THE UNIVERSITY OF HULL

# Perspectives on parenthood,

# subfertility and fertility treatments:

## A comparative study of British and

## Greek sub-fertile and fertile couples

being a Thesis submitted for the Degree of Doctor of Philosophy

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by

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## Summary

This research aimed to explore the areas of parenthood, fertility/subfertility and fertility treatments in relation to fertility status and culture (British or Greek). Two hundred couples took part in this study. One hundred were British, 50 of which were subfertile couples and 50 fertile couples. The remaining one hundred couples were Greek, 50 of which were sub-fertile and the other 50 were fertile. The methodologies used were both quantitative and qualitative. In the quantitative part, not only the British and the Greek cultures were compared, but differences due to gender and fertility status (fertile vs. infertile) were also examined. Attitudes to parenthood and to fertility treatments were the main focus of the quantitative study. Furthermore, a variety of demographic characteristics, well being and social support variables were explored. These were all explored through the use of questionnaires. The main focus of discourse analysis (qualitative part) was the similarities and differences between the Greek and the British cultures in the way they construct issues like parenthood, subfertility and fertility treatments. All participants filled in the questionnaires, while only 10 British and 10 Greek couples from the subfertile sample were interviewed. Quantitative results, as was expected, suggested that Greek couples placed higher value on parenthood than the British couples. Similarly, Greeks were found to have more positive attitudes to reproductive technologies than the British. Also, subfertile couples attributed higher value to parenthood than did fertile individuals. No gender differences were found either within or between cultures. Similarities and striking differences were found between the British and the Greek interviewees in relation to

their constructions of parenthood, subfertility and fertility treatments. The quantitative and qualitative results of the study inform each other in an interesting way, bringing more light to the area of research and insight to future research.

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## Acknowledgements

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## Abstract

This research aimed to explore the areas of parenthood, fertility/subfertility and fertility treatments in relation to fertility status and culture (British or Greek). Two hundred couples took part in this study. One hundred were British, 50 of which were subfertile couples and 50 fertile couples. The remaining one hundred couples were Greek, 50 of which were sub-fertile and the other 50 were fertile. The methodologies used were both quantitative and qualitative. In the quantitative part, not only the British and the Greek cultures were compared, but differences due to gender and fertility status (fertile vs. infertile) were also examined. Attitudes to parenthood and to fertility treatments were the main focus of the quantitative study. Furthermore, a variety of demographic characteristics, well being and social support variables were explored. These were all explored through the use of questionnaires. The main focus of discourse analysis (qualitative part) was the similarities and differences between the Greek and the British cultures in the way they construct issues like parenthood, subfertility and fertility treatments. All participants filled in the questionnaires, while only 10 British and 10 Greek couples from the subfertile sample were interviewed. Quantitative results, as was expected, suggested that Greek couples placed higher value on parenthood than the British couples. Similarly, Greeks were found to have more positive attitudes to reproductive technologies than the British. Also, subfertile couples attributed higher value to parenthood than did fertile individuals. No gender differences were found either within or between cultures. Similarities and striking differences were found between the British and the Greek interviewees in relation to

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# Preface

*"The wisdom of God and the perfection of the universe become evident when compared even with the greatest of the human achievements."*

*S. Kazantzidou, 3/12/2001*

This work is about parenthood, fertility/subfertility and reproductive technologies. It is a cross-cultural study comparing the British and the Greek cultures in relation to the above areas of interest. Both quantitative and qualitative methodologies are used, thus dividing the study into two parts. The quantitative section allows for comparisons between groups and subgroups of interest for a range of issues and the qualitative part enabling the exploration of meanings and constructions in relation to these issues. In the quantitave part, not only are the British and the Greek cultures compared, but differences due to gender and fertility status (fertile vs. infertile) are also examined. Attitudes to parenthood and to fertility treatments are the main focus of the quantitative study. However, a variety of demographic characteristics are also investigated in oder to revealing any possible effects of these on the attitudes measures. Well being variables were used to check whether there were any differential effects related to membership in any of the subgroups (males vs. females, fertile vs. subfertile, British vs. Greeks). Finally, the effect of social support for the subfertiles is explored in relation to nationality and gender. The support received by others was not investigated for the fertile group, since the focus of this study was the support received solely for subfertily problems.

One of the aims of the qualitative part of this study is to understand the way subfertile participants construct issues like parenthood, subfertility and fertility treatments. The content, the context and the function of the discourses are investigated in relation to the above issues. The main focus of discourse analysis is the similarities and differences between the Greek and the British cultures. However, there is particular interest in the argumentative context of these constructions, too.

The role of culture is explored in the introductory chapters, which review literature on attitudes to parenthood (Chapter One), subfertility (Chapter Two) and fertility treatments (Chapter Three). However, the number of cross-cultural studies is limited in relation to these issues, which was one of the reasons for undertaking this research. In Chapter Four, an overview is given of the theoretical background of the methodologies used, incorporating also a detailed presentation of the research goals, methods and procedures of the study. In Chapter Five, the quantitative results of the study are presented. Then follow three chapters (Chapters Six, Seven and Eight) which present the results of the discourse analysis conducted about parenthood, subfertility and fertility treatments respectively. Finally, Chapter Nine tackles critical issues of this study (e.g., contribution to current knowledge, limitations) and guides for future research.

# Chapter 1

# Attitudes to procreation, children and parenthood

## 1.1 Motivation: why are children wanted?

Recent literature has pointed out the importance of parenthood and procreation across the world (Zelizer, 1985; Jones & Brayfield, 1997; Burns & Covington, 2000). Parenthood is seen as offering a variety of benefits in one's life. True adulthood happiness, pressures outside the couple to procreate, achievement and fun are some of the main reasons given for desiring parenthood by fertile samples (Hoffman, 1975; Oakley, 1981; Fawcett, 1988; Woollett, 1991; Nicolson, 1993; Burns & Covington, 2000). These reasons were also given by unmarried, childless people (Michaels, 1988). Also, establishing close relationships with other people, expressing and receiving affection were found to be the most important reasons for wanting a child among people with no known fertility problems (Arnold, Bulatao, Buripakdi, Chung, Fawcett, Iritani, Lee & Wu, 1975; Hoffman & Manis, 1979; Michaels & Brown, 1987; Secombe, 1991).

Furthermore, infertile couples have been found to express similar motives for parenthood (Newton, Hearn, Yuzpe & Houle, 1992; Van Balen & Trimbos-Kemper, 1995; Colpin, De Munter & Vandemeulebroeck, 1998; Burns & Covington, 2000; Langdridge, Connolly & Sheeran, 2000; Van den Akker, 2001). The main reason for wanting children offered by involuntary childless couples was happiness and well being. Social pressures and the wish to live on through one's children after death

(continuity) were not found to be important for either gender (Van Balen & Trimbos-Kember, 1995). Similar findings were revealed by Colpin, De Munter and Vandemeulebroecke's (1998) exploratory study of IVF mothers. The overall parenthood motivation of IVF-mothers was quite similar to that of mothers who conceived naturally. For both groups happiness was the most important motive, closely followed by well being. It has to be noted though that in the above two studies there were no items regarding establishing close relationships with other people or expressing and receiving affection (Langdridge et al., 2000).

In Langdringe et al.'s (2000) methodologically sound study, a network analysis (interview approach) was used to explore the reasons for wanting a child by both fertile and subfertile samples. Thirty-four couples took part in this study. Ten of them were married and were expecting their first child. Ten couples were about to start receiving IVF treatment due to primary female factor infertility. The remaining 14 couples were about to receiving donor insemination treatment due to primary male factor infertility. Participants were asked to choose from the 24 reasons (see Appendix 1), presented to them on index cards, those that influenced their wish to achieve parenthood. Also, they were asked to "generate" their own reasons and to make causal links between all those reasons they had selected. Finally, they had to prioritise their selected reasons from the most to the least important.

Overall, the results indicated great similarities across the three groups. The most important reasons were the need to give and receive love and the enjoyment a child

could bring. These reasons were found to be interconnected. These results are consistent with previous research (Hoffman & Hoffman, 1973; Arnold et al., 1975; Callan, 1982; Woollett, 1991). These motives for parenthood appear to be not only the most important, but also stable over the last three decades. Emphasis was also placed on children as a common creation by both partners, referring to biological ties. Finally, no significant gender differences were found either within or across groups.

DI couples were distinguishable from the other two groups because they selected out of the 24 reasons, the "give a child a good home" reason (75 per cent endorsement). Neither of the other two groups chose this. The DI couples also gave more causal interconnections than the other two groups. This might be due to the complexity of the issues involved in conception with donated genetic material (discussed in Section 3.7).

It is worthwhile noting in this study that none of the participants chose "religion", "pressures from family", "pressures from friends", or "enhance masculinity/femininity". According to Michaels and Goldberg (1988), pressures from society seem to have a secondary role in a person's decision to become a parent. Thus, it seems that internal reasons and not external pressures are responsible for one's motivation for parenthood. It could also be that people do not want to acknowledge the influence of others, therefore they present themselves as being more in control (Deci & Ryan, 1985). More generally, presenting themselves in the best way possible, could be another explanation for this finding.

In summary, this evidence indicates that parents, potentially fertile individuals and subfertile couples seem to be supported in their desire to have children by the same predominant pronatalistic beliefs. Receiving/offering love and becoming a family constitute the most important reasons for desiring parenthood. Overall, these beliefs seem to be shared by all people across the world, regardless of gender.

## 1.2 Culture and attitudes to children

The motivation and the meaning attached to parenthood might seem universal. However, there are a variety of cultural elements involved in attitudes to children. For instance, in agrarian settings, it has been found that there are financial benefits arising from having children (Blake, 1979; Baluch, Al–Shawaf & Craft, 1992; Jones & Brayfield, 1997). Contrary to the above, in industrialized societies having children is an economic burden overall to the family (Phoenix, Woollett & Lloyd, 1991; Jones & Brayfield, 1997). However, as Zelizer (1985) puts it, children are financially worthless, but emotionally invaluable in industrialized societies.

Thus, in order to have a better understanding of the factors influencing attitudes to having children, studies that consider seriously the concept of culture are essential. The information that has been published till recently is limited (Kaufman, 1997; Yüksel & Kentenick, 1988). A worthy step was made in this field by Jones and Brayfield (1997). In their study, cultural aspects of parenthood were investigated across six European countries. Participants' mean age was 44.2 years. Men and women, both with children and without children were included in the study.

Respondents were asked to express their opinion regarding the essentiality of children in one's life by indicating their degree of agreement or disagreement with the three items that follow: i) watching children grow up is life's greatest joy, ii) a marriage without children is not fully complete and iii) people who have never had children lead empty lives. Attitudes towards the centrality of children were studied in relation to nationality, gender, age, marital status, attitudes towards women's work and family roles, religion, educational status and employment.

Traditional attitudes towards women's roles, lower levels of education and the combination of being married and living with children were the only variables that seem to be related in a universal way with favourable attitudes towards the centrality of children. The best predictor among these was attitudes towards women's work and family roles. Individuals with more liberal attitudes towards women's family roles were found to be less likely to consider children as central. In fact, women and men who held more egalitarian ideologies in this respect were more likely to experience conflicting dynamics regarding their feelings about children and parenthood.

The latter is congruent with Yüksel and Kentenick's (1988) cross-cultural study, investigating attitudes to parenthood and infertility between Turkish and German subfertile women. Specifically, it was reported that the Turkish women showed less ambivalence and usually experienced enhanced self-worth and self-confidence through childbearing. German women were, by comparison, more oriented towards their partner and career and faced more conflicting feelings regarding parenthood.

Furthermore, Jones and Brayfield (1997) found no significant effect for gender on attitudes to the centrality of children in Austria, Ireland, Italy, and West Germany. In the United Kingdom and the Netherlands women held less favourable attitudes towards centrality than men on average. Results also suggested that older individuals viewed children as more central than did younger ones, though this was not the case in Ireland and the Netherlands. Additionally, in the U.K., Italy and the Netherlands significant differences were found between religious affiliation and attitudes towards the centrality of children. Specifically, it was indicated that religious individuals held stronger views in favour of the centrality of children than the non religious individuals did.

In Austria and Germany, being under employment was found to have a negative effect on attitudes to the centrality of children. The latter effect was much stronger for men than women in Austria. In the rest of the countries, there were no significant differences between employment status and attitudes to the centrality of children, regardless of gender. Employment and occupational status did not affect either women or men's pro-child attitudes in the U.K., Ireland, Italy, or the Netherlands. Moreover, only in the U.K. never-married persons with children reported more favourable attitudes towards the centrality of children than never-married persons without children. Overall, ever-married persons and persons with children were found to view children as more central than never-married and childless individuals were.

Although the above findings suggest that there are significant differences in the way children are viewed among Western Europeans, only eight per cent of the 26 per cent of the explained variation in attitudes towards the centrality of children can be attributed to country of residence alone. Italians were found to have the strongest view for the centrality of children, while Austrians were next. The British, German, and Irish respondents had the third place and the Dutch were the last.

Although the number of the participants was large (N=6,679), we don't know if some of the participants had or were facing infertility problems. Furthermore, the dependent variable could have been measured more adequately. Specifically, more items could have been included to assess the centrality of children. Also, it should have been made explicit if the reference person for completing the scales was one's self or a generalized other. Regardless of the above methodological considerations, this study is considered as very important, because it has been the first one to look at the ways that the centrality of children varies across individuals and across countries.

Another cross-cultural study which considered a variety of sociodemographic characteristics in determining attitudes to parenthood was that of Kaufman (1997). Only men's attitudes were investigated. They were either married (N=372) or single (N=1013) and had no children. Single men were less than 45 years old. Married or cohabiting men's age was not taken under consideration, but their partners' age, which had to be less than 40 years old. American Black and Hispanic men were compared with American non-Hispanic white men. The factors tested were the stress and worry

of raising children (psychological), being able to make major purchases (economic), having time and energy for my career (career), having time for leisure or social activities (social), having someone to care for me when I am old (security) and having someone to love (emotional). A seven–point scale was used to assess the importance attributed to each one of the factors.

The results showed that all factors, except that of old age security, were considered to be quite important. Black and Hispanic men were more likely to attribute more importance to old age security than were non–Hispanic white men. This could be due to the extended family scheme that exists in Black and Hispanic cultures, which probably made these respondents to expect that their children will live with them under the same roof and will take care of them in old age. Black men were also more likely to consider love as more important in deciding whether to have a child than non–Hispanic white men. The high divorce rates among Black people may be the answer to why they look more to children for love than a wife.

Marital status was also found to have an effect on considerations. Specifically, single participants placed more importance on all the specific factors than married men did. 'Love' was the only factor considered as very important, regardless of marital status. Since married men are more likely to be getting ready to have children, it seems reasonable to be concentrating less on negative factors than men who are not married. In relation to age, younger men were more likely to consider all six factors as more important than older men were.

Results were more complicated in relation to the role of education in fertility decisions. In particular, time for career and social activities were given more importance by highly educated men than by less educated men. Having someone to love was considered to be less important in deciding whether to have children from the higher educated men than from the less educated ones. Also, the more educated men attributed less importance to economic considerations and old age security than did the less educated.

In this study, it is not clear if single men, when answering, had in their minds unmarried parenthood or a future marriage. Similarly, one cannot tell if married men replied by thinking only about themselves or in the context of their relationship with their wives. This study would be more useful if both men and women were included. Apart from the latter methodological considerations, Kaufman's (1997) study shed more light on the neglected area of male attitudes to parenthood. Furthermore, it highlighted the importance of race and ethnicity on pronatalistic ideas.

Conclusively, the limited cross-cultural empirical work on attitudes to parenthood indicates the importance of cultural factors. Jones and Brayfield (1997) suggested that mostly cultural and not so much demographic elements were responsible for the differences found among the specific Western countries. Similarly, Kaufman's (1997) work with two different subcultural groups revealed significant differences between them regarding the factors considering fertility decisions. Further research is needed

in order to explore in more depth the reasons for the differences found among nationalities and subcultural groups in relation to attitudes towards children.

## 1.3 Gender and parenthood

In this section the meanings attached to fatherhood and motherhood are studied separately. The focus is on men and women's views of having children, which of course reflect societal views.

### 1.3.1 Parenthood for women

Initially, an overview of findings is given regarding the experience of motherhood for women. The existing literature has used qualitative methodologies to investigate in depth this complex issue. Specifically, being a mother is a synthesis of both positive and negative elements for women (Hoffman & Hoffman, 1973; Oackley, 1980; Boulton, 1983; Nicholson, 1993; Berryman, Thorpe & Windridge, 1995; Letherby, 1997; Weaver & Ussher, 1997). However, the positive side is more prominent than the negative one.

Parenthood for women is conceived as a way of completing a female's identity (Wallman, 1978; Notman & Nadelson, 1982; Salmon, 1985; Busfield, 1987; Phoenix et al., 1991; Ogden, 1995). Being a mother is synonymous with being a woman (Weaving, 1984; Sandelowski, 1990; Phoenix & Woollett, 1991; Lee, 1997). Thus, it is perceived as normal that women desire children (Woollett, 1991). Motherhood is

seen as providing women with more control and autonomy over their lives than many of the jobs available to them (Sharpe, 1984). It is believed to provide a status and a positive identity (Ussher, 1989).

On the negative side, mothers may also feel that they have less status than before they had children (Ussher, 1989). A loss of identity was also described because women were putting their own needs after their children and spouses' needs (Boulton, 1983). Women having children usually feel isolated, deprived of personal freedom (Boulton, 1983; Sharpe, 1984; Backett, 1987). Being a mother involves a heavy and consequently tiring workload. This is more intense in the first year of child care (Berryman et al., 1995).

Societal views give emphasis mostly to the positive side of motherhood. They beautify the whole experience (Jones & Brayfield, 1997). This leads mothers to be less prepared for the demands of their role and sometimes to feel guilty and inadequate because they unsuccessfully try to fit with the delusional picture of happy mothers (Ussher, 1989; Coward, 1993).

Fortunately, these contradictory aspects of motherhood have been more accepted as part of social reality for the last two decades. Several studies have highlighted these aspects with the help of qualitative methods (Oakley, 1980; Nicolson, 1993; Berryman et al., 1995). All these aspects of motherhood were found in a methodologically sound and recent study conducted by Weaver and Ussher (1997). This piece of research not

only presents the negative as well as the positive dimensions of motherhood, but it also presents the complex relationship among these themes.

In particular, Weaver and Ussher's (1997) study investigated both positive and negative aspects of motherhood, focusing on the changes in women's lives with the acquisition of a child. Participants were British, white, married mothers. A discourse analytic technique (Potter & Wetherell, 1987) was employed on one–to-one semi-structured interview material.

Six themes were identified by the analysis. The first theme was motherhood as mandatory. It is referring to the powerful view that motherhood is a natural and undoubted component of womanhood. Other literature distinguishes clearly the mandatory or normative dimension of parenthood for women (Sharpe, 1984; Beckett, 1986; Woollett, 1991; Coward, 1993; Nicolson, 1993). Another theme was the myth of motherhood. This theme touches on the gap between the widely held romanticized views of motherhood and the less pleasant reality of the experience (Oackley, 1980; Nicolson, 1989; Sharpe, 1984). Thus, references made to this theme were mostly negative.

Self-sacrifice was the biggest and the most widespread theme in Weaver and Ussher's (1997) study. References to this theme have to do with the demands of child care, the responsibilities, the tiredness, the isolation imposed upon a mother and the setting aside of her needs. This theme has also been identified by other authors (Sharpe,

1984; Backett, 1987; Nicolson, 1988; Berryman et al., 1995; Daniel & Taylor, 1999). As with Boulton (1983), it was the practical aspects of motherhood that were usually described negatively. The emotional aspects were likely to be referred to positively.

Overwhelming love was a positive theme having to do with the emotional benefits of motherhood. The love and the enjoyment in the upbringing of one's child seem capable of compensating for the negative effects of motherhood. This was reported clearly by Boulton (1983). However, this theme was not used as pervasively as other themes. As Berryman et al. (1995) suggested, this could be because the positive aspects of motherhood are less tangible than the negative ones.

The 'just a mother' theme was another theme identified by Weaver and Ussher's work. A woman after having a child she was simply viewed as just a mother. Her status as a mother seemed to overshadow the rest of her personal particularities. This theme was viewed to be depreciative of a female's value. This theme has been previously identified too (Sharpe, 1984; Coward, 1993; Nicolson, 1993). The last theme that came out of the analysis was 'the real me' theme. Women reported that they had not changed as people. What had changed were parts of their lives and the way others viewed them. This theme can be seen as a reply to the negative view of women as 'just mothers'.

These results present a coherent reality, where negative and positive elements can coexist meaningfully. Weaver and Ussher's (1997) study found themes similar even with those identified in longitudinal studies (Oackley, 1980; Nicolson, 1993; Berryman et al., 1995). Finally, this specific study presented a complete and multidimensional picture of motherhood. Future research could usefully build on this by similarly investigating males, or people with subfertility problems.

Woollett's (1991) widely reported study explored the meaning attached to motherhood by involuntary childless women and women who became mothers after facing subfertility problems. It has given emphasis on the positive aspects of having children for women. Motherhood was perceived as a normative and mandatory event, which is a sign of adult female identity. Motherhood was also perceived as a way for establishing intimate relationships with one's child and with other adults (e.g., partner, wider family). It is not clear though, what methodology was followed and if the questions themselves were responsible for the positively monodimensional attitude towards motherhood of these specific subfertile women. According to Woollett (1991), such a positive stance can easily be explained by the fact that the participants of the specific study had a great desire in achieving parenthood. However, Letherby's (1997) unpublished thesis with subfertile women, pinpointed both positive and negative aspects of motherhood.

### 1.3.2 Parenthood for men

Similarly with the previous Section (1.3.1), a brief presentation is made of the experience of parenthood for men. The evidence provided came mainly from qualitative studies. Notions of parenthood for men are caught between two main models, the traditional and the modern (Clarke & Popay, 1998; Barclay & Lupton, 1999; Kaufman & Uhlenberg, 2000). The traditional model of fatherhood perceives fathers as breadwinners and disciplinarians, whereas modern fatherhood entails nurturing and caring for one's children as well (Clarke & Popay, 1998). However, these societal expectations about 'modern' fathers seem to be unrealistic and very difficult to accomplish (Barclay & Lupton, 1999). This was also addressed in the literature review conducted by Daniel and Taylor (1999) regarding fatherhood.

Although, fathers are increasingly involved and important in their child's up bringing, their role is a supporting one, complementary to that of the mother (Parke & Stearns, 1993; Kaufman, 1997). The father's role is perceived as a luxury, as an add-on extra in parenting (Clarke & Popay, 1998). The major responsibility for child care still falls on the mother (Ferri & Smith, 1995; Daniel & Taylor, 1999). Also, when men practice actively their role as fathers, they do so in a different way than mothers do (Johnson, 1988; Gerger, 1996; Clarke & Popay, 1998). Daniel and Taylor's (1999) findings suggest that fathers spend more time in joyful activities with their children and less time in domestic tasks than women do.

