2008, van Balen and Gerrits 2001). One-fourth of female South African clinic patients had been looking for treatment for more than five years before their initial consultation at an infertility clinic, according to research by Dyer et al. The biggest obstacle seems to be the lack of access to primary care. According to Sundby (2002), neither The Gambia nor Zimbabwe's official medical systems are able to provide the level of care that is required. The high rate of hospital admissions indicates that infertility is a big problem,

yet the treatment given to women is often insufficient (Sundby et al. 1998, Sundby and Jacobus 2001). People may get the same therapy more than once because of a lack of coordination between the various healthcare professionals. Rich women have access to advanced gynecological facilities and ART in The Gambia, India, and Egypt, but the needs of poor and middle-class women are not met (Sundby et al. 1998, Widge 2005).

The higher accessibility, acceptability, and use of alternative care systems in emerging nations is a significant distinction between infertility treatment in developed and developing societies (Kielman 1998, Okonofua et al. 1997). Many patients at clinics in South Africa and Zimbabwe claim to have initially sought out a traditional healer (Dyer et al. 2004, Folkvord et al. 2005). According to Nahar et al. (2000), the most typical "therapy" for males in Bangladeshi slums is remarriage, whereas the most typical "treatment" for women is the usage of herbalists and healers. Yebei (2000) notes that due to the exorbitant expense of biological therapy, Ghanaian women often had to turn to alternative practitioners like herbalists and spiritual healers even after they had emigrated to The Netherlands.

The sociocultural context of infertility therapy seems to have a significant impact on how it is delivered. Given the Indian concept of marriage and the family, the inability to adopt has a significant impact on how infertility is treated in India. Islam forbids adoption, according to Inhorn (2000), since there are no maternal bonds and no biological ties to the father. Jenkins (2002) contrasts this by describing the scenario in Costa Rica, where adoption is a socially acceptable solution to the infertility issue since unwed pregnancies are a problem and abortion is prohibited. Religious authorities in places where Islam is prevalent consider donor implantation to be wrong (Folkvord et al. 2005, Meirow and Schenker 1997). According to Handwerker (2002), the Chinese ART business is supported by the ideology that having boys is important in China. Inhorn (2000) has spoken particularly persuasively on how cultural perceptions and reproductive technologies interact in Egypt. According to Mitchell (2002), the increasing marketing of reproductive technology has caused couples to seek assistance early and may have led to treatments that weren't essential.

The subject of what variables impact help-seeking is an important one since only approximately half of infertile people globally seek therapy. White et al. (2006) draw the conclusion that identifying oneself as infertile is essential for seeking therapy based on research using a population-based sample of infertile women. It is still unclear from this cross-sectional research whether describing oneself as infertile is a need for receiving treatment or whether therapy causes people to consider themselves as infertile. Women who were more worried about being referred to as infertile were less likely to seek therapy, according to Bunting and Boivin's (2007) research. Greil and McQuillan (2004) discovered that infertile people who intended to become pregnant were more likely to seek therapy than infertile people who didn't. It is clear that not all American women who meet the medical criteria of infertility consider themselves to be infertile. On the other hand, Gerrits (1997) points out that

Macua women in Cameroon who sought both conventional and western medicine were not necessarily infertile by the criteria used in biomedicine.

Greil's early qualitative research (1991a) revealed that women were substantially more inclined than husbands to begin therapy. More recently, Daniluk (2001) observed that, of the 65 infertile couples she spoke with, the woman in every single instance was the one to begin therapy (see also Webb and Daniluk 1999, Throsby and Gill 2004). Women are particularly treatment-oriented, yet despite this, they find the treatment process to be quite stressful (Peddie et al.

Schmidt 1998; 2005). Yebei (2000) observed that therapy for infertility was emotionally taxing and unpleasant for Ghanaian women in the Netherlands. Treatment may be difficult for husbands as well (Schneider and Forthofer 2005), however supportive healthcare practitioners are seen as having a positive impact on men's stress and anxiety levels (Brucker and McKenry 2004). Patients report feeling that they have little influence over their treatment and that they are not being treated like persons, according to Redshaw et al. (2007).

Numerous studies have shown that patients, particularly when there are language issues, feel frightened by the technical components of infertility therapy and the language of biomedicine (Becker et al. 2005, Ulrich and Weatherall 2000, Wingert et al. 2005). The experience of receiving infertility therapy has been defined as a condition that engulfs people and takes over their everyday activities (Daniluk 2001, Redshaw et al. 2007). The treatment of infertile women is best described by Greil (2002) in terms of three paradoxes: I their sense of loss of control leads them to treatment where they lose even more control; (ii) their feelings of loss of bodily integrity leads them to treatment where the body is invaded; and (iii) their sense of loss of identity leads them to treatment where they feel they are not treated as whole people. However, Greil (2002) believes that American infertile women should not be seen as helpless victims (see also Letherby 2002, Parry 2005). Similar observations concerning women in southern India and Bulgaria are made by Riessman (2000, 2002) and Todorova and Kotzeva (2003), respectively.

Patients with infertility need more information and patient-centered treatment than they now get (Schmidt et al. 2003). (Souter et al. 1998). According to Redshaw et al. (2007), infertile patients expressed frustration with the treatment's inconveniences, lack of continuity of care, and financial and emotional expenditures. However, women showed stoicism and saw the challenges of therapy as the cost of having a kid. According to Malin et al. (2001), Finnish women who underwent therapy before 1990 expressed more dissatisfaction than those who did so thereafter. If patients thought their treatment was customized, helpful, and pleasant, they reported pleasure. Slow treatment progress and a bad connection with healthcare professionals were the main causes of discontent. Women vary in what components of therapy they perceive to be the most distressing (Benyamini et al. 2005).

Patients' challenges in stopping their

therapy have also been explored (Greil 1991a, Sandelowski 1991). Women find it particularly difficult to quit therapy, but their husbands intervene to exercise a "logical veto" by taking into account their wives' mental and physical health, according to Throsby and Gill (2004: 12). According to Olivius et al. (2004), 26% of women who voluntarily discontinue IVF therapy do so due to the psychological strain it involves. Verhaak et al. (2007) claim that even if it is tough to quit treatment, IVF women who do so have less despair and anxiety after doing so. Couples that undergo unsuccessful IVF do not regret the process; rather, they see it as their greatest opportunity to conceive (Daniluk 2001, Johansson and Berg 2005, Throsby and Gill 2004). Before accepting their infertility, women who have ended IVF therapy often engage in a period of introspection (Peddie et al. 2005). Two years after failed IVF, a study of Scandinavian women revealed that the women refocused on other issues while still holding onto hope for a child (Johansson and Berg 2005). Women who maintain optimism even after stopping therapy are described by Johansson and Berg (2005), at least until menopause. Studies on a small number of women who are unable to produce biological children have shown that many of them redefine family to encompass adoption and childless living (Parry 2005, Su and Chen 2006, Ulrich and Weatherall 2000).

The lives of infertile people do not always return to normal after becoming pregnant. While Cox et al. (2005) found no indication of poorer self-esteem for individuals who got pregnant through IVF, Eugster and Vingerhoets (1999) state in a literature review that pregnancy for persons undergoing IVF is more stressful than for those without reproductive difficulties (Bevilacqua et al. 2000). According to Letherby (1999), infertile women who have given birth with ART report experiencing worry, remorse, and a sense of duty to be excellent moms. On the other hand, successful infertility patients reportedly thought they had put infertility behind them six months after giving birth, according to Hjelmstedt et al. (2004). Parents claim that experiencing infertility has made them feel more strongly about having children, more understanding of parenting challenges, and more appreciative. Men believed that their emotional connection with their children had become stronger as a result of their infertility. Infertile moms have worse self-evaluations and take longer to embrace the motherhood identity, according to the limited scientific research that have been done on the subject (Gibson et al. 2000, McMahon 1999). However, there is no proof of unfavorable maternal conduct, marital issues, or psychiatric issues (Repokari et al. 2007).

According to Ulrich and Weatherall (2000), infertile women who give birth soon learn that parenting offered more difficulties than they had anticipated. IVF parents and other parents exhibit identical parenting styles, according to Eugster and Vingerhoets (1999).