Consistent with the view that fatherhood is a luxury, the father role is also perceived as optional (Weaver & Ussher, 1997). Even when both partners were equally available for their children, the greater responsibility for child care remained with the mother (Boulton, 1983; Backett, 1987; Coward, 1993; Nicolson, 1993; Ribbens, 1994). Parenthood is perceived mostly as a female responsibility (Haas, 1993; Clarke & Popay, 1998; Daniel & Taylor, 1999). Fathers chose their degree of involvement regarding their child's up bringing. In Weaver and Ussher's (1997) study the majority of the women praised their husbands for being involved. It has also been reported in the latter study that fathers usually need encouragement and guidance from their partners in order to help in childcare.

### 1.3.3 The construction of fatherhood

Most of the recent studies regarding fatherhood have captured the struggle between the traditional and the modern models of fatherhood. Studies exploring the competition between these two models have adopted a qualitative methodology (Barclay & Lupton, 1999; Edley & Wetherell, 1999).

Edley and Wetherell's (1999) work was one of these studies that, by using discourse analysis, caught the struggle between the two models of fatherhood. This was a longitudinal study. About eight interviews were conducted over a period of three months. Participants were white British, middle class male students, 17 to 18 years old, with no children. They were asked to talk about their possible future lives.

All the participants saw themselves getting married, having children and getting a job. A good father was constructed as a matter of parental obligation. Also, he would be highly involved in his child's up bringing. This theme appeared most clearly when it was discussed in the context of how participants would manage being employed and child care takers at the same time. In such instances, the discourse of the father as breadwinner mostly emerged. However, the participants often resisted their alignment with the traditional father role. Even in cases of modern, egalitarian relationships, a traditional discursive construction of fatherhood was eminent. The man was perceived as the main wage earner and the woman as the major domestic and child carer.

The superiority of the traditional fatherhood over the modern notion of the father role was accomplished with the use of a variety of rhetorical strategies. One of the major ones concerned the division of theory and practice (Wetherell, Stiven & Potter, 1987). According to this strategy, ideally or in a theoretical sphere, the modern fatherhood construction was eminent. However, at a practical level, such a discourse was not able to survive.

Also, Barclay and Lupton's (1999) longitudinal study captured the two dominant discourses of fatherhood and the use of the theory/practice device. The participants were 15 Australian first-time fathers. Their experiences of fatherhood were explored with the employment of a discourse analytic technique. Semistructed interviews were employed on at least four occasions. They were conducted a few days before the birth of the first child and during the five to six months after the child was born.

Findings showed that at a theoretical/cognitive level, participants seemed to have accepted both their roles as providers and heads of the family, as well as their roles as nurturers and carers. Being involved, bonding and being there, were used in the construction of good fatherhood. Participants' fathers, who were 'absent', constituted a negative model to be followed. Similar findings were found in previous studies too (Daly, 1993; Christian, 1994; Brandth & Kvande, 1998). In practice though, such a positive construction of fatherhood was impossible to achieve. The men underestimated the disruption a baby would bring to their lives.

Only one of the participants believed that it was not 'proper' for men to be involved in child care. Most of the interviewees were prevented from doing so by the requirements of paid employment. Some were not allowed to do so by their partner. However, the few men who chose to become closely involved with their infant and the requirements of their job allowed them to do so, experienced the importance of the emotional compensations gained. Also, most interviewees reported that they were becoming emotionally and practically closer with their child after the end of the breast feeding period.

Although, there has been a great advancement in discourses concerning fatherhood at a theoretical level, in reality these ideas cannot be adopted. This is due to the powerful societal conditions and not due to men's unwillingness. Thus, Barclay and Lupton (1999) suggested that in order for men to be able to combine the traditional fatherhood with the modern role, structural and social changes are required. However,

since the majority of the findings reported in this section were based on white British/Australian samples, they are not representative of the general population. The issue of fatherhood for men needs to be investigated more cross-culturally.

## 1.4 Parenthood and the marital relationship (partnership)

Marriage and parenthood have been closely connected (Kaufman, 1997). This relationship still remains a strong one, especially in tradition-oriented individuals and societies. Also, in most religions the relationship of marriage and procreation is inseparable (Burns & Covington, 2000). However, because marriage is no longer seen by all to be a precondition to parenthood (Nock, 2000), in many studies couples were not married or even if they were, this was not always indicated (Brandth & Kvande, 1998; Barclay & Lupton, 1999; Pancer, Pratt, Hunsberger & Gallant, 2000).

The impact of having children on a couple's relationship can be negative, as well as positive. On the one hand, a limited number of studies have captured parenthood's positive effects on the relationship between a couple (Hoffman & Hoffman, 1973; Townes, Beach, Campbell, Martin & Wood, 1980; Feldman, 1981; Mason, 1993). These studies investigated motivation to parenthood. Some of them included only subfertile individuals, while others included only fertile participants. On the other hand, a growing number of studies have indicated an adverse effect (Waldron & Routh, 1981; Polonko, Scanzoni & Teachman, 1982; Belsky, Spanier & Rovine, 1983; Feldman & Nash, 1984; Callan, 1987; Weaver & Ussher, 1997; Barclay & Lupton, 1999; Pancer et al., 2000). These studies either measured psychological well being

and marital happiness from pregnancy to first parenthood, or they explored the experiences of men and women with respect to parenthood, or they compared parents with the subfertile and the voluntary childless.

Specifically, Pancer et al.'s (2000) study was one of these studies indicating an adverse effect. One of the aims of this work was to examine whether participants with more complex expectations about parenthood would adjust better to their parenting roles than individuals with more simplified expectations. Participants were 69 couples. They were assessed by interviews and questionnaires three months before their babies were born and six months after their birth. Results suggested that both parents were less satisfied with their marital relationship after the birth of their baby than before. Also, it was found that individuals with positive and simplified expectations towards parenthood coped less well with the demands of parenthood than individuals who had a more complex attitude.

Furthermore, Barclay and Lupton's (1999) work suggested that a baby brings tension to a couple's relationship. Participants, as was presented in Section 1.3.2, were first time fathers. The tension brought to the relationship by the baby was a surprise for those parents. The couples that held different views concerning fathering had the greatest tension between them. On the contrary, the couples that agreed on a set of rules regarding their parenting roles experienced the least tension. A negative impact on the marital relationship due to having children was also reported by Weaver and Ussher's (1997) study with mothers (see Section 1.3.1). According to the participants,

the demanding nature of motherhood left a limited amount of time for them to communicate and socialize with their partners. Some women experienced their relationship with their partners as another responsibility, which oppressed even further their personal needs.

Similar findings were reported by Callan's (1987) quantitative study. The psychological well being and marital happiness of mothers, voluntary childless and long-term infertile wives currently undergoing an IVF technique were investigated and compared. Mothers reported having the lowest affectionate relationship with their husbands. Mothers were found to spend less time with their partners than the infertile and the voluntary childless and they were the least satisfied with their marriage. These results though could easily be explained by the fact that the infertile couples taking part were not a representative sample of individuals facing fertility problems. They probably had very strong relationships with their husbands and happy marriages in order to emotionally survive infertility and to cope with it in an active way by pursuing a medical treatment. Similarly, intentionally childless couples willing to participate in a study presumably had a very good and fulfilling marital relationship. Without the interventions of children, voluntary childless couples have more time together to be involved in each other's activities (Callan, 1987).

## 1.5 Overview

Social ideas concerning parenthood are usually centred on its beneficial side. Positive expectations and romanticized views are the most powerful, usually overshadowing the negative side of parenthood. Although parenthood is different for men and women, these studies indicate that they both desire greatly having their children. However, neither gender is well prepared for the complex reality of parenting and thus, they face many problems. The findings indicating the negative impact of parenthood on the relationship between partners is increasing. Last, but not least, there was evidence indicating that attitudes to parenthood are largely influenced by cultural elements, which need to be explored cross-culturally in a variety of settings.

# Chapter 2

# The Experience of infertility/subfertility

## 2.1 Definitions

The term infertility is commonly used to describe the inability to conceive during one year of regular sexual intercourse without using any contraception (Benson, 1983; Keye, 2000). It has been observed that approximately 25 per cent of couples will conceive within the first month, 60 per cent within six months, and 80 per cent within one year of unprotected sexual intercourse (Keye, 2000).

Infertility is subcategorized as primary or secondary. Primary infertility is defined as the inability to conceive by a couple which has never conceived or problems with bringing a pregnancy to term (30 per cent of infertile couples). Secondary infertility refers to the failure to conceive by a couple who had previously conceived (70 per cent of infertile couples) or by a partner who had conceived with a previous partner (Keye, 2000). The term of infertility covers the terms of sterility and subfertility. However, because of the extraordinary advancement of the reproductive technologies today, there is no sterile couple. All couples are considered subfertile, meaning that they have a chance of conception, even if this means the use of donated genetic material or of a surrogate womb. In this chapter the terms infertility and subfertility will be used interchangeably.

It is estimated that 8-14 per cent of couples experience subfertility (Keye, 2000). These rates have remained the same for at least the last 45 years (Mosher, 1987; Keye, 2000). So, the impression that fertility problems are increasing is not accurate. Rather, it is the advancement of the new technologies, the arrival of greater numbers of men to the medical centers, the publicity regarding the problem of subfertility and the variety of the medical interventions that have been dramatically growing (Keye, 2000).

## 2.2 Psychogenic subfertility

Subfertility problems might be due to a physiological, an anatomical or a pathological factor (Naish, 1994; Keye, 2000). These factors will not be described in more detail in this thesis. Subfertility might be attributed: a) only to the woman, b) only to the man, c) to both of them or d) to an unknown cause. Thus, it is essential that both partners undergo medical investigation, and not only the woman, as was common practice till recently.

In spite of the rapid development of technology, the causes of subfertility are not always identifiable. Unexplained infertility causes great distress to couples, because the medical inability to trace the cause means that the couple can not be helped by a specific treatment (Hull, 1992). The rates of unexplained failure to conceive after two years of regular sexual contact are five per cent (Hull, 1992; Burns & Covington, 2000). The inability to conceive, when there is no cause found, might be a matter of luck. Couples who are trying unsuccessfully to conceive and whose diagnostic test

results are normal, have a very good chance to achieve conception without any help within three years (Hull, 1992). Unexplained infertility could also be due to an unsuccessful or imprecise diagnosis from a laboratory or a clinic. There have been cases where couples have been given a more complete diagnosis and better results in terms of treatment by a different medical center (Naish, 1994).

It is these unexplained cases that led many researchers to hypothesize that subfertility problems might be attributable to psychological factors (Noyes & Chapnick, 1964; Slade, 1981; Edelmann & Connolly, 1986; Edelmann, Connolly, Cooke & Robson, 1991). Although, some studies have indicated a relationship between psychological factors and the ability to conceive, none of them has proved a causal relationship (O' Moore, O'Moore, Harrison, Murphy & Carruthers, 1983; Harrison, O'Moore & O'Moore, 1986; Greil, 1997; Clarke, Klock, Geoghegan & Travassos, 1999).

Specifically, Harlow, Fahy and Talbot (1996) found that levels of state anxiety, prolactin and cortisol all increased during IVF, but that there was no relationship between increased anxiety, hormone concentrations and pregnancy outcome. Similarly, Milad, Clock, Moses and Chatterton's (1998) study of IVF patients investigated both psychological and physiological markers of stress and their relationship to pregnancy outcome. No association was found between psychological scores and physiological stress hormone concentrations. Also, it was suggested that psychological and physiological markers of stress were not related to pregnancy outcome among IVF patients. Thus, the hypothesis, arguing that raised anxiety levels

may lead to increased prolactin concentrations and perhaps to a reduction in conception rates, needs further investigation.

Other studies found that certain male psychological factors, like self-esteem, depression and anxiety, distinguished couples who achieved a pregnancy from those who did not (Slade, Raval, Buck & Lieberman, 1992; Stoleru, Teglas, Fermanian & Spira, 1993). Also, Kedem, Mikulincer and Nathanson's (1990) study found that infertile men have higher anxiety and more somatic symptoms than do the fertile ones. However, the above could easily be explained by the fact that infertility itself can be a significant stressor. Thus, elevated anxiety may be a consequence rather than a cause of productive failure (Edelmann et al., 1991).

It has also been suggested that infertile couples frequently conceive after adopting a child, because they 'relax'. However, some researchers, after examining the evidence, have concluded that this apparent relationship is groundless (Denber, 1978; Seibel & Taymor, 1982; McCartney, 1985). Furthermore, Steward, Boydell, McCathy, Swerdlyk, Redmond and Cohrs's (1992) well-controlled study investigated the impact of psychological counselling on infertile couples. It was expected that there would be an elevated pregnancy outcome for successfully counselled couples, if distress was responsible for infertility. However, although improved psychological test scores were found (indicating lower distress), there was no increase in the pregnancy rate of the study group compared with controls that were not counselled. Contrary to the latter, increased pregnancy rates and decline in distress were found in infertile women

that followed a behavioural treatment program, including relaxation response training and stress management (Domar, Zuttermeister, Seibel & Benson, 1992). However, a control group was not included.

Moreover, from a psychoanalytical perspective, infertility has been viewed as a female psychological problem. Women's reproductive ability has been linked to the unconscious rejection of sex roles (Abbey, Frank & Hallman, 1991; Kikendall, 1994; Miall, 1994) or to an unconscious fear of pregnancy for women (Bardwick, 1974; Stanton & Dunkel-Schetter, 1991). Also, it has been argued that a psychogenically infertile woman may unconsciously resist pregnancy due to hatred of her own mother, or even immaturity (Mozley, 1976; Christie, 1980). These studies are not able to provide a convincing account for victims of rape, comatose women, and women who clearly do not want to become pregnant but that do conceive. Involuntary childless men too were thought to have conflicted feelings about parenthood or masculinity, causing them to be infertile (Rubenstein, 1951; Belonoschkin, 1962).

Thus, as Brkovich and Fisher (1998) concluded, studies that show increased pregnancy rates had many methodological problems, such as small sample sizes and non-blinded interviews. Although since 1980s studies have become more methodologically sophisticated, no evidence of causal relationship between psychological factors and infertility has been found (Brkovich & Fisher, 1998). The majority of the studies suggested that infertile participants are more distressed than control groups, but failed to differentiate between cause and effect (O'Moore, 1983;

Harrison, Callan & Hennesey, 1987; Demyttenaere, Nijs, Evers-Kiebooms & Koninckx, 1992; Clarke et al., 1999). It might be that such cases are extremely rare, or that the complexity of the mechanisms involved has not been adequately identified. Most simply, it could be that such a relationship does not exist.

Of course, further research is needed in order to investigate the possible effect of psychological variables on failure to conceive. Future research could provide more satisfying answers by employing either longitudinal studies with participants who have not been diagnosed as infertile or well-controlled experimental studies treating psychological distress and measuring physiological markers of stress.

## 2.3 Psychological and social aspects of infertility

A plethora of studies have investigated the way infertility can cause psychological problems. It has been found that the experience of infertility can affect well being, relationships with partners and with others (Mahlstedt, 1985; Greil, Porter, Leitko & Riscilli, 1989; Greil, 1991; Woollett, 1991; Tarlatzis, Tarlatzis & Diakogiannis, 1993; Odden, Tankelaar & Nieuwenhuyse, 1999; Singer & Hunter, 1999). The existing studies suggest that infertility is a difficult experience in a variety of cultural settings. Of course, it might be more (or in different ways) difficult in some cultures than in others.

However, it was just in 1999 that the first cross-cultural piece of work was published (Odden et al., 1999). Until recently, the appearance of cross-cultural studies or of

different studies following the same methodology across cultures was almost non-existent. However, the influence of culture is evident throughout the existing literature. Furthermore, there is evidence suggesting that the experience of infertility is not all negative.

### 2.3.1 Psychological effects of infertility

Infertility is perceived as a real threat to one's identity (Olshansky, 1987a; Olshansky, 1987b; Greil, Leitko & Porter, 1988; Greil, 1991). It has been found that the experience of infertility may create feelings of shame, failure and loss (Greil et al., 1989; Singer & Hunter, 1999). Furthermore, the experience of infertility is characterized by a sense of role failure and feelings of defectiveness, especially for women (Valentine, 1986; Mahlstend, MacDuff & Bernstein, 1987; Papreen, Sharma, Sabin, Begum, Ahsan & Bacui, 2000).

The involuntarily childless may feel guilty and inadequate about not meeting role-related expectations concerning parenthood and feel unfeminine and unmasculine (Rosenfeld & Mitchell, 1979; Kraft, Palumbo, Mitchell, Dean, Meyers & Wright - Schmidt, 1980; Van Hall, 1984; Mahlstedt, 1985). Edelmann, Humphrey and Owens (1994) found that infertile men experienced a lot of guilt over the perceived inability to prove their manhood. Miall (1994) also found that infertility for men seem to concern their status as men or as sexual beings.

Subfertile persons may feel sexually inadequate, even if they do understand intellectually that fertility and sexuality are independent matters (Mazor, 1980; Pfeffer & Woollett, 1983; Miall, 1986; Dunkel-Schetter & Lobel, 1991). They are also likely to feel sexually unattractive (Rosenfeld & Mitchell, 1979). The involuntary childless may feel that they are prematurely old, alternatively, or they may worry about not being able to become real adults (Mazor, 1984; Mahlstedt, 1985). Guilt, self-accusation, and low self-esteem may be suffered by the infertile person (Freeman, Garcia & Rickels, 1983). Self-esteem is more specifically implicated in reactions to infertility in males (Raval, Slade, Buck & Lieberman, 1987).

It has to be noted that the majority of the studies investigating the psychological effects of infertility used American and English samples. An exception was Tarlatzis et al.'s (1993) study, which used a Greek sample. In this study, it was reported that the Greek participants' initial reactions to the news of infertility were denial and surprise. Guilt and anger superceded these emotions. Guilt was reported by 52 per cent of women and 33 per cent of men and anger by 43.5 per cent of women and 33 per cent of men. Participants' most intense loss was that of parenthood, followed by the loss of love giving, while the least important was the loss of social approval. Tarlatzis et al.'s (1993) study can only give us some preliminary findings on Greeks' responses to infertility. The sample size was small, especially for the male spouses (N=69 for females, N=18 for males). Thus, as the authors suggest, we can not really look into gender differences. Furthermore, the reply rate was not indicated.

In addition to emotional responses noted above, feelings of loss of control and attempts to regain it were reported by the infertile (Woollett, 1985; Mahlstedt et al., 1987; Becker, 1994). In particular, infertile women were likely to feel that they had lost control of their lives and that they had to confront a situation that made no sense to them (Matthews & Matthews, 1986). Thus, while both husbands and wives asked 'Why me?', wives were more likely to let infertility take over their lives than men were. Although most respondents asked, 'Why me?', few were able to arrive at satisfying answers (Greil et al., 1989).

Even religious beliefs did not seem to be used as an important source of meaning for subfertile individuals (Greil et al., 1989). Many couples, though, perceived infertility as a punishment from God (Spring, 1988) and reported that their faith had been shaken (Devor, 1994). For others, religious beliefs helped them to view infertility as 'God's will' or a 'test of faith' (Miranda, Larrazabal & Laban, 1995). Apart from the difficulty of dealing with infertility at the level of meaning, the elements of statuslessness and ambiguity characterize the experience of infertility (Sandelowski, 1987; Greil et al., 1988; Sandelowski, Harris & Holditch-Davis, 1989; Greil, 1991; Sandelowski, 1993).

To be more specific, it is evident from qualitative studies that the status of infertile persons' situation might be unclear (Letherby, 1997). Depending on the context, some view their situation as a problem and others do not. It was found that subfertile couples had difficulty in labeling the situation as a problem especially when they were

still at the stage of medical investigations. Also, the participants did not make references to themselves as fertile or infertile, but as not being able to conceive (Jones & Hunter, 1996).

### 2.3.2 Culture and infertility

As was mentioned in Section 2.3, cross-cultural research in the area of infertility is limited (Ericksen & Brunette, 1996; Kazantzidou & Levine, 1996; Olsen, Basso, Spinelli, Kuppers-Chinnow [& the European Study Group on Infertility & Subfecundity], 1998; Odden et al., 1999). Consequently, the number of published studies on the psychological effects of infertility across a number of cultural settings is even smaller (Kazantzidou et al., 1997; Odden et al., 1999).

Odden et al. (1999) conducted a well-controlled study that investigated the psychosocial impact of infertility across different national groups. It took place in France, Belgium and the Netherlands. Unfortunately, this study was limited to the study of female subfertile persons. The questionnaires used were the self-administration type.

Results indicated that, although the mean score for depressed mood among patients (0.31) was below the cut-off point of 0.43 for depressive disorders (Hunter, 1992), 24.9 per cent of the patient group had a score indicating such disorders (20.3 per cent of the Belgian patients, 26.1 per cent of the Dutch patients and 27.7 per cent of the French patients) as compared with 6.8 per cent of the controls (6.9, 4.0 and 11.8 per

cent respectively). The control group consisted of women who did not have any fertility problems. These group differences were statistically significant for each one of the national groups. There were no statistically significant differences between patients and the control regarding anxiety disorders.

Somatic symptoms, anxiety/fears, sleep problems, difficulties with memory/concentration and feelings of lost attractiveness were more intense (greater) among French women (both patients and controls) than among Belgian or Dutch women. However, in all three countries the same differences between patients and controls were detected. Overall, patients were found to have greater problems than the controls.

Also, Kazantzidou et al.'s study (1997) examined the effect of nationality and gender on attitudes to infertility between British and Greek men and women with no known fertility treatments. Ninety-two Greek and seventy-eight British participants completed a questionnaire with open-ended and closed-ended questions. There were roughly equal numbers of men and women in the two national groups. Results indicated that British participants perceived infertility in a more negative way than did the Greek ones. No gender differences were found either between or within the national groups in relation to the latter.

Furthermore, the British participants appeared to know more about infertility than did the Greek participants and in both countries men were less well-informed than were

women. There were indications in the data that for the Greek participants parenthood (and infertility) had primary significance in the context of the extended family life. For British participants, personal identity and life style choice were more dominant themes. Also, Greeks were more likely to choose seeking treatment as a way of responding to finding out that they were infertile than were the British.

### 2.3.3 Gender and the response to subfertility

Gender differences in emotional responses to infertility have been reported in a number of studies. Wright, Allard, Lecours and Sabourin (1989) concluded that women tended to report more distress than did men. Link and Darling (1986) found that 40 per cent of women and 16 per cent of men had scores indicative of clinically significant depression. Harrison, O'Moore, O'Moore and Robb (1984) reported higher state anxiety scores for women but not for men in infertile partnerships, when compared with control groups. Also, Suarez and Gallup (1985), from a sociobiological perspective, argued that the greater commitment of women to procreation will also make them more vulnerable to depression as a consequence of reproductive failure.