The effects of infertility over the long term have been studied by certain researchers. 20 years after a failed tubal resection, 14 Swedish women participated in in-depth interviews done by Wirtberg et al. in 2007. Despite the fact that all but three of the ladies were able to achieve a fulfilling childfree lifestyle, they discovered that the

women still had strong recollections of their time as infertility patients. However, when their contemporaries started having grandkids, a few of them felt like they were going through infertility again. In contrast to women who had other reproductive issues, infertile women were more likely to remember emotions of failure and uncertainty, according to qualitative interviews done by Zucker (1999). Sundby et al. (2007) discovered that women recalled the time of infertility as a challenging era in their life in a 10-year follow-up study of IVF women. In the Sundby et al. (2007) research, the majority of the IVF women became moms. Whatever the conclusion, they all managed to deal with their circumstances. There is evidence that only involuntary childless people experience the long-term detrimental effects of infertility (see also Jacob et al. 2007, McQuillan et al. 2003, 2007). Whether they have biological or adoptive children, ever-infertile moms' distress levels are comparable to those of fertile women. Van den Akker (2004) discovered that regardless of the method chosen to have children, women who adopted, used ART, or sought out surrogacy reported a greater quality of life than childless women.

Conclusions

The publishing of scientific studies on infertility has increased during the previous decade. Researchers continue to investigate the degree to which infertility is a cause of psychological suffering and to gather data about the significance of gender in the infertility experience. Continued research examines in depth the characteristics of IVF patients and other facets of the IVF treatment experience. Additionally, new tendencies are obvious. There has been an explosion of ethnographic research that examines the societal environment of infertility. The examination of the long-term repercussions of infertility is now receiving more focus. There is also a trend toward a greater focus on the research of the dialectical link between infertility and stress, as well as the evaluation of the efficacy of psychological therapies. Some methodological flaws exist, although progress has been made. The significance of researching couples and understanding more about the male experience of infertility is increasingly acknowledged. The dependence on tiny, nonrepresentative, clinic-based samples of treatment seekers is becoming recognized as problematic, and academics have started to address these difficulties. While underrepresentation of economically disadvantaged and culturally diverse groups remains a concern in the study of infertility in industrialized cultures, the release of ethnographic studies of infertility in poor nations has highlighted the need for more of this kind of research. By applying sociological and socio-psychological theories to the experience of infertility, research and analysis are advancing in the direction of situating the experience of infertility within its social context.

In the social-scientific study of infertility, there are presently two prominent research lines. One tradition studies clinic patients with a view toward enhancing service delivery and determining the need for psychological therapy using predominantly quantitative methods. The other tradition focuses mostly on qualitative research to capture the social experiences of infertile persons. In an effort to begin the process of unifying these two traditions, we have

attempted to weave them together in this piece. There is much to be gained by integrating the scientific rigor of the clinical research with the cross-cultural literature's sensitivity to the socially constructed aspect of infertility. The recent (2008) study of a Dutch reproductive clinic by Gerrits is an outstanding illustration of an anthropological approach to the contemporary clinic environment. In an attempt to increase the generalizability of their ethnographic findings, Sundby et al. (1998) and Leonard (2002a, 2002b) have adopted advanced sampling approaches. Recently, Bunting and Boivin (2007) have employed quantitative tools outside of the clinic environment to study early infertility decision-making among women. The NSFB affords researchers the ability to examine themes such as self-definition, social impact, and others that have been largely ignored in the quantitative literature. The COMPI research program is a noteworthy attempt to apply quantitative analytical tools to concerns concerning the social construction of infertility. It seems that infertility researchers have started to employ sociological concepts from the sociology of health and sickness, the sociology of gender, the sociology of the body, and the sociology of deviance to the study of infertility. Less evident is the effect of infertility research on these subjects, although the study of infertility has much to give to the larger field. The infertility studies recounted here may teach sociologists a great lot about the role of power and social structure in the social construction of reproduction, which is well encapsulated by the term "stratified reproduction" (Ginsburg and Rapp 1995: 3). Women are not only passive victims of medicalization and male reproductive control, but rather active actors in defining their own experience and crafting meaningful moral worlds in settings they did not choose. The literature discussed here delivers a strong message about the significance of self-identification in the process of seeking medical assistance and the significance of the body for identity. The infertility literature may also serve to remind us that not only women reproduce, suffer medicalization, and are stigmatized, and that males must be included in gender and health studies.

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