Several authors suggest that men tend to under report and conceal their psychological distress. This might be responsible for the observed gender differences (Harrison et al., 1984; Lalos, Lalos, Jacobsson & von Schoultz, 1985a; Harrison, O'Moore & O'Moore, 1989; Lasker & Borg, 1989; Berg & Wilson, 1990). Furthermore, it was found that involuntary childless men report general rather than infertility-specific

distress. Abbey et al.'s (1991) study suggested that men worry more about home life issues, one of which is their wives' distress regarding their fertility problem. This may also hint a more diffusing impact that infertility has on men (Stanton, Tennen, Affleck & Mendola, 1991). Thus, Oldinger (1988) concluded that it may be the man who is most affected psychologically by childlessness.

Furthermore, research on coping strategies has shown that women deal differently with chronic stress. In particular, women tend to ruminate about it and this can exacerbate depressive reactions, while men repress and deny the problem by remaining active (McEwan, Costello & Taylor, 1987; NolenHoeksema, 1987). What is more, women are more likely to reveal their fertility problem to others than are men (Hjelmstedt, Andersson, Skoog-Svanberg, Bergh, Boivin & Collins, 1999).

Moreover, women's more open expression of feelings and greater involvement in social and recreational activities agree with suggestions that they may seek emotional and social support in their milieu, while men cope with infertility through greater involvement in work-related activities (Newton, Hearn & Yuzpe, 1990). Arguably, evidence suggesting that women or men are more distressed by infertility than persons of the opposite gender may not be peculiar to infertility, but to more general gender differences in response to stress (Abbey et al., 1991; Edelmann & Connolly, 1994).

Interestingly, Edelmann and his colleagues (1994), in a study conducted with subfertile couples mainly due to a male factor fertility problem, found that distress was

associated with femininity and motherhood for women and with masculinity and fatherhood for men. Overall, it seems to be the case that both men and women react negatively to infertility, but they do so for different reasons (e.g., Kazantzidou & Levine, 1996). For men this may be due to the link between infertility and virility (Callan, 1982), but for women the link is between infertility and motherhood (Miall, 1985).

### 2.3.4 Marital relationships/partnerships and infertility

After finding out about infertility, some marriages or partnerships do not survive. It is interesting to note that in Egypt the word "couple" does not exist. A 'family' cannot be if there are no children. Thus, those who marry and remain childless have no recognized existence; they are a social aberration (Inhorn, 1996). Also, in McWhinnie's (1992) study with British subfertile participants the suggestion that the fertile partner should seek another partner was almost always raised directly or indirectly. Tarlatzis and his colleagues (1993) in a study conducted with Greek participants reported that infertility seems to have caused marital problems in 19.25 per cent of the participants, whilst nine per cent of the participants were even considering divorce.

Another possible damaging consequence of infertility has to do with couples' sexual life. Studies suggest that the sexual relationship is particularly likely to suffer during the diagnosis and treatment of infertility (McGrade & Tolor, 1981; Goodman & Rothman, 1984; Keye, 1984; Mahlstedt, 1985). Lalos et al. (1985b) reported both

deterioration in feelings for each other and in sexual satisfaction over a two-year period following surgery for tubal dysfunction. Odden et al.'s (1999) study found that the frequency, spontaneity, satisfaction, interest and pleasure regarding subfertile women's sexuality from three different countries were all lower than in the control group. This may occur partly because different coping strategies, which may cause alienation between the partners (Mahlstedt, 1985). Some individuals may need more privacy than their partners in order to cope with the infertility. As a consequence, one of the partners may feel betrayed (Goodman & Rothman, 1984).

It has also been found that which partner is the primary cause of infertility influences the way couples deal with infertility and its treatment (David & Avidan, 1976; Berger, 1980; Mazor, 1980). When one partner is identified as the one responsible for the infertility, the more fertile partner, even if s/he seems concerned and supportive, may be suppressing other feelings of anger and resentment. The infertile partner may feel guilty and fear abandonment by his or her partner (Mazor, 1984). It seems that both partners may repress their conflicting feelings in order to maintain a sense of unity (Goodman & Rothman, 1984).

However, other studies suggest that whichever of the partners has the reproductive impairment does not affect the response to infertility (Bell, 1981; McEwan et al., 1987; Raval et al., 1987; Snarey, Son, Kuehne, Hauser & Vaillant, 1987; Bernstein, Mattox & Kellner, 1988; Connolly, Edelmann & Cooke, 1992; Morrow, Thoreson & Penney, 1995). It has also been suggested that female factor infertility leads to higher

rates of sexual inadequacy for men (Kedem et al., 1990). Other reports suggest that a diagnosis of male infertility may be more damaging for the couple concerned than a diagnosis of female infertility (Owens & Read, 1984; Connolly, Edelmann & Cooke, 1987; Slade et al., 1992). Furthermore, two studies indicate that unexplained infertility correlates with higher sexual dissatisfaction in couples (Daniluk, 1988; Jones & Hunter, 1996). So, the literature is unclear with respect to this issue.

On a more positive note, Raval et al. (1987) suggested that infertility might be beneficial for a couple's relationship. Some studies have found that a couple's relationship may improve by sticking together in order to face the difficulties of their shared problem (Leiblum, Kemmann & Lane, 1987). Callan (1987) found that infertile women reported more loving marital relationships. They were generally more satisfied with their marriage than were mothers and the voluntarily childless. It has to be noted though that the infertile women in Callan's study were members of a support group for couples following IVF.

Conolly et al. (1987) also found that the infertility experience served to protect and support the relationship. Others found that there was no difference in relationship satisfaction in comparison with fertile controls (Raval et al., 1987; Daniluk, 1988; Wright, Duchesne, Sabourin, Bissonette, Benoit & Girard, 1991; Benazon, Wright & Sabourin, 1992; Connolly et al., 1992; Slade et al., 1992). In fact, infertile couples may be closer and happier than fertile couples (Callan & Hennessey, 1989; Downey & McKinney, 1992).

Even in Tarlatzis et al.'s (1993) study, that reported sexual dysfunction and marital problems, most of the participants indicated having a very close and understanding relationship too. Furthermore, in the cross-cultural study conducted by Odden et al. (1999) both positive and negative influences were reported regarding participants' relationship with their partner. Although, subfertile women claimed to have less satisfying relationships with their partners than the control group, they also reported closer relationships. We have to keep in mind that the groups studied are those whose marriage has survived the stress of infertility and who proceeded to treatment.

In relation to the attribution of 'blame' within a relationship, Miranda et al.'s (1995) study looked at the psychosocial impact of infertility on Hispanic women and found that they often held themselves responsible for the infertility. These women protected their male partners from dealing with social stigmatization, even when it was evident that male factors were involved. Also, in most African countries, women bear the responsibility for infertility, even if it is known that male factors are involved. It is hard for African men to admit to any type of disability or illness, because it is viewed as a sign of weakness (Molock, 2000). Papreen et al.'s (2000) study in Bangladesh found that infertility is particularly attributed to women. The same was indicated in studies conducted in Australia, China, Israel, Canada and India (Rowland, 1985; Chan, Tsoi, Hoy, Wong, So & Ho, 1989; Carmeli & Birenbaum–Carmeli, 1994; Neff, 1994).

Overall, it seems that this tendency of placing responsibility on women regarding infertility is universal. Infertility places women at risk of social displacement, and

women clearly bear the social stigma of infertility. Women tend to present their partners' problem of infertility as theirs, in order to prevent their partners from being exposed to the social outcry (Rowland, 1985; Carmeli & Birenbaum-Carmeli, 1994). Women might act like this in order to save their husbands' face vis-a-vis relatives and friends (Rowland, 1985).

### 2.3.5 Others, subfertility and social support

Involuntarily childlessness is likely to cause problems in subfertile couples' relationships with significant others. To be more specific, several studies have identified feelings of alienation from the 'fertile world' (Lalos et al., 1985b; Valentine 1986; Sandelowski & Jones, 1986; Sabatelli, Meth & Gavazzi, 1988; Greil 1991). Involuntarily childless couples might feel socially stigmatized (Miall, 1985; Sandelowski & Jones, 1986; Miall, 1989; Sandelowski et al., 1989; Greil, 1991; Whiteford & Gonzalez, 1995). Thus, many exclude themselves from gatherings where children would be present. Many avoid their pregnant friends in order to avoid feelings of personal deficiency (Miall, 1986).

In Tarlatzis et al.'s (1993) study it was also indicated that the Greek participants usually did not talk to others about their problem, except their immediate family. They felt that they did not want to share their personal problem because it was sexual, because they feared unsolicited advice and mostly because they did not want to be subjects of pity. However, it was found that despite the social unacceptability of

childlessness only nine per cent of the women and none of the men reported that they isolated themselves from places where children were found.

Odden et al. (1999) suggested that patients awaiting or being prepared for treatment were more likely than the fertile controls to discuss their attempts at getting pregnant with significant others. The control group was asked about their attempts prior to their first pregnancy. The most frequently mentioned persons chosen for discussion, other than the partner, were best friends, followed by siblings and mothers. The patients felt more supported by their partners than the controls did, although they were less likely to talk to their partners about the unsuccessful attempts to become pregnant than was the control group. When patients were specifically asked whether, at the time of the survey, it was easy to discuss their problems, 46 per cent mentioned that talking about children was difficult for them and 53 per cent indicated that other people, not themselves, were hesitant to talk about children with them. Moreover, 84 per cent of the patients reported being envious of people with children.

Furthermore, it was suggested that involuntarily childless women often have to struggle with finding ways to elicit support from their friends and family members, without risking further pain and rejection (Daniluk, 1996). Callan and Hennessey's study (1988) suggested that Australian women were dissatisfied with others' reactions although they realized that others had good intentions. For example, many women were told that they were lucky for being childless, because having children would affect their lives in a negative way. Although the aim of such comments was to make

the subfertile person feel better, the outcome was quite the opposite. It was also reported that subfertile persons might become annoyed and angry through insensitive remarks, teasing and pressure put on them to reproduce by relatives or friends (Menning, 1980).

In Letherby's (1997) work there are accounts of infertile persons indicating that many people are less than understanding when they are told of someone's inability or problems in achieving parenthood. Involuntarily childless women felt that other people viewed their position as pitiable. For example, a female participant said: "I want people to understand not to pity me" (p.145). However, both male and female respondents felt that the response of many people (usually men) towards male infertility was less likely to be one of pity and more likely to be one of amusement and hostility.

Miall (1994) also found that men were more likely to be ridiculed or devalued than women if they revealed their fertility problem. Also, according to Karow (1982), infertile women are offered emotional support and consolation by society, while the infertile man becomes "a target of ridicule". It appears that within the marital relationship, women report that they provide more support, and are more satisfied with the support they receive than are their husbands (Abbey et al., 1991; Beaurepaire, Jones, Thiering, Saunders & Tennant, 1994; Abbey, Andrews & Halman, 1995). This finding is surprising, since it is women, who usually are held responsible for infertility, even when it is clear that there are male factors involved.

Additionally, Miall (1994) and Wasser, Sewall and Soules (1993) suggested that the support functions provided by interpersonal relations may exacerbate rather than alleviate the distress associated with infertility. Involuntary childless respondents' perceptions of community constructions contribute to their stress. Abbey et al. (1991) reported that friends and family members' ideas about what may help individuals through crises might not be accurate. If significant others misunderstand their loved ones' needs, then they are more likely to behave in ways which are not perceived as supportive.

The social constructs of infertility held by others may influence, in a negative way, their capacity to act as social supports for childless couples (Miall, 1994). Moreover, significant others may recommend solutions which are perceived as stigmatizing (e.g., instructing them in matters of sex and reproduction) and behave in ways that are considered unsupportive (Abbey et al., 1991). From the above, it can be concluded that social factors are a significant component of the overall distress associated with infertility (Abbey et al., 1991; Wasser et al., 1993; Miall, 1994).

According to Mahlstedt and Johnson (1987), significant others have to be in a position to understand the couple's needs and the losses associated with infertility in order to be able to provide support and not discomfort to the couple. Social support may act as a buffering mechanism between stress and health (Coburn & Eakin, 1993). Sherbourne and Hays (1990) have concluded that interpersonal relations provide a variety of support functions. These include emotional support, solutions to problems

through information, guidance or feedback and appraisal support, which involves information relevant to self-evaluation. Also, it has been suggested that non-directive social support might be of great help to sufferers of pregnancy loss (Rajan & Oakley, 1993). Thus, it might be best to let the subfertile individual guide others in relation to the support needed. Consequently, a sense of control and self-confidence is cultivated.

## 2.4 Overview

Infertility is an extremely stressful experience with medical, social and psychological dimensions. It is a socially constructed reality with mainly negative effects on one's well being. The dominant pronatalistic stereotypes require infertile couples to redefine their identities as individuals, as partners and as members of social groups. Both men and women are affected by the experience of subfertility, although they respond to it in different ways. Social norms also seem to be more accepting of female infertility than of male infertility. Cultural norms have a tremendous impact on the meaning attached to infertility by subfertile couples and significant others. Thus, the limited number of cross-cultural studies in this area needs to be expanded.

# Chapter 3

# Attitudes to reproductive technologies

## 3.1 Traditional versus new technology solutions to subfertility problems

The sociocultural context influences considerably subfertile individuals' efforts towards achieving parenthood. For instance, in industrialized countries medicine is a powerful tool for dealing with subfertility. In more primitive cultures though, spiritual healers and practitioners are presented as solutions to subfertility (Molock, 2000; Yebei, 2000). In this thesis, medical treatments are one of the main objects of study. However, it is essential to look briefly at other ways for dealing with fertility problems preferred by different populations.

Specifically, Yebei's (2000) study, with migrant Ghanaian women in the Netherlands, suggested that male infertility was kept a secret. In order to deal with the husband's inability to get his wife pregnant, a third person performed the task of acting as a 'donor'. This person would be somebody from the couple's extended family, a healer or a priest. Yebei also found that Ghanaian women, who did visit a medical setting for their fertility problem, faced difficulties in communicating with the staff due to cultural differences and language limitations. Bornstein (1995) indicated similar difficulties faced by Hispanic families living in the States.

In rural Malaysia, infertile women consult spiritual mediums that enter a trance and speak to the spirits on their behalf. In South Africa, even the practice of polygyny was adopted as a way of dealing with female infertility (Gbadegesin, 1993). Infertile women were also encouraged to informally adopt a child of a relative. A less common approach to infertility is coming to terms with it, without taking any further action. In Native American communities, for example, accepting childlessness is in accordance with their philosophy, while pursuing treatment is not well accepted (Molock, 2000).

A different attitude to dealing with infertility is usually adopted by westernized populations, where reproductive technologies are widely accepted and powerful. Industrialized societies could be referred to as treatment-oriented, since the variety of treatments available is often the first option chosen to solving involuntary childlessness. Stepparenthood is another way of dealing with involuntary childlessness. It is not considered though as an excellent opportunity for parenting since the biological mother cannot usually be replaced in children's hearts and minds (Sewall, 2000). Thus, for establishing a good relationship stepmothers have to play other significant roles, other than that of a mother (Lang, 1991). Although, these relationships may not be the same as those of biological parenthood, they can be exceedingly warm and rewarding (Hafkin & Covington, 2000). Adoption is a popular solution, although in western societies it is seen as the second best option to 'treat' childlessness after the unsuccessful use of reproductive technologies (Halman, Abbey, Andrews, 1992; Grand, 1997; Van Den Akker, 2001).

Although reproductive technology is regarded favourably, not all treatments have the same standing. In some cultures, certain medical techniques are seen to be less favourable or even unacceptable, causing cultural conflicts. Religion is one of the factors that have a catalytic role on attitudes to treatments. Specifically, most of the religions are positive to all kinds of fertility treatments except ones using a donor's genetic material. However, there are religions that are more conservative in their attitudes towards the new reproductive technologies. For instance, Roman Catholicism favours only drug treatments and gamete intrafallopian transfer (GIFT)[1]. Although, the latter treatment has many similarities with IVF, it is distinguished from IVF because fertilization takes place in the woman's body and not in vitro.

Also, the guidance of the priests and pastors might influence western, religious individuals' choices either positively or negatively towards reproductive technologies. This depends on the spiritual leader's personal standing on issues like adoption, childfree living and medical treatments (Molock, 2000). Although the cultural influences on attitudes to fertility treatments is intriguing, the number of cross-cultural studies in this area is limited (Yüksel & Kentenich, 1988; Olsen et al., 1998; Odden et al., 1999).

[1] Eggs are collected from the ovary and are transferred back to the fallopian tube soon after collection, together with a small sample of sperm.

## 3.2 Psychosocial reactions to the treatments

As was mentioned in Section 3.1, the main purpose of study in the present research concerning solutions to subfertility comes from the medical perspective. In this section, the psychosocial experiences of subfertile couples undergoing a medical fertility treatment are presented. Initially, an overall picture of the treated subfertile patient is given, as was successfully captured by Olshansky (1988). The primary aim of Olshansky's study was to explore individuals' and couples' experiences of infertility. However, a secondary analysis was employed on seven of the couples that were pursuing a medical treatment, focusing on their perceptions of reproductive technologies. Each spouse was interviewed separately and five couples were also interviewed together in order to address their personal and common experiences as a couple. A total of 19 in-depth interviews were analyzed based on grounded methodology (Glaser, 1978; Strauss, 1987). Six themes emerged from the analysis.

The first theme was drivenness. This refers to the intense need most couples have to use all the options available to them in relation to reproductive technologies. Even in cases where they might be ambivalent about electing a new treatment or an extra attempt, they might continue their pursuit in order to be sure they had tried everything. This drive to continue with fertility treatments appeared to prevent couples from moving on with their lives. In fact, 'difficulty getting on with life' was the second theme that was identified by Olshansky's (1988) analysis. Possibilities such as alternative parenting or a child-free life were hard to accept since the pressures placed on subfertile couples by the medical establishment are powerful. The health care

settings were dominated by the attitude that the only success is a baby (Pfeffer, 1987; Sandelowski, 1990).

Directly connected with the first two themes is the next theme: exacerbated cycles of hope and despair. This theme is the most important and interesting of those having to do with the psychological well being of patients of medical fertility treatments.

The hope/despair cycle has been reported extensively in the existing literature (Meyers, Diamond, Kezur, Scharf, Weinshel & Rait, 1995; Mori, Dadaoka, Morioka & Saito, 1997; Weaver, Clifford, Hay & Robinson, 1997; Schmidt, 1998). Several studies suggest that patients undergoing fertility treatment become progressively less hopeful regarding a prospective pregnancy across attempts (Callan & Hennessey, 1988; Blenner, 1990).

Although participants' degree of hope is being elevated across attempts, they continue their pursuit to biological parenthood. Consequently, they deprive themselves of coming to terms with the losses involved in every unsuccessful trial by not taking the time to grieve and heal the emotional wounds. Arguably, women following an advanced reproductive treatment (e.g., IVF related techniques) experience a non-conception as similar to an early miscarriage (Greenfeld, Diamond & DeCherney, 1988; Lasker & Borg, 1989; Weaver et al., 1997). The distress and disappointments accompanying the negative outcome of the treatment can not be dealt with properly. The loss is minimized or even denied with the renewal of hope that derives from a future attempt. According to Tyler (1995), these unresolved losses put one's

psychological health at great risk. Other researchers have also suggested that the more the treatment goes on without success, the more patients face the risk of developing clinical depressive symptomatology (Beaurepaire et al., 1994; Odden et al., 1999).

An extra risk factor concerning the subfertile couples' health is the financial stress caused by the pursuit of advanced fertility treatments. This is another theme suggested by Olshansky (1988). Couples were pressurized by the economic aspect of their pursuit of parenthood via medical treatments. Thus, more burden was added to that already experienced by the subfertile couple (Mao & Wood, 1984; Tarlatzis et al., 1993).

A different theme arising from Olshansky's (1988) analysis was marital and sexual disruption. The pursuit of fertility treatments was found to cause difficulties in the marital and sexual life of the couple. Of course, such an effect is not surprising, considering the other stresses imposed on the subfertile couple. A couple's relationship may be viewed as a failure. Decisions regarding which treatment to follow might bring great tension to a couple, especially when there is disagreement. One of the partners may agree to a specific treatment only to please his/her partner (Olshansky, 1988).

However, the overall picture suggested by the existing literature about the effect of treatments on a couple's relationship is conflicting. There are studies that agree with

Olshansky's findings, indicating that fertility treatments put a strain on marriage (Mori et al., 1997; Tarlatzis et al., 1993). This strain was found to increase the longer the couple was involved with fertility treatments and after extensive unsuccessful attempts to achieve parenthood (Benazon et al., 1992; Leiblum et al., 1998). Most of these studies though had methodological problems, such as the inadequate sample sizes.

A smaller number of studies reported contrary findings to those reported above. Specifically, Raval et al. (1987) reported that marital problems which appeared with the diagnosis of infertility subsided after the initiation of infertility treatment. Raval et al. suggested that any negative influences of investigation may be outweighed by the positive feeling that action has been initiated. However, this could have been due to the short period of intervention studied in this report. Particularly, the mean duration of clinic attendance was only seven months. Results could have been different after longer interventions. Schmidt (1998) also found that the treatment process brought some of the participants closer together as a couple. Unfortunately, the duration of clinic attendance was not indicated in Schmidt's study.

Findings regarding the effect of fertility treatments on a couple's sexual life is more congruent than the results concerning the couple's marital life. Overall, studies suggest that the sexual relationship is particularly likely to be negatively affected during the diagnosis and treatment of infertility (Drake & Grunert, 1979; McGrade & Tolor, 1981; Goodman & Rothman, 1984; Keye, 1984; Eunpu, 1995; Mahlstedt, 1985;

Schmidt, 1998; Odden et al., 1999). Most couples experience a loss of pleasure in sex when they have sex only for reproductive purposes. This attitude often takes over in the partnership and causes the couple to avoid or reduce the frequency of sex (Kemeter & Fiegl, 1989). Leiblum et al. (1998) also reported that infertility treatment has been shown to affect sexual desire, frequency and satisfaction for many couples. Only Schmidt's (1988) qualitative study suggested that for some participants infertility treatment helped them start enjoying their sexual relationship as they did before they experienced infertility. They reported feeling relieved because, while they were undergoing treatment, the doctors had responsibility for 'producing' a pregnancy.

'Uniqueness of responses' is the last theme that came out of Olshansky's (1988) analysis. This theme refers to the uniqueness of every person's response, depending on the personal meaning they attributed to the infertility and the treatment. Gender physiologic causes of infertility seem to influence participants' responses. Factors like gender and treatment related characteristics (e.g., stage of treatment) were investigated more extensively by several studies from a quantitative perspective. For instance, oocyte retrieval was found to be associated with more physical distress in women than men (Leiblum et at., 1987; Boivin & Takefman, 1995). Additionally, women were found to be more likely than men to seek support from family and friends during treatment (Baram, Tourtelot, Muechler & Huang, 1988; Boivin et al., 1998a).

### 3.3 Treatment stages and patients' psychological status

The stage of treatment has been found to be an important factor affecting subfertile patients' psychological well being (Mori et al., 1997; Weaver et al., 1997; Boivin et al., 1998a). The most frustrating periods reported by the patients were those in which they had to wait for a specific development, for example, waiting for results or for eggs to develop (Mori et al., 1997; Weaver et al., 1997).

Additionally, Boivin et al. (1998a) suggested that both partners recalled the two week waiting period and the beginning of menstruation (or a negative pregnancy test) as having been the most stressful stages of IVF. Similar results were reported by other studies (Baram et al., 1988; Newton et al., 1990; Connolly, Edelmann, Bartlett, Cooke, Lenton & Pike, 1993; Slade, Emery & Lieberman, 1997). Furthermore, women reported great discomfort produced by ovulation suppression or ovum retrieval. Men's major worry was the production of a sample (Mc Grade & Tolor, 1981; Carmeli & Birenbaum - Carmeli, 1994; Boivin et al., 1998b). Some men were worried that they would not be able to perform at the requested time. Thus, men in some cases were allowed to bring a sample from home.

### 3.4 Opinions regarding subfertility treatments

The existing studies addressing the psychological meaning of treatments asked couples' opinions about specific attributes of one or two treatments (Lalos et al., 1985b; Stauber, Maassen, Spielmann & Dincer, 1985; Wallace, 1985; Callan & Hennessey, 1986; Fagan, Schmidt, Rock, Damewood, Halle & Wise, 1986; Johnston,

Shaw & Bird, 1987; Blaser, Maloigne-Katz & Gigon, 1988; Chan et al., 1989). Shiloh, Larom and Ben-Rafael's study (1991b) was one of the limited number of studies (Shiloh, Larom, Ben-Rafael & Mashiach, 1991a; Grand, 1997), which concentrated on information about infertile couples' cognitions regarding a range of treatments. Additionally, its methodological soundness made Shiloh et al.'s (1991b) follow up study a valuable piece of work.

Specifically, Shiloh and her colleagues (1991b) tried to explore in depth infertile couples' cognitions regarding a variety of treatments. This study was based on the findings of the study conducted earlier by the same authors (Shiloh et al., 1991a). The latter study elicited directly, and without a priori assumptions, infertile couples' cognitions regarding a variety of treatments. It was found that perceptions of treatments for infertility can be described as profiles along 15 perceptual dimensions (see Appendix 2). In this research the 15 descriptive scales emerged from a pilot study in which 10 patients undergoing in-vitro fertilisation and 10 non patients reported their free associations, opinions and worries in relation to 10 infertility treatments. The 10 treatments were: medical treatment for females (ovulation induction), pelvic reconstruction surgery, intrauterine manipulation, medical treatment for males, surgery for males, artificial insemination with husband's semen, artificial insemination with donor semen, in-vitro fertilisation with husband's semen, in-vitro fertilisation with donor semen and surrogacy. It has to be noted that each treatment was followed by a couple of sentences explaining the procedure.

The purpose of the follow–up study conducted by the same authors (Shiloh et al., 1991b) was to determine how infertility treatments were perceived and the cognitive structure underlying their perception. One hundred women took part in Shiloh et al.'s (1991b) study. Half of them were IVF patients with no children, while the other half was composed of fertile women who had at least one child of their own. It was hypothesised that the perceptions of treated women would be more positive than those of the fertile women. The ten treatments for infertility had to be evaluated along the 15 bipolar scales describing psychosocial features (Appendix 2). Each dimension was presented as a 13-point Likert scale.

Results of MANOVA between fertile women and infertile women for each of the 10 treatments showed that there were no differences found between the two groups in any of the male-centered treatments or treatments involving donors. This may indicate that only actual personal experience (as with the female-centred treatments) influences attitudes to treatments. In contrast, there were significant differences in all of the five female-centered procedures. Specifically, in the five female-centered treatments, patients perceived treatments more positively than non-patients did. Results also showed that the most important dimension differentiating between the groups was that treated women perceived social exposure as a more salient feature of the treatments, whereas fertile women were more concerned with the potential risk to the fetus.

On the one hand, infertile women's perception of social exposure can easily be explained by the traumatic social experiences regarding their childlessness. Most of

them try to hide their problem. Thus, they isolate themselves in order to avoid embarrassment. On the other hand, fertile women because of their clear image of a child and of their roles as mothers are more concerned with the health of the fetus than infertile women are. Moreover, the finding that infertile women underestimate the risks of the treatment can be explained by the positive attitude that patients adopt in order to be able to cope with the demands of the treatment (Callan, Kloske, Kashima & Hennessey, 1988; Callan & Hennessey, 1988; Johnston et al., 1987; Woollett, 1985). It may also be that the most optimistic and determined couples continue with the demanding treatments.

From a different analytic perspective (cluster analysis), it was suggested that the underlying cognitive structure of treatments for infertility in the patient group was organised according to the most important features of the treatments being applied and the individuals involved in the various treatments. In the non patient group, the underlying cognitive structure seems to follow the division of responsibility for infertility between husband and wife.

Overall, Shiloh and her colleagues' (1991b) follow up study showed that subfertile participants had more positive attitudes towards a variety of fertility treatments than the fertile controls did. On the same grounds, Grand's (1997) work tried to investigate whether significant differences in opinion and acceptance of the techniques existed among people with and without infertility problems. Some of these techniques were: adoption, donor insemination, in vitro fertilization, legality of the techniques,

surrogacy, sex predetermination and access to the techniques to single and homosexual individuals. It also intended to find out which techniques were more accepted and what reason.

A self-administered survey was completed by 153 individuals; 72 of them were infertile and the remaining 81 were not infertile. Thirty-eight were males and 115 were females. Forty were White Americans, 10 African American, 94 Hispanic and nine were from other ethnic backgrounds. One hundred and forty-eight were heterosexuals. The survey's reliability and validity were checked in a pilot study. Grand's study can be considered as an exploratory study with methodological inadequacies. For example, although the mean age of the sample was 34.24 years old, the range was between 18 to 80 years of age. The number of male participants was small. Thus, any comparisons between genders were not reliable. Similarly, due to inadequate number of participants no comparisons could be made among the different ethnic groups. Its importance though lies in the variety of issues that it touched upon and by providing backing up evidence to the hypothesis that the more traditional and known medical interventions are more acceptable than the newer or more advanced ones (e.g., donor insemination, treating single individuals, menopausal women or homosexuals). Results also showed that people with infertility had a more positive opinion and acceptance of the new reproductive technology than the people who did not have a fertility problem.

## 3.5 Coping with subfertility treatments

As has been reported in Section 3.2, the medical techniques treating subfertility problems affect patients' psychological well being. In some cases, the effect might be detrimental leading to clinical depression (Beaurepaire et al., 1994; Odden et al., 1999). Of course, the overall impact of reproductive treatments on patients' well being depends on the coping mechanisms employed by the individual and the external factors supporting the patient to cope with the variety of demands imposed on him/ her.

Adopting a positive attitude towards the treatment has been found to be one of the main coping mechanisms employed by the subfertile (Callan & Hennessey, 1988; Lasker & Borg, 1989; Mori et al., 1997; Schmidt, 1998). Callan and Hennessey (1988), in their study with 77 female IVF patients, reported that women generally expected to have a number of attempts, and, if an attempt was not successful, another attempt might be successful. Furthermore, men and women were more optimistic on the day of retrieval and the day of transfer than the rest of the days from the beginning of the IVF cycle till the day of the outcome of the treatment, which according to Boivin et al. (1998a) are days of high frustration.

Overall though, this positive attitude might not be beneficial to a couple's well being since in the long run it extends the hope/despair cycle. Additionally, as was reported by Callan and Hennessey (1988), the majority of women reported being moderately to highly optimistic with a first attempt. With the following attempts though optimism

levels started to drop considerably. Thus, there are indications that being too positive before an attempt might not be that effective in helping couples cope with the treatments' demands.

However, being able to construct a positive attitude after an unsuccessful attempt was found to be a sign of successful adaptation to the unlucky event (Parkes & Weiss, 1983; Callan & Hennessey, 1989). For instance, in Schmidt's (1998) study, all of the participants felt that being a patient was a negative experience in itself. It was reported though that learning about their bodies and human reproduction was positive. Similarly, in Callan and Hennessey's (1989) research, some participants felt good because they had done their best.

Other coping strategies reported were distraction mechanisms, like keeping busy prior to an attempt (Callan & Hennessey, 1988). Some tried to prepare themselves emotionally through physical rest, relaxation techniques, social or sporting activities. Others used isolation coping behaviours such as sleep and self-talk (Lukse & Vacc, 1999). Talking to others about their problem and trying to get their support was also reported as another attempt to cope with the emotional demands of treatments. Perceived support from partners, medical personnel and other infertile women was found to contribute to women's decisions to continue with IVF after an unsuccessful attempt (Callan et al., 1988). Last, but not least, support perceived by counsellors has been reported as very important in coping with the emotional and physical aspects of

the treatments (Daniluk, 1988; Sundby, Olsen & Schei, 1994; Schmidt, 1998). The role of subfertility counselling is considered in Section 3.5.1.

### 3.5.1 Counselling for the subfertile patient

In general, counselling aims to help clients to achieve their goals, to enhance their quality of life and to solve their problems (Egan, 1994). In the case of subfertile individuals, counselling could help them gain a greater insight into their feelings and thoughts regarding their motivation for parenthood and their fertility problem. It could help patients to deal with trauma and loss, which are integral to the experience of subfertility and in cases of unsuccessful attempts to achieve pregnancy (Menning, 1988; Meyers et al., 1995). It could also help them in problem-solving, which usually concerns the available fertility treatments (Rosenthal & Kingsberg, 2000).

Depending of course on the couple's needs, couples could obtain information and discuss aspects of their subfertility with the counsellor (information counselling). Other couples may need to be given support (support counselling) or to discuss the implications of the options available to them (implications counselling). Finally, others might need help in improving their life satisfaction, well being and psychological adjustment or their communication with their partners (therapeutic counselling).

Mao and Wood (1984) reported the need for more intensive counselling of patients before admission to the programme. They suggested that the likely total cost, rather

than the cost per treatment cycle, needs to be clarified and that patients should be warned about and given advice on how to cope with the social and psychological stresses involved. Similarly, Glover, Gannon, Platt and Abel (1999) stressed the importance of routine and early involvement of psychology or counselling services to improve the patients' quality of life, to raise the issue of possibly not achieving pregnancy and to help patients to explore alternative lifestyles. The need for post-treatment counselling after an unsuccessful attempt was also addressed by Weaver and her co-researchers (1997).

Thus, in some countries, for instance, Australia and the United Kingdom, policies exist requiring clinics to offer patients the opportunity to receive counselling before, during and after treatment (HFEA, 1995). Also, couples going for donor insemination are considered a special case and thus they are obliged by law to meet with the counsellor once. Such discrimination can be fully understood after considering all the special issues involved with the use of donated genetic material. An extensive analysis of the latter is offered in Section 3.7. It has to be clarified that the counsellor's role is to help patients and not to judge them. In such cases, couples may try to hide their worries and concerns in order to present themselves as strong and suitable in order to gain the counsellor's approval. Then, the counselling session will not be able to offer them help and support of any kind.

The role of preparation for treatment through counselling is of crucial importance for the well being of subfertile patients and their families. Several studies have confirmed

patients' request for counselling (van Balen & Trimbos-Kember, 1993; Berg & Wilson, 1995; Weaver et al., 1997; Kerr, Brown & Balen, 1999). However, only 30 per cent of patients take up the opportunity to use this facility when it is offered to them by the medical center (Bresnick & Taymor, 1979; Edelmann & Connolly, 1987). Similarly, in Callan and Hennessey's study (1989), 40 per cent of the patients replied yes when asked if they would find it useful to have help/guidance from someone other than the medical specialist.

As Bresnick and Taymor (1979) suggested this per centage might be similar to the proportion of take up among fertile couples offered counselling to help them cope with other life difficulties. This response rate could also be explained by the possibility that counselling is perceived as an extra threat for the subfertile individual, while support of partners, friends, relatives or other subfertile people is seen as more reassuring/comforting.

Callan and Hennessey's (1987) study, in relation to the factors predicting the need for counselling or some other form of support, indicated that psychological rather than medical variables may well be of use. For both the male and the female partner isolation, anxiety and frustration were variables discriminating between those who would welcome the opportunity to join self-help groups and those who would not. Self-help groups also seem to be the favoured choice if the problem is shared by both partners.

## 3.6 Subfertile individuals' satisfaction with treatment-related aspects

The existing literature, referring to subfertile patients' satisfaction with treatment, pinpoints the importance of information giving about aspects of the treatments and support concerning patients' emotional needs (Mao & Wood, 1984; Callan & Hennessey, 1988; Halman, Abbey & Adrews, 1993; Schmidt, 1998; Souter, Penney, Hopton & Templeton, 1998; Glover et al., 1999). However, information expectations have been found to be more important than support for emotional needs for both women and men (Souter et al., 1998; Glover et al., 1999).

In Souter et al.'s (1998) quantitative study, conducted with Scottish female subfertile patients, it was found that 47 per cent of the participants felt they were not given a clear plan for the future and 23 per cent of those who had been given drug treatments reported receiving little or no information about the possible side effects and other aspects of the treatments. About 80 per cent of the sample expressed a wish for more written information. Also, 86 per cent reported that adequate help with the emotional aspects of the treatment was not provided to them.

Schmidt's (1998) study, from a different methodological perspective, reported similar findings to those above. Grounded methodology was used to analyse the interview material that was provided from 16 Danish heterosexual couples. The analysis revealed that participants' emotional needs were not met in the health care system. It was also found that subfertile participants' satisfaction with the treatment was not related to factors such as outcome of treatment, gender or length of infertility. There

were though associations between patients' satisfaction and the way they managed their fertility problem in relation to other people.

Specifically, it was found, that the more participants shared with others feelings and formal information concerning the infertility experience, the more was expected from the professionals. These participants wanted detailed information about technical aspects of infertility and the treatment, as well as psychosocial and sexual advice and support. Similarly, Halman et al. (1993) found that many of the American participants recommended that doctors should explain all the available options to them, including adoption and a child-free life. Both men and women wanted infertility specialists to provide more information and compassion to them.

Overall, the existing literature on patients' satisfaction with fertility treatments agrees on the need to provide more information and psychological support to subfertile patients (Schmidt, 1998; Halman et al., 1993; Souter et al., 1998; Glover et al., 1999). The importance of these results for subfertile patients becomes greater when considering that the specific studies were conducted in different countries with different health care systems (e.g., Schmidt, 1998).

## 3.7 Special issues for patients following donor treatments

The couple using gamete donation[2] as a way to achieve parenthood have to deal with particular psychological, social, ethical and legal issues. Snowden and Mitchell (1981) reported that the child may stand as a reminder of the failure of the person to have his/her 'own' child. Snowdon's (1994) later study reported that while some women felt clear that the child is their child, others did not. For example, one woman believed that despite the fact that she had conceived, carried and given birth to a child, she would not think of it as 'hers'. Furthermore, the donor may be viewed differently by each partner (Back & Snowden, 1988). For the infertile partner, the donor may be a reminder of his/her own failure and may be seen as a potential rival. The other partner may feel psychologically close to the donor, but also aware of the threat of this to their principle relationship.

A further concern when using donated gametes in infertility treatment is whether to tell the child and others about the nature of the child's conception and genetic origins (Daniels & Taylor, 1993; Brewaeys, 1996; Shenfield & Steele, 1997). Brewaeys's (1996) literature review concluded that studies, conducted from 1990 to 1996, did not reveal a shift towards more openness as might have been expected. Results of studies that investigated the issue of confidentiality showed that the majority of DI parents did not intend to tell their children that they were conceived by DI (range 47-92 per cent).

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[2] Gamete donation involves the donation of eggs or sperm by a third party to enable people to have children (Cramond, 1998).

Another important issue that accompanied the donor insemination treatments concerned donor anonymity (Daniels, 1988; Back & Snowden, 1988; Mahlstendt & Greenfield, 1989; Bruce, 1990; Haimes, 1993; Snowden, 1993). Appeals for less secrecy in DI practice highlighted the potential difficulty that children who were aware of their DI origin would have problems if no detailed information about the donor were available. Consequently, they regarded the disclosure of the donor's identity as essential. They argued that anonymity ignores the rights of children in preference for supporting the practitioners', the parents' and the donors' needs.

Donor patients should also be informed regarding the legal aspects of the treatments. Daniel's (1988) study, conducted in New Zealand, found that there was considerable confusion amongst both semen donors and recipient couples. Eighty percent of donors and 87 per cent of recipients intended to place the husband's name on the birth certificate, regarding him as the legal father, when this can be done only after the legal adoption of the child by the husband. However, Brewaeys (1996) after reviewing a variety of studies found that DI was practised only within a strictly confidential doctor-patient context, in which the doctor guaranteed the anonymity of the donor and advised the patients to keep the matter a closely guarded secret.

## 3.8 Overview

The impressive advancement of reproductive technologies has managed to give hope to subfertile individuals. Simultaneously though, a variety of psychosocial and ethical issues have emerged. The psychological well being of patients of medical fertility treatments can seriously be affected after repetitive unsuccessful attempts. Especially, when the patients have not been emotionally and cognitively prepared about a treatment cycle, the risk on one's health becomes greater. Overall, subfertile persons' attitudes towards the fertility treatments are very positive. This positive attitude acts as a coping mechanism helping patients to keep out the negative aspects of treatment of their pursuit to parenthood. The sociocultural context considerably affects attitudes to reproductive technologies and alternative forms of parenting.

## 3.9 Rationale of the study

The role of culture has become evident in the introductory chapters concerning attitudes to parenthood, subfertility and fertility treatments. In the literature review of this thesis, a presentation of the most methodologically sound studies was made and of those that had been widely published. However, in the case of cross-cultural studies, due to their limited number, their choice was also based on the interesting findings provided in relation to the specific areas of study and/or in relation to different cultural groups. Furthermore, the majority of the existing cultural studies investigated western European populations and/or had considerable methodological inadequacies.

The need to expand our knowledge on the experience of subfertility and of reproductive technologies in non-western European societies is emerging, since such experiences are expected to be different in some of their aspects from those in western European societies and thus, they might require a different kind of care and overall handling. The best way to unravel the similarities and differences among western and non-western European societies would be the employment of cross-cultural studies. The findings of such studies would help professionals (doctors, psychologists, nurses, counsellors) from western and mostly from non-western European societies to meet subfertile couples' needs more adequately.

Aim of this research was to study and understand the experience of subfertility of couples living in technologically developed European societies, where medical treatments constitute the main solution for dealing with fertility problems. More specifically, the research question addressed was what are the differences and similarities in the experience of fertility/subfertility and the attitudes to reproductive technologies between English and Greek males and female partners. To understand the experience of subfertility in these cultures, it is also necessary to understand what parenthood means to individuals inhabiting these different social worlds.

While the United Kingdom and Greece are both European countries, there are a number of differences between them that might make a cross-cultural examination of the two informative. Britain is a pioneer in technological advancements, while Greece follows these advancements. The latter might mean that the specific advancements

could be less suitable for a country like Greece, that has a strong religious affiliation. The fact that Greece is a religious country and England is a secular country might mean that subfertility and the pursuit of medical treatments create a greater ambivalence in the Greek subfertile couples, due to the religious values about the sanctity of life and natural relations and the counter pressure to conceive, because of the high value placed on parenthood. This conflict, if it exists in Greek individuals, may be less pronounced in the British.

Furthermore, this comparison is of particular interest because of the geopolitical position of the two countries. Specifically, Britain is part of North Western Europe and Greece is part of South Eastern Europe. Also, Britain is a modern multicultural society, while the population of Greece is a homogeneous group with a mixture of modern and traditional societal conditions and it is only very recently that Greece has started to accept and to assimilate in its core a variety of other cultural ethnic groups. The above cultural differences might mean that the Greek society might find it harder to assimilate the social meaning linked with the new economy, part of which are the reproductive technologies, than does the British society. Another speculation could be that, on the one hand, the protagonistic elements of individualism and equality of opportunity in the British culture could be responsible for the personal and powerful effect of subfertility on the self-identity of the British individuals. On the other hand, the major elements of conformity to social norms and collectivity in the Greek culture would be responsible for the threatening aspect of subfertility for the Greek individuals, in terms of not being able to meet with the parental role and thus, not being able to reproduce the highly valued, family system.

It was expected that by such a comparison our knowledge would be informed in an interesting and useful way. By pinpointing the common and different elements of these two different cultural/ethnic groups regarding subfertility, the needs of subfertile couples could be understood better and thus, they could be met more adequately.

Furthermore, based on the latter, it was speculated that the effect of subfertility on people's well being and quality of life would be different, either in terms of degree and/or in terms of particular aspects in the British and the Greek cultures. Similarly, the experiences of men and women were expected to be different in some respects between and across the two cultures. The above rationale was accompanied by the thought that the experiences of people could be affected by their sex-role characteristics, too. For example, if no differences were found between men and women, this could be because both groups did not differ in the feminine and masculine sex-role characteristics. Moreover, based on the above distinct cultural elements of Britain and Greece, it was speculated that the social support received from significant others in each of the countries would be different. The involvement of couples with no suspected subfertility problems as control groups in each culture was considered to be essential for the evaluation of the soundness of the quantitative findings.

Another objective of the researcher was to investigate the topic in terms of achieving a more complete view, by placing subfertility within a broader context, which is the meaning attributed to parenthood and the common way that subfertility is dealt with in both cultural settings, i.e., via the reproductive technologies. The current literature is

looking either at the meaning attributed to parenthood by subfertile individuals, or at the experience of subfertility, or at attitudes to fertility treatments by fertile and subfertile individuals. This study is focused on subfertility by studying simultaneously all the above highly connected issues.

Finally, for ensuring a more complete exploration, both quantitative and qualitative methods were employed. The information gained by each paradigm would complement each other in relation to knowledge on the specific issues (see Part I of Chapter 4 for more information about the epistemological paradigms used).

### 3.9.1 The notion of culture in the study

Culture here is seen as the system of learned information that codes the manner in which the people in an organized group, society or nation interact with their social or physical environment (Reber, 1985). It is characterized by dynamism and multivoicedness. Specifically, culture is a dynamic phenomenon which is continually being constructed and re-constructed in individuals' efforts to respond to a variety of situations by mixing and adjusting different and often competing discourses (Lee, 1992). Also, it is heteroglossic, meaning that it contains many different voices that are in dialogue with each other (Bakhtin, 1981, 1986; Wertsch, 1994). In this piece of work, the focus is on the accepted beliefs and expressions of parenthood, subfertility and reproductive treatments as expressions of cultural meanings.

The above qualities of culture justify the choice of discourse analysis as the best qualitative method for investigating our area of interest, since it is the only one that has illustrated how texts are not as coherent as they first seem and how they are constructed out of cultural resources (Parker, 1994). In the search for 'culture' in the areas of fertility, subfertility and fertility treatments, a constantly changing dialogue of voices and tools – and the sociocultural knowledge and patterns they carry will come forward (Wertsch, 1994).

Other worthwhile methods that could deal with cultural elements adequately had a different perspective, other than that of understanding. For example, feminism research and action research's main objectives are change and intervening in people's lives (Taylor, 1994). Grounded theory's major objectives are the development, maintenance and change of individual and interpersonal processes (Smith et al., 1995). One method congruent with the scope of this research would be focused ethnography, but this has a problematic epistemological evaluation (Muecke, 1994).

One of the aims of the research was to unravel both similarities and differences intra-culturally and cross-culturally. This necessitates unraveling the argumentative and contradictory aspects of people's perceptions. Hence, rhetorical discourse analysis was chosen, as this method of qualitative analysis complied most closely with the focus of this particular study, i.e., understanding the culture of the selected national groups and their subcultures, defined by gender and fertility status.

### 3.9.2 Overview

The main aim of this study was to understand deeply the experience of the subfertile couple living in a treatment-oriented society. The focus of this study was the cultural elements of the subfertility experience. Thus, a cross-cultural study was perceived as appropriate for unraveling these elements. Two distinct national groups (English vs. Greek) were chosen to be studied comparatively. Apart from the obvious aim of advancing knowledge and theory in this area, revealing their similarities and differences would help professionals to improve their cultural awareness and thus, the appropriateness of the psychological and medical services offered by them to the subfertile couples. Consequently, the latter's needs could be more adequately met.

# Chapter 4

# Methodological framework

This chapter consists of two parts. In Part I, a brief presentation and justification of the methodologies adopted is given. In Part II, a detailed description of the aims, the rationale and the way this research was conducted is offered.

## Part I

### 4.1 Epistemological paradigms: the quantity-quality co-existence

The methodology adopted in this piece of research is derived both from the quantitative and the qualitative paradigms. According to Leininger (1994), these two perspectives can be used in a complementary way. The view that the use of mixed methodologies can be mostly beneficial to research (Forrest, 2000) is adopted in the specific work with the quantity-quality co-existence.

Each perspective has its own philosophy, epistemological background, aims, methods and limitations (Leininger, 1994; Lincoln & Guba, 1985). Thus, any evaluation or critique should be derived exclusively from within each paradigm. Only then can the knowledge produced by each paradigm be considered credible and valid (Leininger, 1994).

### 4.1.1 The quantitative paradigm: its principles and methods

The main assumptions of the traditional scientific paradigm are based on the notions of realism (objectivity), rationality and regulation (McBurney, 1990). To be more specific, it is generally accepted from the positivistic paradigm that there is only one reality, which is ruled by principles of logic and lawful relationships. Based on these assumptions, the traditional scientific paradigm aims in organizing knowledge and explaining laws, predicting new laws, guiding research and formulating theories (McBurney, 1990). The latter is considered to be the ultimate goal. The methods used in the discipline of psychology were also adopted from the positivistic perspective (Banister & Fransella, 1986).

A general guide for the traditional scientific methodology consists of an exact description of the objects under investigation, the formulation of at least one hypothesis and the testing of the truthfulness of the hypothesis via careful investigation (Reber, 1985). The above and other critical areas of planning and executing a study depend on the type of study (e.g., experimental or non experimental), the nature of the phenomenon under study, the procedure followed, the theoretical framework and last, but not least, on the statistics. Since it is highly unlikely that a perfect and absolute relationship will exist between the variables of a study, due to the complexity of the human behaviour, these relationships (laws) are explored and described in statistical form (Banister, Burman, Parker, Taylor & Tindall, 1996).

Despite the objectivity of the methods, the expertise (statistical, cognitive) and ethos of the researcher, quantitative research can be very complex and subjective. Specifically, Tabachnick and Fidell (1989), indicated that the complexity of factors, scientific utility, theory, good hunches, even art have a place in the employment of statistical testing and in the interpretation of its outcomes. Thus, since statistics and logic are not the only components of the traditional psychological inquiry, scepticism is required in claims regarding the role of objectivity in the specific paradigm.

### 4.1.2 The qualitative perspective

The qualitative epistemological paradigm is a relatively new one (Banister et al., 1996). However, its roots can be found in the ancient discipline of philosophy (Billig, 1987). This perspective is varied and complex, since it includes several different theoretical and methodological approaches (Banister et al., 1996; Henwood & Nicolson, 1995). All the qualitative approaches regardless of theory and method aim to find meaning in and understanding of human behaviour through the study of language. Understanding human behaviour is achieved through interpretation and empathy. Phenomenology characterizes this paradigm, which values and studies subjective experience. It is crucial for a qualitative researcher to be able to view the experience from the participant's perspective (Morse, 1994).

Variability is important for this perspective, which accepts the existence of multiple realities. There is not one reality, but multiple and contradictory versions of the world. The aim of the qualitative perspective is to study the complex and contradictory nature

of the social world through understanding. By paying close attention to the use of language, discourse analysts have shown that people do not have a single "attitude" in the ways that social psychological theory has often assumed. Instead people use complex, and frequently contradictory, patterns of talk to accomplish different functions. The latter is true even for people who hold very strong views (Billig, 1987; Potter & Wetherell, 1987).

In this methodology, subjectivity is not a problem, but a resource (Banister et al., 1996). Awareness of this subjectivity is a valuable tool for transforming this potential 'horror' to a methodological virtue (Woolgar, 1988; Johnson, 1997; 1999). For this awareness the term of reflexivity is used. It is the researcher's reflection and critical evaluation regarding the research topic, design and process. Most importantly though it is a high quality of self awareness (Wilkinson, 1988). Self-development and co-counselling are two ways for achieving an awareness of high standards for oneself with respect to the researcher's standing to the investigated topic (Reason & Rowan, 1981; Heron, 1973; Marshall, 1986). Thus, validity in qualitative research is focused on personal and interpersonal qualities, rather than method.

### 4.1.3 Rhetorical discourse analysis: theoretical perspective and methodological perspective

The qualitative approach adopted in this piece of research is the discourse-analytic approach as perceived by Potter and Wetherell (1987). Also, particular emphasis is given to the rhetorical aspect of discourse (Billig, 1987). This form of qualitative

analysis was chosen because of its richness in theory and method. It was felt to be the most appropriate approach for identifying and analysing the contradictory aspects of the discourses, which was a major aim of the study (see Section 4.2.2)

Discourse analysis shares the common philosophy of phenomenology. In other words, it is a method that is used to describe the world of the persons under study (Smith, 1995). It is part of modern psychology. Moreover, this perspective provides explanations of the kinds of concepts such as intention, meaning and interpretation. According to discourse analysis, whatever has meaning can be considered part of discourse.

By studying language or interaction we study discourse (Parker, 1992). For Billig (1987) discourse is synonymous with 'logos', which means word making in general. According to Potter and Wetherell (1987), discourses do not just reflect, but they also do actively construct a version of the world. In this perspective, in contrast to traditional psychology, all language is perceived as constructive and never just as descriptive. Language is used to construct and create social interaction. Discourses do not simply describe the social world, but categorise it by the different meanings words are given from one discourse to another.

This perspective, in contrast to the cognitive perspective, argues that an individual is not a victim of mechanical categorisation processes, but s/he is active in making sense of preformed categories through language. Billig (1985) suggested that both

categorization and the opposite process of particularisation are necessary for dealing with the world. Particularly, the study of categories, according to discourse analysis, is linked with the organisation of discourse and its consequences. On the one hand, people construct different versions of the social world based on categories. On the other hand, categories themselves have to be part of a discourse in order to be used in various accounts.

The process of categorisation is important for studying a discourse, which can only exist in relation to other discourses. In either written or spoken language, a discourse may be identified by the institutions (e.g., medical, psychological) to which it relates and by the positions of those who speak and those whom they address. According to the ancient Greek philosopher, Protagoras, any logos could be matched by a counter-statement (anti-logos) - (Billig, 1987). Thus, it could be said that discourse is two-sided. In order to understand fully a position of a discourse we should be able to identify the counter-positions that are explicitly or implicitly rejected (Billig, 1991).

In addition, interviewee's answers are treated differently by a discourse analyst than by a traditional social analyst (Brenner, 1985; Cannell & Kahn, 1968). Specifically, the researcher's questions become just as much a topic of analysis as the interviewee's answers. Unlike traditional interviews, that treat researchers as passive and neutral participants, in discourse analysis interviewers are perceived as active contributors and thus, their talk should be included in the analysis.

Furthermore, in order to form a better understanding of this perspective it would be necessary to find out how such an analysis can be performed. Apparently, there is no fixed method for doing discourse analysis (Potter & Wetherell, 1987). To be more specific, analysis involves a lot of careful reading and rereading. Analysis also follows two stages. First, the researcher tries to recognise elements that are common to different accounts and then s/he studies their function and consequence. The second stage consists of an attempt to form hypotheses about these functions and search for the linguistic evidence.

Only rough guidelines are offered with a number of stages, which can be followed with flexibility and judgement (Billig, 1997) – (see Appendix 3). The reason for discourse approach not developing specific techniques like the rest of psychological theories have done, is that it does not aim to smooth, but study the variability of interpretation and response. Variability for a discourse analyst is an interesting and important element of social life. The fact that people contradict themselves (Marsh, 1982) is perceived as an indication of the way people deploy their language. Consistency is important for the discourse analyst too, but only for identifying regular patterns in language use.

Similarly, there are no fixed ways for evaluating the results of a discourse analytic study. According to the main criteria, all data should be explained. The identified discourses should be able to account for all of the data and offer explanations even for the limited number of exceptions. The most validated research is that which is in a

position to bring to light fresh discourses and to offer new explanations regarding content, intention, resources, function, dilemmas or power (Potter & Wetherell, 1987).

### 4.1.4 Overview

The production of scientific knowledge is accomplished differently by the quantitative and the qualitative paradigms. Each paradigm has its own philosophy, limitations and evaluation criterias. Although there are differences, they can be used in a complementary way. Using both perspectives benefits the scientific enquiry. In particular, the main accomplishment of the quantitative study is to enlighten us in relation to the effect of a variety of elements on attitudes to parenthood and to fertility treatments. The major aim of the qualitative study is to explore in more depth subfertile participants' experiences in relation to parenthood, their fertility problem and the medical aspect of it. Each of these perspectives can be used in an enlightening way for each other. Some of their results can be compared to establish and inform further each other's findings.

# Part II

## 4.2 Research aims and rationale

The role of culture has become evident in the introductory chapters concerning attitudes to parenthood, subfertility and fertility treatments. However, the number of cross-cultural studies has been limited in relation to these issues. The methodology used is derived both from the quantitative and qualitative perspectives, in order to provide a more complete picture of the areas of interest, i.e., by looking at them from different angles. One was the interview and the other was the questionnaire method. They were used in a complementary way. On the one hand, the questionnaires present objective, quantifiable and more summarized view of patients' general psychological functioning and also some particular aspects of parenthood/subfertility and fertility treatments, which are of interest to the researcher. On the other hand, the interviews provide qualitative, in depth information. Both types of information are valuable for analyzing the cognitive and discursive constructions of British and Greek, fertile and subfertile couples.

### 4.2.1 The quantitative study

This study compares the British and the Greek cultures. Also, differences due to gender and fertility status are examined. Furthermore, a variety of demographic characteristics (e.g., age, residing with children, education, etc.) are investigated in order to have an overall picture of the sample's characteristics and for revealing any possible effects of these characteristics on attitudes to parenthood and to fertility

treatments. Well being variables were used to see whether subfertility has any differential effects on any of the subgroups (males vs. females, fertile vs. subfertile, British vs. Greeks). Gender stereotypes are also investigated in order to investigate any impact on attitudes to parenthood and fertility treatments across cultures. Finally, the effect of social support for the subfertile individuals is explored in relation to nationality and gender. The support received by others was not investigated for the fertile group, since the focus of this study was the support received solely for subfertily problems.

There are five main hypotheses addressed through the quantitative measures employed in the research. First, it was expected that Greek couples will place higher value on parenthood than the British couples, since the Greek culture, although a mixture of modern and traditional ideas, is more traditionally oriented in comparison with the British culture. Secondly, Greeks were expected to have more positive attitudes to reproductive technologies than the British. It was speculated that the greater importance attributed to children in the Greek culture would make the Greek participants more fond of ways of helping them to achieve biological parenthood (e.g., medical interventions) than the British. Thirdly, it was hypothesized that, compared with fertile couples, subfertile couples would value parenthood more since they have problems in achieving it. Also, it was expected that subfertile couples will have more positive attitudes to fertility treatments than would fertile individuals as a coping mechanism, which supports their decision to continue with the treatments. Next, based on the idea that parenthood is more central for women than men, it was

speculated that women would attribute more importance to parenthood than men and lastly, that women would be more positive towards fertility treatments than men.

### 4.2.2 The qualitative study

The approach and methods of discourse analysis are used in order to understand the way subfertile participants construct issues like parenthood, subfertility and fertility treatments. Also, the construction of the ingroup (e.g., other subfertile persons) and the outgroup (e.g., fertile participants, medics) are looked into. The content and context of the discourses are investigated in relation to the above themes. Further, the function of the different discourses and the argumentative context of these constructions are of great interest. However, similar variations and striking differences between the Greek and the British cultures constitute the main focus of the qualitative analysis.

## 4.3 Participants

Four hundred individuals took part in this study. Two hundred of the participants were British, one hundred of which were 50 subfertile couples and 50 fertile couples. The British sample was restricted to white English couples in order to achieve the same degree of racial/cultural homogeneity in the British sample as in the Greek sample and thus, to avoid any biases deriving from a racial diversity within the British sample. The remaining two hundred of the participants were Greek, 50 of which were sub-fertile couples and the other 50 were fertile couples. All couples had to be in a relationship for at least one year and the woman's age had to be under the age of 40

years. All of them filled in the questionnaires, while only 10 British and 10 Greek couples from the subfertile sample were interviewed. The first 10 subfertile couples in each group who agreed to be interviewed formed the interview sample.

As can be seen in Appendix 4, participants varied in age from 21 to 58 years old and were distributed similarly between the two national groups. The mean age for all the participants was 33.06 years, with a standard deviation of 5.82 years. Actually, the subfertile group is slightly older (1.38 years) than the fertile group and men's age is slightly older (2.74 years) than women's age. The sociodemographic characteristics of the interview sample are presented in Appendix 4a in order to facilitate an understanding of the discourses in relation to their socio-economic status. The sociodemographic characteristics of the latter are roughly comparable to those of the whole sample.

Also, in Appendix 4b the treatment-related characteristics of the interview sample are given. It is worth noting that, although in the whole sample 27 Greek couples attributed their subfertility to a male cause, only 14 British couples reported a male subfertility problem. Regarding the sample that took part in the interviews, only one Greek couple reported a male factor, compared to six British couples. In other words, most couples that came forward to be interviewed from the British sample had a male factor infertility, while this was not the case for the Greeks.

The group of British participants was contacted in Hull. Hull is situated in Northern England and its population is about 450,000. The group of Greek participants was contacted in Thessaloniki, which is situated in Northern Greece and its population is 946,864. The fertile couples, from these same two cities, were recruited by snowball sampling. The subfertile couples were contacted personally or by mail with the help of the public and the private medical sector (see Sections 4.5.1, pp.94-98).

## 4.4 Measures

### *Questionnaires*

*Participant Information Record:* A questionnaire was constructed in order to gather basic demographic information (e.g., age, place of origin, educational level) and the couple's subfertility history (e.g., cause of subfertility, length of time trying to conceive, type of current treatment) - (see Appendix 5). The last two questions (18 & 19) were not addressed to the subfertile participants. Questions 11-17 did not apply to the fertile participants.

*Bem Sex Role Inventory*[3] *(BSRI):* The short version of BSRI consists of 30 items. The first adjective and every third one thereafter are masculine. The second adjective and every third one thereafter are feminine. The third adjective and every third one thereafter are filler (unscored). Each item is rated on a seven point Likert type rating scale. The BSRI is a widely used instrument that assesses masculinity and femininity

[3] BSRI is not presented in the Appendices due to copyright restrictions.

with the ultimate goal being the classification of the participants into four sex role groups. Participants who are high on the Femininity Scale and low on the Masculinity Scale are considered feminine and those who are low on the Femininity Scale and high on the Masculinity Scale are classified as masculine. Those participants who are below the median on both scales are classified as undifferentiated and those who are above the median on both scales are considered androgynous. A distinguishing feature of the BSRI from most masculinity-femininity scales is that it treats masculinity and femininity as two distinct items and not as a bipolar dimension (Bem, 1981).

The short version of BSRI has been widely used and has been found to be a highly reliable and valid research instrument (Bem, 1981). In this study, the participants were classified as feminine, masculine, androgynous or undifferentiated by the Median – Split method as recommended by Bem (1981) because of its simplicity. Participants were classified on the basis of the sample's own medians (5.70: raw score for femininity and 4.80: raw score for masculinity).

According to Bem (1981), participants classified as non-androgynous (i.e., masculine, feminine, or undifferentiated) restrict their behaviour in accordance to the cultural stereotypes, whereas androgynous individuals have a less conforming and typical behaviour.

*General Health Questionnaire*[4]*:* The 12-item short form of the GHQ was used (Goldberg, 1978). The 12-item version is apparently as efficient as the 30-item version as a case detector (Bowling, 1991). Although it is culture specific in development, it works well in a variety of cultural settings (e.g., Goldberg & Williams, 1988; Bowling, 1991). Each item consists of a question concerning whether the respondent has recently experienced a particular symptom or item of behaviour on a scale ranging from ' less than usual ' to ' much more than usual '. The General Health Questionnaire measures general psychological well being. Each item was rated on a four point Likert type rating scale from 0 (the least distressed) to 3 (the most distressed).

*Quality Of Life:* The QOL (see Appendix 6) consists of ten seven-point bipolar scales which formed part of a large - scale study on the quality of American life by Campbell, Converse and Rodgers (1988). Three scores were recorded for this measure: the total of the eight-item "life in general" score and a score for each of the two discrete dimensions "easy / hard" and "free / tied down" as suggested by the authors (Campbell et al., 1988). The above pattern was supported by a couple of British studies, involving both fertile and subfertile groups (Weaver, Clifford, Gordon, Hay & Robinson, 1993; Weaver et al., 1997). Thus, three scores were recorded in the present study, too. High scores were used in the present study to indicate more negative evaluations to be consistent with direction of scoring with GHQ.

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[4] GHQ is not presented in the Appendices due to copyright restrictions.

*The Meaning of Fertility Treatments:* A fertility treatment questionnaire (Shiloh et al., 1991b) was used in which six generic treatments for subfertility were evaluated along 15 bipolar scales describing psychosocial features (see Appendix 7). Each treatment was followed by a brief explanation of the procedure. These treatments were: a) ovulation induction, b) medical treatment for male, c) in-vitro fertilization with husband's semen, d) intracytoplasmic sperm injection, e) artificial insemination with donor eggs and f) in-vitro fertilization with donor semen. The aim of this questionnaire is to determine how the above treatments for infertility are perceived, and the cognitive structure underlying their perception.

The treatments chosen for this study were different from the ones used in Shiloh et al.'s (1991b) study (see Section 3.4, p.54). In particular, artificial insemination and surgery for men and women were excluded, since the rest of the treatments did capture the same underlying cognitive structures. The selection of treatments in the present study was based on three underlying pairwise dimensions: a) male versus female infertility (e.g., IVF vs. ICSI, hormones for females vs. drugs for males, egg donor vs. sperm donor insemination), b) level of interference with nature (e.g., hormone treatment vs. IVF vs. insemination by egg donor, drug treatment vs. ICSI, etc.) and c) use of a third party genetic material or not (ICSI vs. donor sperm, hormone treatment vs. egg donor insemination). Each dimension was presented in the questionnaire as a seven–point Likert scale (high score = unfavourable attitude), in which both ends are defined and the middle–point denotes equal agreement or disagreement with both ends. Participants were asked to express their beliefs about each treatment by putting

a tick in the space that best represented their point of view regarding the specific treatment in accordance with each of the statements.

A pilot study was conducted with four Greek couples, half of which were fertile and the rest were subfertile. Only Shiloh's et al (1991b) instrument regarding fertility treatments was piloted to check the understanding of the explanatory introduction regarding each treatment and the use of the scales. These treatments were: a) drug treatment for females (ovulation induction), b) artificial insemination with donor eggs, c) in-vitro fertilization with husband's semen and d) in-vitro fertilization with donor semen. Each dimension was presented in the questionnaire as a 13- point Likert scale (6 ....0....6), like Shiloh et al. (1991b) did when used this scale. Both ends of the scale were defined and the middle point denoted equal agreement or disagreement with both ends. Participants were asked to express their belief about each treatment by circling the number that represented their agreement with the given statement. There were no problems with the completion of the instrument by the participants. However, it was decided to use a seven-point scale in the present study since the rest of the instruments used in this study did not exceed the seven-points in rating.

*Meaning Of Parenthood Scale:* The MPS consists of nine, five-point scales (Edelmann et el., 1994) - (see Appendix 8). The purpose of the Meaning of Parenthood Scale is to evaluate social and personal identity needs. Participants were asked to rate the degree of importance of each of the statements for themselves (from 1 = not at all important to 5 = extremely important). Seven of the statements were derived from a

set of items from the Value of Children studies (Arnold et al., 1975). Two additional statements, relating to gender differences in disappointment over childlessness and in acceptance of subfertility, were also included (Edelmann et al., 1994). In particular, these two items were: a) "becoming a mother makes a woman truly female" and b) "a man can never be sure about his masculinity until he is a father" (see Table 5.8 for all the items of the MPS).

*Social Support Questionnaire:* The six-item short form of the SSQ (SSQ6) - (see Appendix 9) was used, which was found to be a highly satisfactory reliable and valid instrument (Sarason, Sarason, Shearin & Pierce, 1987). The Social Support Questionnaire measures people's perceived available support and appraisal of this support in a variety of situations and in this case regarding the participants' fertility problem. It consists of six items. Each item has two parts. The first part of each item asks the participants to list the people who are available to them in times of need. The first part measures the number of people offering support. The second part of each item measures the individual's degree of satisfaction with the available support by using a six-point Likert scale from one (very satisfied) to six (very dissatisfied). This questionnaire was not given to the fertile participants, since the interest of the specific study was solely in the support received in relation to subfertility problems. Thus, in the specific study's instructions it was indicated that help or support received in relation to the participant's fertility problem and fertility treatment was of interest (see Appendix 9).

All questionnaires could be completed in approximately 30 to 45 minutes.

### 4.4.1 Internal reliability and translation of the instruments

Intereliability item analyses were employed to check if the scales used were reliable (psychometrically) for the two different sample populations in the study. The internal reliability (cronbach alphas) of all the instruments was satisfactory from a psychometric viewpoint (alpha > .68). Overall, the lowest reliability was found for the Social Support Questionnaire (alpha=.76) and the highest for the Shiloh et al.'s scale across the six fertility treatments (alphas .80 - .89). The reliability item analyses conducted separately for the two national groups showed that the lowest alpha for the Greeks was that found for the MPS (alpha=.68), while for the British it was for the SSQ (alpha=.77). A detailed presentation of all the cronbach alphas can be found in Appendix 10. An item analysis was not employed for the Quality of Life Questionnaire, but the three scoring system was followed (see the Questionnaire Section 4.4, p. 88).

All the questionnaires, except the General Health Questionnaire, were translated into Greek by the researcher and a fellow psychologist to ensure accuracy of the translation. Both were bilingual, meaning that they were fluent in both languages and had lived for more than a year in each country. Thus, they were considered as bicultural (Garyfallos, Karastergiou, Adamopoulou, Moutzoukis, Alagiozidou, Mala & Garyfallos, 1991). A highly accurate translation and standardization of the General Health Questionnaire was done by Garyfallos et al. (1991) for the 60, the 30 and the

28 item versions of the GHQ, but not for the 12-item version. However, after getting permission from the Greek copyright holders, the items that comprise the 12-item version of the GHQ were extracted from the 60-item Greek version of the instrument.

### 4.4.2 Interviews

Semistructured interviews were conducted. Partners were interviewed separately. Three main areas were explored in the interviews: a) the meaning of parenthood, b) the perception of subfertility and c) accounts of fertility treatments. The questions were open-ended (see Appendix 11a). Prompts were used when needed to help participants provide a clearer and more complete answer.

Furthermore, two fertile couples and two subfertile women were interviewed for piloting purposes. The answers provided helped in finding out about how the specific questions worked. Consequently, some of the questions were excluded and some were rephrased (see Appendix 11b for the pilot interview questions used initially).

## 4.5 Procedure

### 4.5.1 Participants' recruitment

*British subfertile couples*

The approval of the relevant ethics committees had been gained prior to beginning the recruitment of the British subfertile couples. A period of approximately six months was needed for the acquisition of the approvals. Specifically, the approval of the Psychology Department Ethics Committee of the University of Hull, the Hull IVF Unit Ethics Committee and the Hull and East Riding Research Ethics Committee had been obtained. After obtaining the approvals from the Committees, a period of 14 months was needed for collecting all the questionnaire and interview material from the British subfertile couples.

British subfertile couples were patients of the Hull IVF Unit in the Princess Royal Hospital in Hull. Some patients had finished treatment and some were scheduled to start receiving treatment. At first, an information letter about the study was posted to the subfertile couples by the medical director of the IVF Unit (see Appendix 12a). A preliminary consent form with an envelope was included in the above letter asking for couples' permission to be sent questionnaires (see Appendix 12b). They were asked to fill in the permission form and return it to the IVF Unit in the envelope provided. The researcher was also available at some evening meetings in the IVF Unit, which were held for couples new to the Unit. In these sessions a group of couples, before starting their first IVF cycle, was informed about the IVF treatment and about the staff

of the Unit. At this time the researcher was presented to the couples by one of the speakers. There was the opportunity for couples to ask questions regarding the study and to be given questionnaires.

***Postage of questionnaires***

The researcher was given the names and addresses of the patients in the Unit for correspondence. Participants' names were kept in the IVF Unit in order to preserve confidentiality. The questionnaire package contained questionnaires for both the male and the female partner and was posted from the IVF Unit for confidentiality reasons. Another information letter (see Appendix 12c) was included in the package spelling out that participation was voluntary and that individuals could withdraw from the study whenever they wanted. Also, a permission form (see Appendix 12d) was attached asking them if they would consider participating in the interview and if so to leave a telephone number where they could be contacted. This permission form and the third paragraph of Appendix 12c regarding the interview part of the study were omitted from the questionnaire package after the recruitment of the 10 couples. Participants were asked to return the questionnaires to the IVF Unit in the prepaid envelope that was included in the provided package. It was also mentioned clearly in this information letter (Appendix 12c) that the interviews would be taped and that confidentiality would be strictly preserved. Otherwise, questionnaires could be anonymous. A reminder letter (see Appendix 13) was also sent to the subfertile couples who were sent the questionnaire package for completion. Couples who had already completed and returned the questionnaires were asked to ignore the letter.

Couples who had forgotten about them were asked to return the questionnaires completed or even uncompleted. In the latter case, they were also asked to state their reasons for not participating.

A 23.7 per cent response rate was obtained for the questionnaires. More information regarding the British subfertile participants' reply rate can be found in Appendix 14.

*Interview*

Participants who returned the completed permission form regarding the interview part of the study (see Appendix 12d) were contacted by telephone. If, following further discussion of the study, they wished to participate then a time was arranged to meet them in their homes. The first 10 subfertile couples who agreed to be interviewed formed the interview sample. Partners were interviewed separately. The interviews were taped (as indicated in the Information Letter). Names were not recorded on the tape. Tapes were identified by a code. Tapes were wiped as soon as transcription was completed. Written consent (see Appendix 15) was obtained prior to beginning the interviews. Also, it was made clear that the interviewee did not have to reply to all of the questions and that at any point the interview would be terminated if (s)he wished it so for any reason.

A partial 'Jefferson style' (1984) transcription was used - (see Appendix 16).

*Greek subfertile couples*

Greek subfertile couples were recruited with the help of both the public and the private medical sector. A small number of the participants were patients of the A Clinic of the Infertility Department of the St. Sofia's Hospital in Thessaloniki. The agreement of the Hospital to conduct the proposed study with their patients was given from the Medical Director of Clinic A and the Head of the Infertility Department. The researcher was given access to the patients' archives in the specific clinics for correspondence purposes always from within the premises of the Hospital. Also, the researcher was present on Tuesday and Thursday mornings for a period of approximately two months in the Infertility Department of Clinic A, as this was when patients had appointments with the doctors. The researcher was either introduced to the couple by one of the doctors or by herself while the patients were in the waiting room before meeting with the doctor. During those times the researcher had the chance to approach personally some couples and to give them the questionnaire package.

Two sets of questionnaires, an information letter (see Appendix 17), a consent form regarding the interview part of the study (see Appendix 12d) and a prepaid return envelope were included in the package. Couples who were recruited by mail were sent the questionnaire package described above in the initial posting. In other words, Greek couples were not contacted by the medical director of the Infertility Department, as was the case for the British subfertile couples (see Appendices 17 and 12a respectively). After the completion of the 10 interviews, the third paragraph of

Appendices 12c and 17 about the interview part of the study was omitting from the information letter, as there was no reason for informing prospect participants about a part of the study that had been completed. Similarly, the consent form regarding the interviews (see Appendix 12d) was excluded. A reminder letter (see Appendix 13) was also sent to the subfertile couples of the hospital. All correspondence was directed to the Hospital for confidentiality reasons.

The largest number of participants was recruited with the help of an urologist with a private medical practice in Thessaloniki in a period of less than three months. Participants were recruited during their visit to the medical practitioner with the help of the doctor who introduced the researcher to the couples. Couples who were willing to participate and who had the time either filled in the questionnaires during their visit to the practice or took the questionnaire pack home with them. Most of the couples who took the questionnaires with them agreed to return the questionnaires personally in their next scheduled visit to the doctor. In cases where the time of the couple's next meeting with the doctor was not known, a prepaid return envelope was provided too. The information letter (see Appendix 17) and the consent form (see Appendix 12d) regarding the interview part of the study were also included in the package. The rest of the procedures were the same as those for the British subfertile group.

A reply rate of 47.1 per cent was obtained for the Greek subfertile couples (see Appendix 18).

### *British and Greek fertile couples*

Prior to starting the recruitment of the British fertile participants, the approval of the Psychology Department Ethics Committee of the University of Hull was essential. In order to recruit the British fertile participants, flyers (see Appendix 19a) were sent around the University of Hull and to one GP practice, inviting them to take part in a study investigating attitudes regarding parenthood and fertility treatments. The interest shown was limited. Thus, most of the respondents were then recruited personally by the researcher and they were asked to recruit other respondents, too. They were asked to fill in a set of questionnaires and return it usually either by hand to the person who gave them the questionnaires or return it via mail to the researcher. An information letter (see Appendix 19b) and a freepost return envelope, addressed to the Department of Psychology of the University of Hull, were included in the package with the questionnaires.

The Greek fertile couples were also recruited by snowball sampling. The same information letter accompanied the questionnaires (see Appendix 19b). Most of the completed questionnaires were collected personally by the researcher, although a few of the respondents preferred to mail the questionnaires. This was the case for both the British and the Greek fertile couples. The fertile couples did not take part in the interview part of the research.

The reply rate for the British and the Greek fertile couples were 40.2 per cent and 52.6 per cent respectively (see Appendix 20 for more information about response rates).

### 4.5.2 Ethical considerations

Participants were all volunteers. It was very clear in all correspondence with patients that they had no obligation to participate in the study and that their decision would not affect their treatment. Participants were sent the preliminary consent forms at their homes (see Section 4.5) and were given the chance to make up their minds about participating or not and to reply in confidence. Also, the letter included in the questionnaire package posted to their homes stated that completing the questionnaires is voluntary and should they consent to be interviewed, this consent may be withdrawn at any time. If during an interview it became apparent that an individual was very distressed, they would be encouraged to contact a counsellor. Due to the extremely sensitive nature of the issue of subfertility, the counselling skills of the researcher[5] played a crucial role in enabling interviewees to disclose without feeling challenged or pressurized.

[5] The researcher had completed at that time four modules from the Postgraduate Diploma in Counselling and one module on qualitative research and interviews, which was part of the MSc in Psychological Research Methods.

# Chapter 5

## Quantitative Results

This chapter is comprised of three sections. In the first section, the basic characteristics of the sample are explored. The demographic, sex role and treatment related characteristics of the sample are presented. Furthermore, an exploration of the well being and the social support variables is undertaken and their relationship with nationality, fertility and gender is explored. The relationship of all the above variables with the two main variables of this study is presented, too. As will be recalled, the main focus of this study is the attitudes to parenthood and the attitudes to fertility treatments. These will be statistically analysed in the second and the third sections of this chapter, respectively. In particular, the effects of nationality, fertility and gender on attitudes to parenthood and the prediction of the latter are investigated in the second section. The role of the three independent variables on attitudes to fertility treatments and the prediction of the latter are presented in the third section of this chapter.

# Section I

# Exploratory Statistics

## 5.1 Descriptive statistics of demographic, treatment-related and sex role characteristics

A full account of the demographic characteristics of the sample can be found in Appendix 4. Participants were distributed similarly for all the demographic characteristics, except membership in a religious group and degree of religiousness. All Greeks were members of a religious group with a mean religiousness score of 3.9 (min. = 1, max. = 7). Only 36 (out of 200) British were members of a religious group. However, the mean degree of religiousness reported by the whole British sample was higher than that of the Greeks (mean = 5.2). Additionally, as could be expected, there were differences between the fertile and the subfertile participants in relation to having a child and residing with a child (see Appendix 4).

In Appendix 21, the treatment-related characteristics of the subfertile couples can be found. Thirty-two of the British subfertile couples were undergoing treatment at the time of their participation in this study, all receiving IVF or a related technique. Out of the 21 subfertile Greek couples that were undergoing treatment when partaking in the study, only six of them were receiving IVF. The majority of the Greek subfertile patients were undergoing drug or hormone treatments. The remainder of both Greek and British subfertile couples were either waiting to begin treatment, or were under medical investigations, or were just having a brake from their last unsuccessful

attempt. From the whole fertile sample of British and Greeks, 22 participants had consulted a doctor about a suspected fertility problem and 21 of them had investigated the suspected problem. None of the fertile participants had been diagnosed with subfertility (see Appendix 22).

The BEM Masculinity and Femininity scores for the British and the Greek participants can be found in Appendix 23a. A number of Pearson's chi-squares were employed to determine whether sex roles were related to nationality or fertility status of the participants. A detailed presentation of the number of participants classified in each one of the four categories is given in Appendix 23b. Cross-tabulations were employed to check for differences between the fertile and the subfertile participants within each national group.

British participants were found to be distributed differently from the Greeks, $x^2$= 26.41, df=3, $p$<. 001. Specifically, the largest classification type for the British participants was the undifferentiated (32%). Masculine sex typed participants followed with 26%. The largest classification type for the Greeks was the androgynous (37%). Feminine sex typed participants followed with 26%. No significant differences were found between subfertile and fertile participants either for the whole sample, $x^2$=4.33, df=3, $p$<.23 or within each of the national groups, $x^2$=4.19, df=3, $p$<.24 for the British and $x^2$=4.25, df=3, $p$<.24 for the Greeks.

### 5.1.1 Basic statistics for the well being variables

As mentioned earlier, participants' well being was assessed via the General Health Questionnaire (total score) and the Quality of Life Questionnaire (three scores) – (see Section 4.4). All the mean values of the four scores are presented in Appendix 24.

The correlations between all the measures are significant and positive, with GHQ and Life in General showing the strongest relationship (see Table 5.1). Correlations between the different sub-groups can be found in Appendix 25.

**Table 5.1: Correlation coefficients for the well being variables for the whole sample**

| N=397 | Total GHQ | Life in general | Easy - hard | Free-tied down |
|---|---|---|---|---|
| **GHQ** | 1.00 | .66* | .38* | .27* |
| **Life in general** | .66* | 1.00 | .36* | .30* |
| **Easy - hard** | .38* | .36* | 1.00 | .41* |
| **Free-tied down** | .27* | .30* | .41* | 1.00 |
| *** significant correlations at p<.05** | | | | |

A number of separate ANOVAs were performed for each of the four well being variables with the independent variables: nationality, fertility, gender. A main effect was produced for gender and for the total GHQ, $F(1,390)=12.03$, $p<.001$. Women presented as more distressed than men. For women the mean score was 12.16 (SD=6.11) and for men 10.23 (SD=4.94). There were no interactions found. Also, no

effects were found for the scores of the Life in General scale (see Table 5.2 for means and standard deviations).

However, main effects were found for nationality and gender for each of the two discrete dimensions of the QOL. Greeks perceived their lives as harder, $F(1,391)=4.86$, $p<.028$, and more tied down, $F(1,391)=8.12$, $p<.005$, than the British. Similarly, fertile participants reported more negative scores in relation to these dimensions than the subfertile, $F(1,391)=5.1$, $p<.025$ and $F(1,391)=9.09$, $p<.003$ respectively. Mean scores and standard deviations are reported in Table 5.2.

**Table 5.2: Mean values and standard deviations* for the two distinct dimensions of the Quality of Life Questionnaire in relation to nationality and fertility**

*** in parenthesis**

| | **Easy - hard** | **Free – tied down** | **Life in General** |
|---|---|---|---|
| **British** | 3.98 (1.68) | 3.60 (1.42) | 2.69 (1.07) |
| **Greek** | 4.38 (1.90) | 4.09 (1.96) | 2.54 (1.23) |
| **Fertile** | 4.38 (1.79) | 4.10 (1.71) | 2.51 (1.09) |
| **Subfertile** | 3.98 (1.80) | 3.59 (1.72) | 2.73 (1.21) |

### 5.1.2 Basic statistics for the social support measures

As mentioned in the method section, this instrument was given only to the subfertile participants in order to look at the perceived social support and its appraisal in relation to their fertility problems. The mean scores and standard deviations for all the subfertile participants and the subgroups can be found in Table 5.3.

**Table 5.3: Means and standard deviations* for measures of social support in relation to nationality and fertility**

*** in parenthesis**

| | **Number of supportive people** | **Satisfaction with social support** |
|---|---|---|
| **British** | 3.01 (1.91) | 1.73 (.95) |
| **Greek** | 2.24 (1.56) | 1.90 (1.16) |
| **Men** | 2.15 (1.50) | 1.96 (1.23) |
| **Women** | 3.11 (1.90) | 1.67 (.85) |
| **All participants** | 2.63 (1.78) | 1.81 (1.06) |

The relationship between number of supportive people (size) and satisfaction with social support (quality) was examined for all the subfertile participants and the sub-groups. Table 5.4 shows that there is a modest, negative correlation for all the sub-groups, indicating that the bigger the number of supportive people the higher the satisfaction with social support (high score = dissatisfaction).

| Table 5.4: Correlations for the number of supportive people and satisfaction with social support | | | | |
|---|---|---|---|---|
| **All subfertile** | **British** | **Greek** | **Men** | **Women** |
| -.27* | -.28* | -.25* | -.25* | -.27* |
| ***significant correlations at $p<.05$** | | | | |

### 5.1.3 The effect of nationality and gender on social support

A two-way analysis of variance was performed using nationality and gender as the between subjects factors and the number of people offering support as the dependent variable.

Results revealed a main effect for nationality, $F(1,193)=10.17$, $p<.002$, indicating that the British participants reported receiving support from a greater number of people than the Greeks. Also, it was found that women felt supported by a bigger number of people than men, $F(1,193)=16.16$, $p<.0001$. Mean values and standard deviations for both effects are given in Table 5.5.

**Table 5.5: Means and standard deviations* for number of supportive people in relation to nationality and gender**

***in parenthesis**

| Supportive people | British | Greek | Total |
|---|---|---|---|
| **Males** | 2.31 (1.56) | 1.98 (1.44) | 2.15 (1.50) |
| **Females** | 3.70 (1.98) | 2.51 (1.63) | 3.10 (1.90) |
| **Total** | 3.01 (1.91) | 2.24 (1.56) | 2.63 (1.78) |

Also, a two-way ANOVA was employed among nationality, gender and the appraisal of the support received. No significant effects were revealed (see Appendix 26 for means).

### 5.1.4 The effect of sex roles on attitudes to parenthood

A one-way ANOVA was performed on the mean scores of the nine statements of the Meaning of Parenthood Scale. The aim of this analysis was to look at the relationship between attitudes to parenthood and sex roles (androgynous, feminine, masculine and undifferentiated). The analysis revealed an effect for sex roles, $F(3,382)=3.71$, $p<.012$ – (see Table 5.6 for means and standard deviations). However, the performance of a planned comparison showed significant differences only between androgynous and masculine typed participants ($p=.01$) and between androgynous and undifferentiated ($p=.003$). It seems that categories containing stronger feminine qualities (feminine, androgynous) have higher values (attribute more importance to parenthood), while masculine and undifferentiated are virtually the same.

**Table 5.6: Means and standard deviations* for attitudes to parenthood and attitudes to treatments across the sex roles**

***in parenthesis**

| BEM sex roles | Androgynous | Masculine | Feminine | Undifferentiated |
|---|---|---|---|---|
| Attitudes to parenthood | 3.49 (.80) | 3.19 (.79) | 3.36 (.76) | 3.15 (.93) |
| Attitudes to treatments | 3.19 (1.08) | 3.43 (.97) | 3.50 (1.07) | 3.55 (.89) |

### 5.1.5 The effect of sex roles on attitudes to fertility treatments

A one-way ANOVA was performed on the mean score of the six fertility treatments[6], with the aim of looking at the relationship between attitudes to fertility treatments and sex roles (androgynous, feminine, masculine and undifferentiated).

The analysis revealed a 'borderline' effect for sex roles, $F(3,367)=2.55$, $p<.055$ – (see Table 5.6 for means and standard deviations). The performance of a planned comparison showed significant differences only between androgynous and feminine typed participants ($p=.03$) and between androgynous and undifferentiated ($p=.01$). It seems that the more masculine (androgynous, masculine) have the more positive attitudes towards the treatments.

### 5.1.6 The relationships between attitudes to parenthood and attitudes to fertility treatments, with demographic, well being and social support variables

A number of Pearson product moment correlations were calculated between attitudes to parenthood, attitudes to fertility treatments, demographic, well being and social support variables. The aim of these analyses was to look at the relationships that attitudes to parenthood and attitudes to fertility treatments have with the demographic, the well being and the social support measures for the whole sample and for different sub-groups. For the attitudes to parenthood the mean score of the nine items was used.

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[6] the mean of each one of the 6 treatments across the 14 items were summed and the mean of the six was taken to achieve an overall 'favourableness' score. One item of the original 15 was excluded from the analysis after the employment of a reliability-item analysis (see Section 5.3.1 for more information).

For attitudes to fertility treatments the mean score of all six treatments across the 14 bipolar dimensions was used (see Section 5.3.1, p.131 for the exclusion of one of the dimensions). The demographic variables included in the analyses were: age, number of natural children, years with partner, educational level, degree of religiousness and number of siblings. The total score of the General Health Questionnaire and the three scores from the Quality of Life Questionnaire (see Section 4.4, p.88) comprised the well being variables. The mean number of the supportive people and the mean of the satisfaction with the available support comprised the two scores obtained for the Social Support Questionnaire.

All Pearson product coefficients are presented in Appendix 27. They are not presented here because most of them are not significant. The correlations that are significant at $p<.05$ and are weak ($r<.30$) are reported below only when they reveal consistent relationships among the sub-groups, in order to reduce the chance of spurious effects being reported.

Before investigating the relationship that attitudes to parenthood and attitudes to fertility treatments have with the other variables, a Pearson correlation was employed to check the relationship between attitudes to parenthood and attitudes to fertility treatments. No significant correlations were found either for the whole sample or for the sub-groups (see Appendix 27 Table I).

The degree of religiousness was negatively correlated with attitudes to parenthood (see Appendix 27 Table II). In other words, people that describe themselves as more religious (a high value) place a higher value on the importance of parenthood. No other of the demographic variables was found to have significant or consistent relationships among the sub-groups with attitudes to parenthood. Also, no significant correlations were found between attitudes to parenthood and the well being variables (see Appendix 27 Table III).

The number of supportive people was negatively correlated with attitudes to parenthood (see Appendix 27 Table IV). Participants who report a bigger number of supportive people attribute lower value to the importance to parenthood. This effect seems to be confined to the Greek couples and to females in particular. No significant correlations were found between satisfaction with social support and attitudes to parenthood.

As Table V in Appendix 27 shows there were weak, negative correlations between education and attitudes to fertility treatments across the sub-groups. This means that the more educated participants are, the more positive are their attitudes towards fertility treatments. Attitudes to fertility treatments were also related to the well being variables (see Appendix 27 Table VI). Specifically, the less distressed (GHQ) the individuals are or the lower their Life in General scores (low score = better quality of life) or the more easy and free they perceive their lives to be, the more positive are their attitudes towards the fertility treatments.

In order to explore the relationship among religion affiliation and employment status with attitudes to parenthood and attitudes to fertility treatments, a number of one-way ANOVA's were employed. Neither attitudes to parenthood nor to fertility treatments were affected by either religion membership, employment or living with children (see Appendix 28 for results). It has to be noted though that only the British participants were included in the analyses for religion affiliation, since all the Greeks were members of a religious group.

### 5.1.7 The effect of cause of infertility on attitudes to parenthood and attitudes to fertility treatments.

Two one-way ANOVAs were conducted on the mean scores of the nine items of the Meaning of Parenthood Scale and attitudes to treatments across the causes of infertility (four levels)-(see Table 5.7). The analysis revealed a main effect for cause of infertility and attitudes to parenthood, $F(3,194=3.47)$; $p<.017$. It seems that couples facing a male type fertility problem attributed more importance to parenthood than the other three groups. A planned comparison revealed that this effect was attributable to the significant differences between male and female infertility ($p=.012$) and between male infertility and unknown ($p=.008$). No effect was found for attitudes to treatments and cause of infertility.

| Table 5.7: Means and standard deviations* for attitudes to parenthood across causes of infertility *in parenthesis | | | | |
|---|---|---|---|---|
| **Causes of infertility** | **Female** | **Male** | **Both** | **Unknown** |
| **Attitudes to parenthood** | 3.22 (.76) | 3.59 (.81) | 3.46 (.73) | 3.17 (.82) |
| **Attitudes to treatments** | 3.20 (.92) | 3.28 (1.12) | 3.56 (.96) | 3.18 (.94) |

### 5.1.8 The effect of type of current treatment on attitudes to parenthood and attitudes to fertility treatments.

Two one-way ANOVAs were conducted: 1) the mean scores of the nine items of the Meaning of Parenthood Scale were collapsed and compared across the types of treatments (three levels) that subfertile participants were undergoing at the time of their participation and 2) the same analysis but comparing 'types of treatment' in relation to attitudes to treatments (averaged across the number of different treatments). As was mentioned in Section 5.1 (and see Appendix 21), the majority of the British subfertile participants was undergoing an assisted conception treatment (n=64), while the majority of the Greek subfertile sample was not undergoing any treatment at the time of the questionnaire completion (n=58). None of the British was undergoing a drug treatment, while 26 of the Greek subfertile sample were undergoing a drug treatment.

The aim of these analyses was to explore the relationships that attitudes to parenthood and attitudes to fertility treatments have with the three types of current treatment. These three types were a) undergoing no current treatment or medical investigation, b) undergoing drug or hormone treatments and c) undergoing an assisted conception treatment (IVF, ICSI, donor treatments).

The first analysis revealed a main effect for type of current treatment and attitudes to parenthood, $F(2,197=3.32)$; $p<.038$ – (see Table 5.7.1). The employment of a Scheffé test revealed that there were significant differences between the subfertile participants that were undergoing *a* drug/hormone treatment and those that were receiving an assisted conception treatment ($p=.040$). The first group attributed more importance to parenthood than the second group.

**Table 5.7.1: Means and standard deviations* for attitudes to parenthood and attitudes to fertility treatments across types of current treatment**

***in parenthesis**

| Types of current treatment | Attitudes to parenthood | Attitudes to fertility treatments |
|---|---|---|
| No treatment | 3.43 (.821) | 3.09 (1.21) |
| Drug/hormone treatment | 3.74 (.688) | 3.48 (.729) |
| Assisted conception treatments | 3.29 (.788) | 3.48 (.782) |

The second analysis revealed a main effect for type of current treatment and attitudes to treatments, $F(2,189=3.58)$; $p<.029$ – (see Table 5.7.1). The employment of a Scheffé test revealed that this effect was attributable to the significant differences between the participants that were receiving no treatment and the other two groups that were both under a treatment ($p=.045$). Participants with fertility problems receiving no treatment at the time of their participation in the study had more positive attitudes (lower mean scores) towards the fertility treatments than the participants who were undergoing treatment, regardless of the type of treatment.

### 5.1.8.1 The effect of type of current treatment on the well being variables

A number of separate ANOVAs were performed for each of the four well being variables in relation to the type of current treatment. A main effect was produced for type of current treatment and for the Life in General variable, $F(2,197=3.35)$; $p<.037$ – (see Table 5.7.2). The employment of a Scheffé test revealed that this effect was attributable to the significant differences between those receiving a drug/hormone treatment and those receiving an assisted conception treatment ($p=.039$). The latter group was found to have a lower quality of life (high score) than the former group. No effects were found between the type of current treatment for the GHQ or for any of the two discrete dimensions of the QOL.

**Table 5.7.2: Means and standard deviations* for the well being variables across types of current treatment**

***in parenthesis**

| Types of current treatment | GHQ | Life in General | Easy-hard | Free-Tied down |
|---|---|---|---|---|
| **No treatment** | 11.20 (5.93) | 2.70 (1.38) | 3.84 (1.90) | 3.56 (1.80) |
| **Drug/hormone treatment** | 9.46 (3.88) | 2.24 (.969) | 4.04 (1.89) | 3.46 (2.16) |
| **Assisted conception treatments** | 11.83 (5.51) | 2.93 (.997) | 4.12 (1.66) | 3.66 (1.46) |

### 5.1.9 Summary

Overall, the demographic characteristics of the participants were similarly distributed. The only notable differences found were between British and Greeks for religious affiliation and degree of religiousness. Surprisingly, although all Greek participants were members of a religious group, they reported lower degrees of religiousness than that reported by all British. People that describe themselves as more religious attributed more importance to parenthood.

In relation to well being, women were found to be more distressed than men. Greeks perceived their lives as harder and more tied down than the British. Also, fertile participants reported higher scores on these negative dimensions than the subfertile. Participants' well being was not related to attitudes to parenthood, but it was related to

attitudes to fertility treatments. Participants having greater well being had more positive attitudes towards fertility treatments.

Furthermore, British participants reported receiving support from a greater number of people than the Greeks. Similarly, women felt supported by a larger number of people than men. Participants who had a bigger support network placed less importance on parenthood (for Greeks and females in particular). Finally, the higher the educational level of participants, the more positive the attitudes towards fertility treatments.

In relation to the treatment-related characteristics of the subfertile participants, differences were found between the two nationalities. Most of the British subfertile participants were undergoing an assisted conception treatment, while most of the Greek subfertile participants were receiving no treatment at the time of their participation in the study. Further analyses revealed significant differences between the types of treatment, attitudes to parenthood, attitudes to fertility treatments and the Life in General variable.

# Section II

## The meaning of parenthood in the British and the Greek cultures

### 5.2.1 Exploration of pattern structure

The dimensions of the Meaning of Parenthood scale were explored by the employment of a number of principal components factor analyses. The aim of these analyses was to identify patterns of correlations among the nine items that reflect underlying structures of attitudes towards parenthood for different groups. Specifically, the purpose of these analyses was to trace differences and similarities in factor structure between British and Greeks, between fertile and subfertile participants and between men and women. In order to include only the important components in the analysis, those components whose eigenvalues were less than one were not retained (Kaiser, 1960; Tabachnick & Fidell, 1989).

Also, an orthogonal rotation was considered as an adequate rotation after comparing the pattern of correlations for each one of the groups in the correlation matrix with factors. The unrotated factor loadings are presented in Appendix 29. To be more specific, correlations were moderate and limited to one pair of factors in each analysis and the remaining correlations were very low, indicating that all the factors were correlated mostly with different variables (Tabachnick & Fidell, 1989). A quartimax normalized rotation was retained for interpretation purposes after performing all the extraction techniques that are available from the Statistica package.

Finally, different cutoffs for size of loading to be interpreted were chosen for the factor analyses below based on Tabachnick and Fidell's (1989) criteria. When strengths of correlation are very high then it is appropriate to use robust criteria which according to Tabachnick and Fidell are the loadings in excess of .71. However, when the correlations are less strong then a lower criteria can be chosen which can be a cutoff point of .63 or .55 or .45 or .32 depending on interpretation purposes and researcher preference (Tabachnick & Fidell, 1989).

Initially, separate principal component analyses were conducted for the British and the Greek participants to explore the pattern in factor structure employed by each one of these two groups. Loadings of .71 and above were used. Loadings of variables on factors and percents of variance are shown in Table 5.8. Factor 1 for the British seems to concern the importance of children for a marriage (items 1, 5 & 7) and the naturalness of wanting children (items 2 & 4). Also, item 8 loaded high on this factor, which seems to be linked with role fulfillment. Items 3 and 6 constituted the second factor for the British. These items perceive subfertility as a threat to sexual identity. The Greek participants though seem to distinguish the items that reflect the fact that having children is a natural expectation for the individual (factor 2) from the items that reflect children's importance for a marriage (factor 1). The items that perceive parenthood to be linked with the sexual identity of the individual did not seem to be of particular importance for the formation of a factor for the Greeks.

**Table 5.8: Factor loadings (Quartimax *normalized*) for the Meaning of Parenthood items for the British and the Greeks**

| Items | British | | Greek | |
|---|---|---|---|---|
| | Factor 1 | Factor 2 | Factor 1 | Factor 2 |
| 1) Having children makes a marriage into a family | **.72** | .07 | **.72** | .06 |
| 2) It is only natural that a woman should want children | **.74** | .21 | .26 | **.81** |
| 3) The disappointment of not having children is greater for a woman than it is for a man. | .25 | **.71** | .33 | -.18 |
| 4) It is only natural that a man should want children. | **.74** | -.05 | .07 | **.86** |
| 5) Having children makes a stronger bond between husband and wife. | **.75** | -.14 | .60 | .38 |
| 6) It is more difficult for a man to accept being sub-fertile than it is for a woman. | .11 | **.75** | .43 | -.33 |
| 7) Having children is the most important function of marriage. | **.73** | -.07 | **.74** | .16 |
| 8) Becoming a mother makes a woman truly female. | **.73** | .35 | .66 | .22 |
| 9) A man can never be sure about his masculinity until he is a father. | .48 | .35 | .60 | .03 |
| **% Total Variance** | 41.84 | 13.06 | 32.29 | 16.19 |
| **Expl. Var.** | 3.57 | 1.37 | 2.59 | 1.77 |
| **Prp. Totl.** | .396 | .153 | .288 | .196 |

Furthermore, separate principal components analyses were employed for the fertile, the subfertile, the male and the female participants. The factor loadings and percentages of variance are presented in Table 5.9. For interpretation purposes, loadings of .63 and above were used, which are considered to be very good (Tabachnick & Fidell, 1989). Factor 1 for the fertile group seems to represent the importance of children for a marriage (items 5 & 7) and the naturalness of wanting children (items 2 & 4). Also, item 8 loaded high on this factor, which seems to be

linked with role fulfillment. Factor 2 and 3 for the fertile are item specific. In particular, factor 2 represents the fact that childlessness is a threat mainly to a woman's identity. Factor 3 reflects the fact that subfertility acts mainly as a threat to a man's identity. For the subfertile, factor 1 reflects the natural expectation of wanting children for the individual. Factor 2 seems to be concerned with the perception of infertility as a threat to a man and a woman's sexual identity. From the above, it seems that the subfertile participants do not distinguish the threat that infertility poses to a man's identity from a woman's identity like the fertile individuals do.

Finally, factor 1 for men seem to be concerned with the naturalness of wanting children. Factor 2 and 3 for men are item specific. Factor 2 represents the threat childlessness imposes on female identity. Factor 3 is representative of children's function into a marriage. For women, the first factor represents the fact that children are a natural expectation for the individual and are mostly important for a marriage. Also, item 8, having to do with role fulfillment, loaded high on factor 1. Factor 2 for women seems to be concerned with the perception of infertility as a threat to a man's identity. It is apparent from the above that men seem to perceive infertility as a threat mainly for a woman's identity. Similarly, women seem to be concerned with the threat infertility poses on a man's identity.

**Table 5.9: Factor loadings (Quartimax normalized) for the Meaning of Parenthood items for the fertile, the subfertile, men and women**

| Items | Fertile | | | Subfertile | | Men | | | Women | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Factor 1 | Factor 2 | Factor 3 | Factor 1 | Factor 2 | Factor 1 | Factor 2 | Factor 3 | Factor 1 | Factor 2 |
| Item 1 | .60 | -.03 | .40 | .22 | .55 | .15 | -.11 | **.77** | .38 | .54 |
| Item 2 | **.80** | .19 | .18 | **.86** | .11 | **.87** | .15 | .08 | **.87** | .11 |
| Item 3 | .10 | **.82** | .28 | -.12 | **.64** | .03 | **.85** | -.03 | .14 | .62 |
| Item 4 | **.78** | -.05 | .13 | **.90** | .01 | **.91** | -.01 | .09 | **.86** | -.09 |
| Item 5 | **.83** | -.16 | -.08 | .55 | .49 | .54 | -.11 | .57 | **.76** | .24 |
| Item 6 | .25 | .14 | **.78** | -.04 | .55 | -.04 | .16 | .57 | .06 | **.66** |
| Item 7 | **.83** | .04 | -.05 | .61 | .45 | .54 | .10 | .60 | **.77** | .19 |
| Item 8 | **.77** | .30 | -.16 | .50 | .60 | .53 | .39 | .50 | **.68** | .36 |
| Item 9 | .36 | .57 | -.39 | .18 | **.63** | .24 | .56 | .33 | .21 | .59 |
| **%Tot. Variance** | 43.9 | 12 | 11.4 | 39 | 14.5 | 40.5 | 12.5 | 11.3 | 42.7 | 13.3 |
| **Expl. Var.** | 3.80 | 1.17 | 1.08 | 2.57 | 2.24 | 2.53 | 1.27 | 1.99 | 3.34 | 1.70 |
| **Prp. Totl.** | .422 | .130 | .120 | .285 | .249 | .281 | .141 | .221 | .371 | .189 |

### 5.2.2 Overview

Somewhat different factor structures were revealed by each of the principal components analyses between British and Greeks, between the fertile and the sub-fertile participants and between men and women. Quite interestingly, the Greek group was the only one that did not pay particular attention to items linking parenthood with sexual identity. The factors extracted for men and women were the same. After performing all the available extraction techniques by the Statistica package, the quartimax normalized rotation technique was retained and presented for interpretation purposes. The differences and similarities in factor structure for all groups could be investigated in more depth with further tests (Cattell & Bagalley, 1960; Tabachnick & Fidell, 1989). However, an extensive exploration of pattern and magnitude of loading in the data sets would be tangential to the objectives of this study.

### 5.2.3 The effect of nationality, fertility and gender on attitudes to parenthood

A four-way repeated measures ANOVA was performed on items of the Meaning of Parenthood Scale. The mean score of these nine items was not used in this analysis because each one of the items was perceived to be of particular importance. This was also suggested by the factor analysis (see Section 5.2.1), where interesting differences in factor structure were found for different groups. The aim of this analysis was to explore the relationship between the nine items of the Meaning of Parenthood Scale and the three independent variables that follow: a) nationality (British and Greek), b) fertility (fertile and subfertile) and c) gender (men and women). The analysis revealed three main effects and three two-way interactions.

In particular, the Greeks seem to value more the importance of having children than do the British, $F(1,390)=130.31$, $p<.001$ – (see Table 5.10 for means and standard deviations). Scores ranged from one to five, with higher scores indicating more importance attributed to the issue represented (item). However, the interaction between nationality and the items, $F(8,3120)=33.38$, $p<.001$, revealed that the main effect for nationality was attributable to the items that reflect the fact that parenthood is a natural expectation for the individual and a marriage (items no. 2, 4, 5, 6, 7 and 8) – (see Table 5.10 for means and standard deviations) - (see Figure 5.1 for interaction). No differences were found between the British and the Greek participants in relation to the items that reflect the fact that parenthood act as a confirmation of the individual's sexual identity (items no. 3 and 9). Also, no differences were found between the British and the Greeks for item 1 that represents the children's function in a marriage.

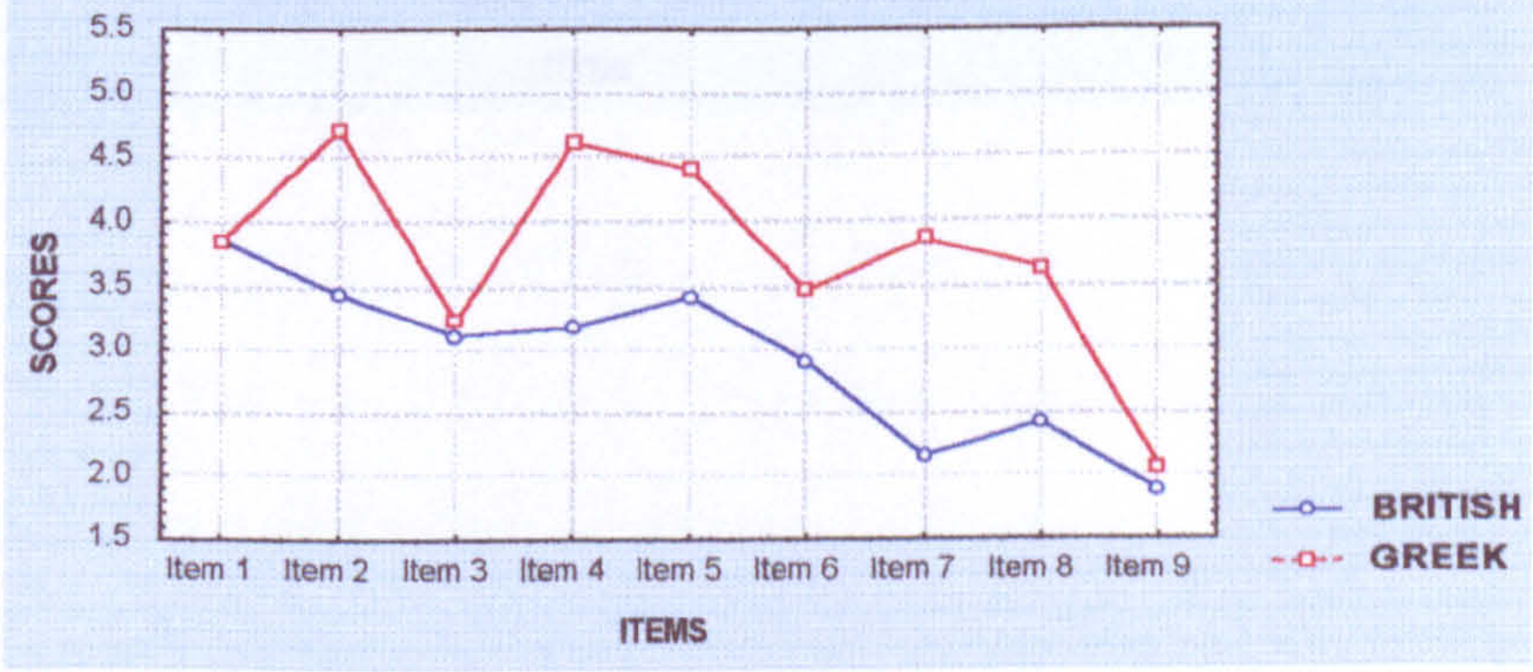
**Table 5.10: Mean values and standard deviations* for nationality, fertility and Meaning of Parenthood items**

*in parenthesis

| Items | All 400 Participants | | | British | | | Greek | | |
|---|---|---|---|---|---|---|---|---|---|
| | Fertile | Sub-fertile | Total | Fertile | Sub-fertile | Total | Fertile | Sub-fertile | Total |
| **Item 1** | 3.92 (1.26) | 3.78 (1.33) | 3.85 (1.29) | 3.72 (1.25) | 3.99 (1.13) | 3.85 (1.20) | 4.13 (1.25) | 3.57 (1.47) | 3.85 (1.39) |
| **Item 2** | 3.88 (1.29) | 4.28 (1.09) | 4.08 (1.21) | 3.14 (1.27) | 3.74 (1.27) | 3.44 (1.30) | 4.62 (0.80) | 4.82 (0.45) | 4.72 (0.65) |
| **Item 3** | 3.13 (1.47) | 3.22 (1.55) | 3.18 (1.50) | 2.93 (1.43) | 3.29 (1.57) | 3.11 (1.51) | 3.33 (1.48) | 3.15 (1.53) | 3.24 (1.50) |
| **Item 4** | 3.66 (1.35) | 4.12 (1.14) | 3.89 (1.26) | 2.84 (1.18) | 3.51 (1.23) | 3.17 (1.25) | 4.48 (0.94) | 4.73 (0.60) | 4.61 (0.79) |
| **Item 5** | 3.82 (1.19) | 4.00 (1.17) | 3.91 (1.18) | 3.20 (1.08) | 3.63 (1.25) | 3.41 (1.19) | 4.44 (0.94) | 4.37 (0.96) | 4.41 (0.95) |
| **Item 6** | 3.22 (1.45) | 3.16 (1.41) | 3.19 (1.43) | 2.93 (1.43) | 2.89 (1.40) | 2.91 (1.41) | 3.51 (1.41) | 3.42 (1.38) | 3.46 (1.39) |
| **Item 7** | 2.93 (1.56) | 3.10 (1.45) | 3.01 (1.50) | 2.01 (1.12) | 2.32 (1.14) | 2.16 (1.14) | 3.85 (1.38) | 3.87 (1.30) | 3.86 (1.34) |
| **Item 8** | 2.94 (1.56) | 3.10 (1.50) | 3.02 (1.53) | 2.18 (1.18) | 2.65 (1.40) | 2.41 (1.31) | 3.71 (1.53) | 3.55 (1.46) | 3.63 (1.49) |
| **Item 9** | 1.90 (1.23) | 2.06 (1.25) | 1.98 (1.24) | 1.81 (1.06) | 1.96 (1.15) | 1.88 (1.10) | 1.99 (1.38) | 2.15 (1.34) | 2.07 (1.36) |
| **Total** | 3.26 (1.37) | 3.42 (1.32) | 3.34 (1.35) | 2.75 (1.22) | 3.10 (1.28) | 2.92 (1.27) | 3.78 (1.23) | 3.73 (1.17) | 3.76 (1.21) |

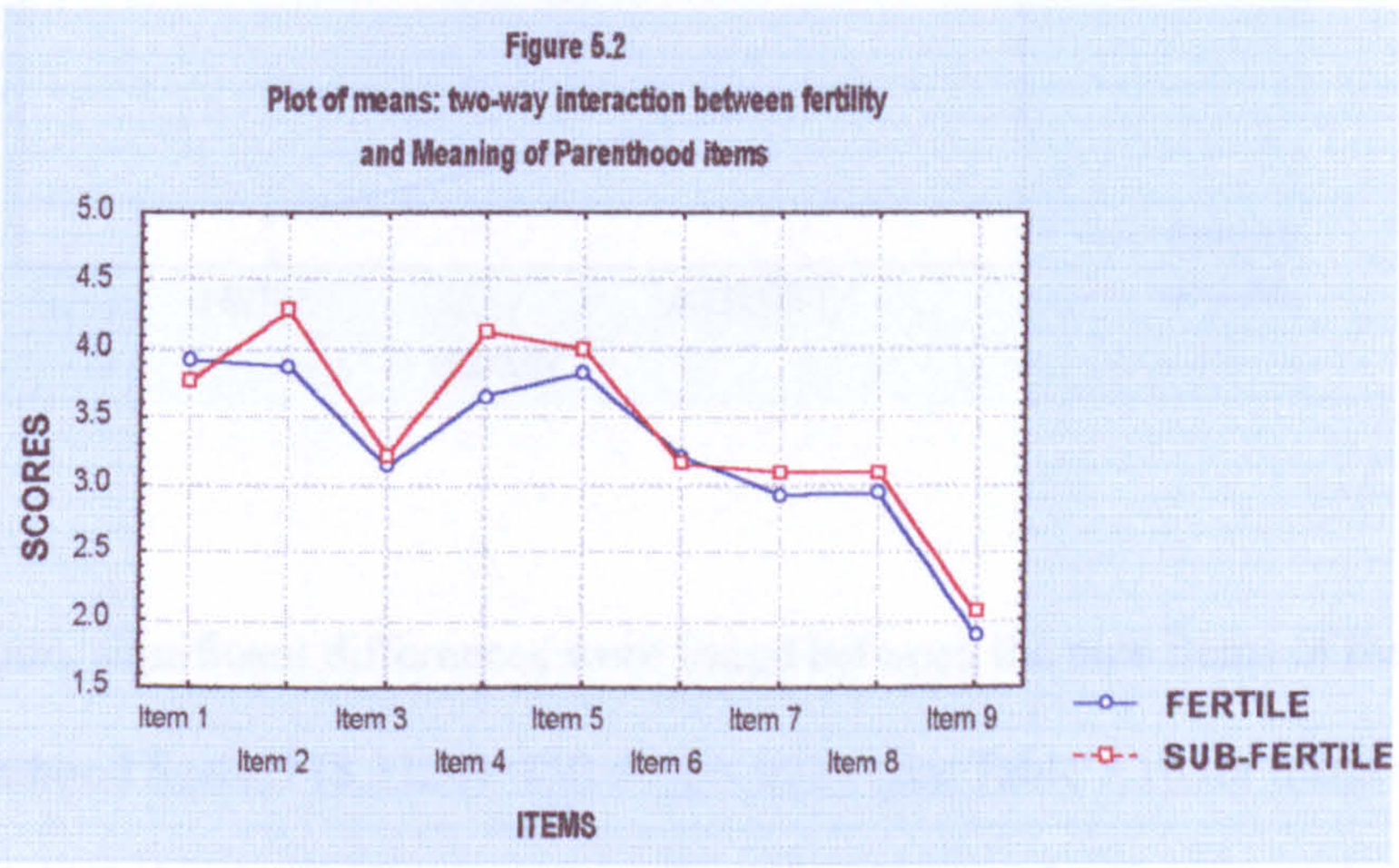
**Figure 5.1**

**Plot of means: two-way interaction between nationality and Meaning of Parenthood items**



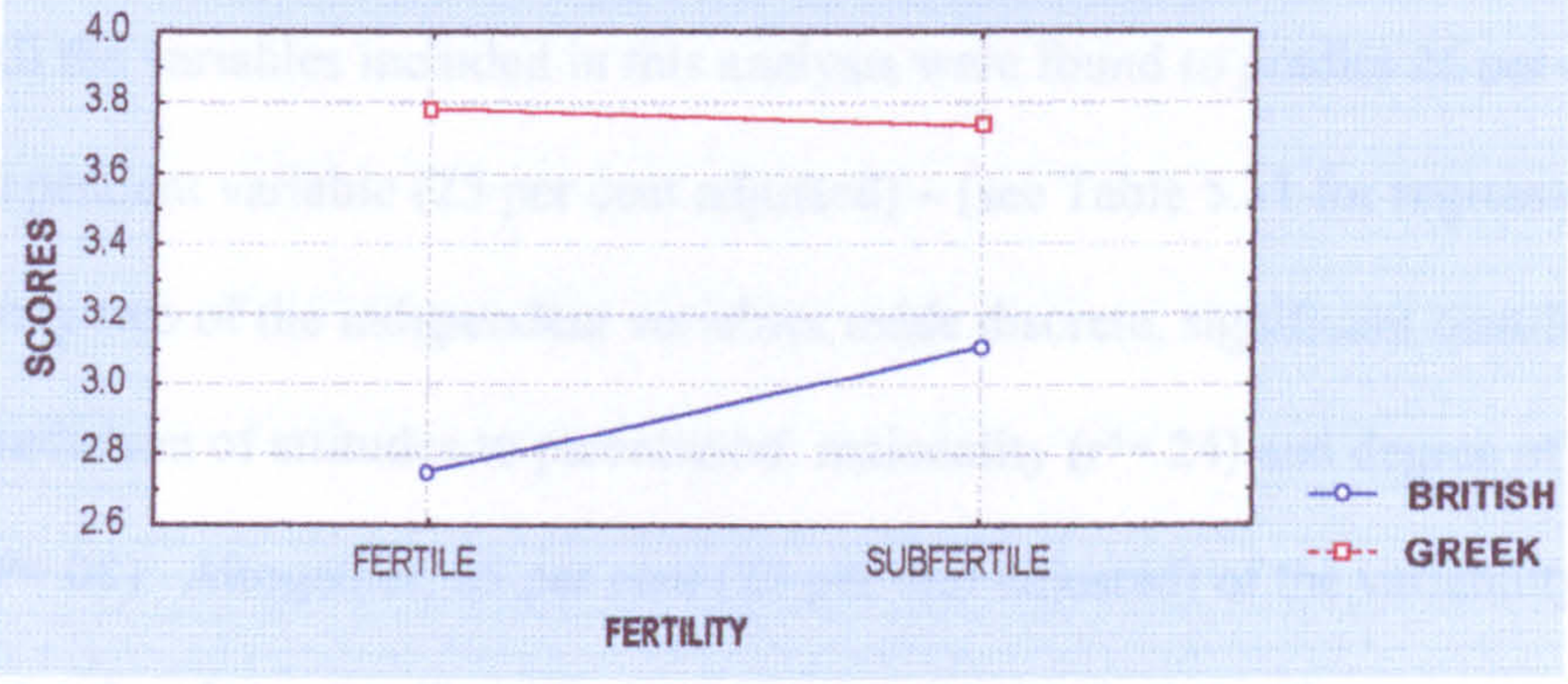
A main effect was also found for the fertility variable. The subfertile participants valued more the importance of having children than the fertile ones, $F(1,390)=4.57$, $p<.04$. The means and the standard deviations of the scores for the subfertile and the fertile participants can be found in Table 5.10. However, the interaction between fertility and the items, $F(8,3120)=3.13$, $p<.002$, revealed that this effect was mainly due to the second and the fourth items (see Table 5.10 and Figure 5.2). The subfertile participants scored significantly higher than their fertile counterparts on these two items only, concerning the naturalness of wanting children. No significant differences were found between the other seven items.

**Figure 5.2**
**Plot of means: two-way interaction between fertility and Meaning of Parenthood items**



Furthermore, as the interaction between nationality and fertility revealed, $F(1,390)=7.76$, $p<.006$, British participants' views of the importance of parenthood differ as a function of fertility, but this is not the case for the Greeks. As it can be seen in Figure 5.3, the British subfertile participants scored (significantly) higher than the British fertile ones, whereas these two Greek groups' scores did not differ. The mean values and standard deviations can be found in Table 5.10.

**Figure 5.3**
**Plot of means: two-way interaction between nationality, fertility and Meaning of Parenthood items**




In addition, significant differences were found between the nine items of the Meaning of Parenthood Scale, $F(8,3120)=150.44$, $p<.001$ - (see Table 5.10 for mean scores and standard deviations). Participants gave the highest scores for items 2, 5, 1 and 4. These items reflect the fact that children are a natural expectation for the individual and a marriage. The lowest score was attributed to the last item of the scale. This item reflects the fact that fatherhood acts as a confirmation of masculinity. There was no main effect for gender, $F(1,390)=.11$, $p<.743$ or interaction.

### 5.2.4 Prediction of attitudes to parenthood

A standard multiple regression was performed with attitudes to parenthood as the dependent variable and nationality, fertility and degree of religiousness as independent variables. The aim of the analysis was to identify the most important predictors of attitudes to parenthood. The rest of the demographic variables and the well being variables were not included in this analysis because they were not found to correlate with the dependent variable.

All the variables included in this analysis were found to predict 26 per cent of the dependent variable (25 per cent adjusted) – (see Table 5.11 for regression summary). Only two of the independent variables made discrete, significant contributions to the prediction of attitudes to parenthood: nationality ($r^2$=.24) and degree of religiousness ($r^2$=.08). Altogether, 25 per cent (25 per cent adjusted) of the variability in attitudes to parenthood was predicted by knowing participants' nationality and degree of religiousness.

**Table 5.11: Multiple regression results for predicting attitudes to parenthood for the whole sample**

| | | |
|---|---|---|
| N=390 | mr=.51, $r^2$=.26,<br>adjusted $r^2$=.25<br>std. error=.19 | F(3,386) = 44.36; p=.000<br>t(386)=12.60 p<0.00 |
| **Nationality: beta=.445, t(386)=9.47, p=.000**<br>Fertility: beta=.080, t(386)=1.82, p=0.7<br>**Religiousness: beta=-.12, t(386)=-2.44, p=.015**<br><br>***significant results in bold** | | |

As was already mentioned, attitudes to parenthood were found to correlate with the number of supportive people (Section 5.1.6). Thus, another standard multiple regression was performed for the subfertile participants. The independent variables were nationality, degree of religiousness and the number of supportive people. All the included variables were found to predict 20 per cent of the dependent variable (18 per cent adjusted).

Only two of the independent variables made discrete, significant contributions. These were nationality ($r^2$=.16) and the number of supportive people ($r^2$=.07). Altogether, 19% (18% adjusted) of the variability in attitudes to parenthood was predicted by knowing nationality and the number of supportive people. In Table 5.12 below, a detailed presentation of the multiple regression's results is given.

**Table 5.12: Multiple regression results for predicting attitudes to parenthood for the subfertile sample**

| | | |
|---|---|---|
| N= 194 | mr=.49, $r^2$=.20,<br>adjusted $r^2$=.19<br>std. error=.31 | F(3,190) = 15.91; p=.000<br>t(190)=10.14 p<0.00 |

**Nationality: beta=.310, t(190)=4.17, p=.000**

Religiousness: beta=-.10, t(189)=-1.42, p=.157

**Number of supportive people: beta=-.20, t(190)=-2.95, p=.004**

***significant results in bold**

### 5.2.5 Overview

Results indicated that the Greek participants placed higher value on most aspects of parenthood as measured by the Meaning of Parenthood Scale than did the British. Also, British subfertile participants valued more the importance of having children than the fertile ones. This is not the case for the Greeks. Furthermore, the interactions between nationality and the items and between fertility and the items are of particular interest. Finally, nationality was the most important variable in predicting attitudes to parenthood, with religiousness and size of social support network also accounting for some of the variances in MPS scores. Specifically, a high degree of religiousness and a big number of supportive people were related with high importance attributed to parenthood.

# Section III

# Cognitive constructions of fertility treatments in the British and the Greek cultures

## 5.3.1 The effect of nationality, fertility and gender on attitudes to fertility treatments

Initially, an item reliability test was employed to check the intraclass correlation of the fifteen bipolar dimensions measuring attitudes to the six fertility treatments. Reliabilities of the 15 items within each of the six treatments separately were consistently high for both British and Greek samples, ranging from .80 to .89, as was mentioned in Appendix 10. The Alpha values improved across all the treatments if the ninth bipolar dimension (sophisticated vs. simple medical technology) was deleted. In particular, if the specific item was deleted Cronbach alpha ranged from .82 to .90 (see Appendix 30). Thus, this item was extracted from the rest. Item 9 (medical sophistication), in contrast with the other 14 items, is not easy to be classified in terms of 'good' or 'bad'. Two analyses were performed; one for the fourteen dimensions and another for the ninth one. Even though the attitude measure was found to have high internal consistency.

A five-way ANOVA was employed using nationality, fertility and gender as between subjects factors. The fourteen bipolar dimensions and the six fertility treatments were the within subjects factors. The analysis revealed main effects for nationality, fertility, the treatments, the dimensions and several interactions. The three-way and four-way

interactions revealed by this analysis will not be presented because they did not add anything significant in terms of meaning to the two-way interactions. Additionally, the effect size for each one of these higher order interactions was calculated and found to be extremely small. According to Cohen (1977), an effect size of .01 is small, an effect size of .06 is medium and an effect size of .14 is considered as large. The proportion of variance accounted for by the largest of these interactions was less than .007 (see Appendix 31a for size effects).

The main effect for nationality, $F(1,365)= 5.42, p<.020$, indicated that the British participants scored higher, or had a more negative attitude, overall towards the treatments than did the Greek ones (see Table 5.13 for means and standard deviations). Also, the main effect for fertility, $F(1,365)= 4.59, p<.033$, showed that the fertile participants had more negative attitudes (scored higher) as Figure 5.4 shows than their subfertile counterparts, although this is due entirely to the British fertile group, $F(1,365)=8.99, p<.003$ for the interaction – (see Table 5.13). This group is more negative than any of the other three groups. Thus, the main effects for nationality and fertility are due to the relatively negative evaluations of treatments from the British fertile group.

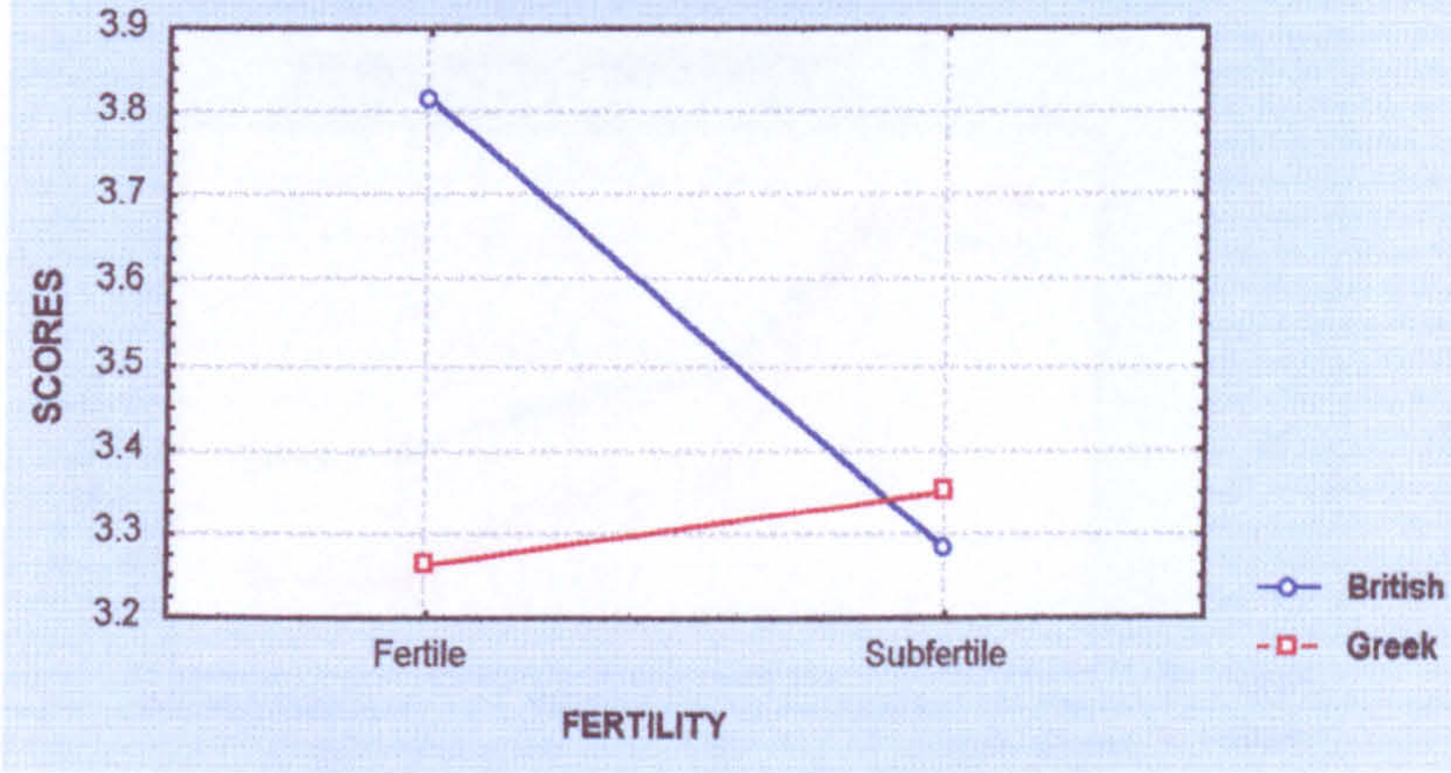
**Table 5.13: Means and standard deviations* of all groups for the six treatments**

*** in parenthesis**

| | BRITISH | | | GREEK | | |
|---|---|---|---|---|---|---|
| | **Men** | **Women** | **Total** | **Men** | **Women** | **Total** |
| **Fertile** | 3.87 (.867) | 3.76 (.919) | 3.82 (.890) | 3.26 (1.02) | 3.27 (1.07) | 3.27 (1.04) |
| **Sub-fertile** | 3.33 (.810) | 3.23 (.981) | 3.28 (.896) | 3.31 (1.05) | 3.40 (1.22) | 3.32 (1.13) |
| **Total** | 3.60 (.877) | 3.49 (.985) | 3.55 (.931) | 3.26 (1.03) | 3.33 (1.14) | 3.29 (1.09) |

**Figure 5.4**

**Plot of Means (unweighted): two-way interaction between nationality, fertility and attitudes to treatments**

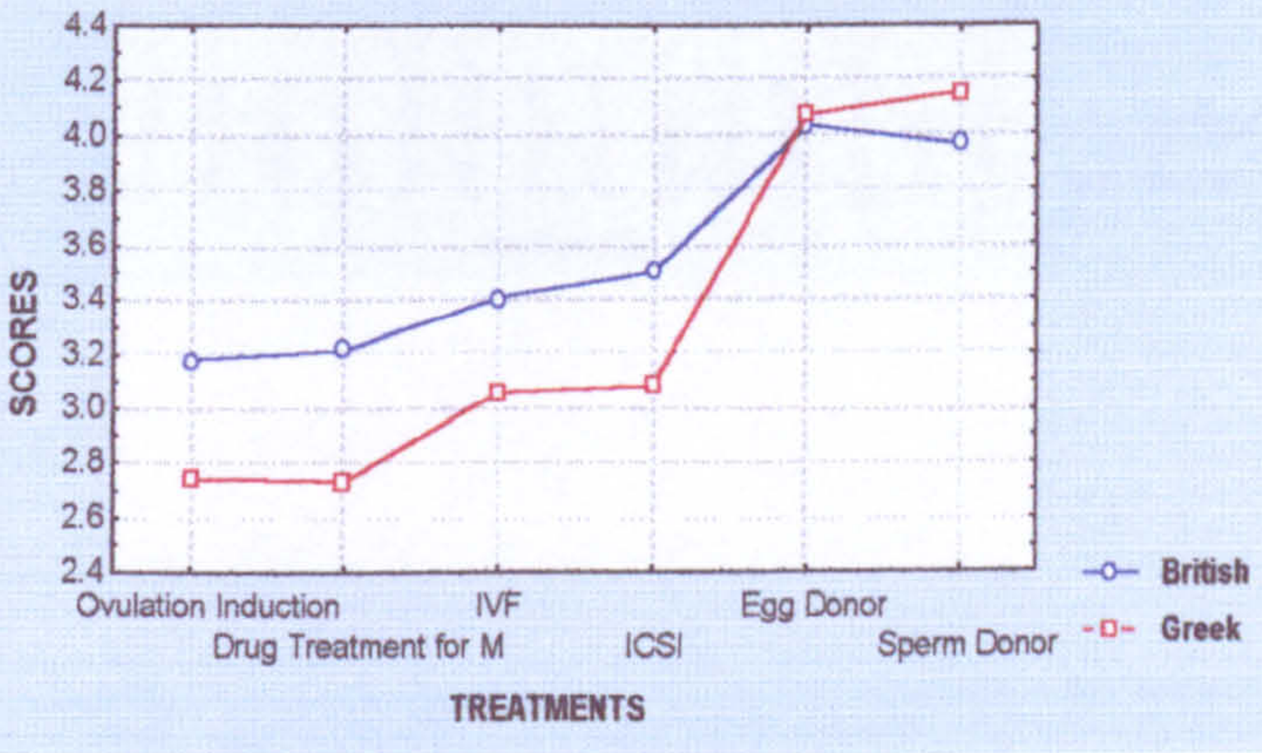



Furthermore, a two-way interaction between nationality and the treatments, $F(5,1825)=19.74$, $p<.001$, revealed that British participants scored higher (more negatively) than the Greeks for all the treatments except the two donor treatments, where no significant differences were found (see Table 5.14 for means) - (see Figure 5.5).

| Table 5.14: Means of attitude scores for nationality and the six treatments | | | |
|---|---|---|---|
| **Treatments** | **British** | **Greek** | **All participants** |
| **Ovulation induction** | 3.18 | 2.74 | 2.96 |
| **Drug treatment for males** | 3.22 | 2.73 | 2.97 |
| **IVF** | 3.40 | 3.06 | 3.23 |
| **ICSI** | 3.50 | 3.08 | 3.29 |
| **Egg donor** | 4.03 | 4.07 | 4.05 |
| **Sperm donor** | 3.96 | 4.15 | 4.06 |

**Figure 5.5**

**Plot of Means [unweighted]: two-way interaction between nationality and the six fertility treatments**




Additionally, although the British made more negative evaluations overall than the Greeks for the six treatments (see Table 5.15 for means), this effect is mainly due to items 8 and 10 (humiliation, $p$=.0001; sexual life, $p$=.043) – (see Figure 5.6). No significant differences were found on the rest of the bipolar dimensions between the two nationality groups.

With respect to the other variables, a two-way interaction, $F(13, 4745)=3.72$, $p<.001$, between fertility and the bipolar dimensions showed that the fertile participants scored higher than the sub-fertile participants particularly in relation to items 12 (moral dilemma, $p=.028$) – (see Table 5.15 for means) - (see Figure 5.7). There were no significant differences on the rest of the items between the fertile and the subfertile participants.

**Figure 5.6**

**Plot of Means (unweighted): two-way interaction between nationality and the 14 dimensions**

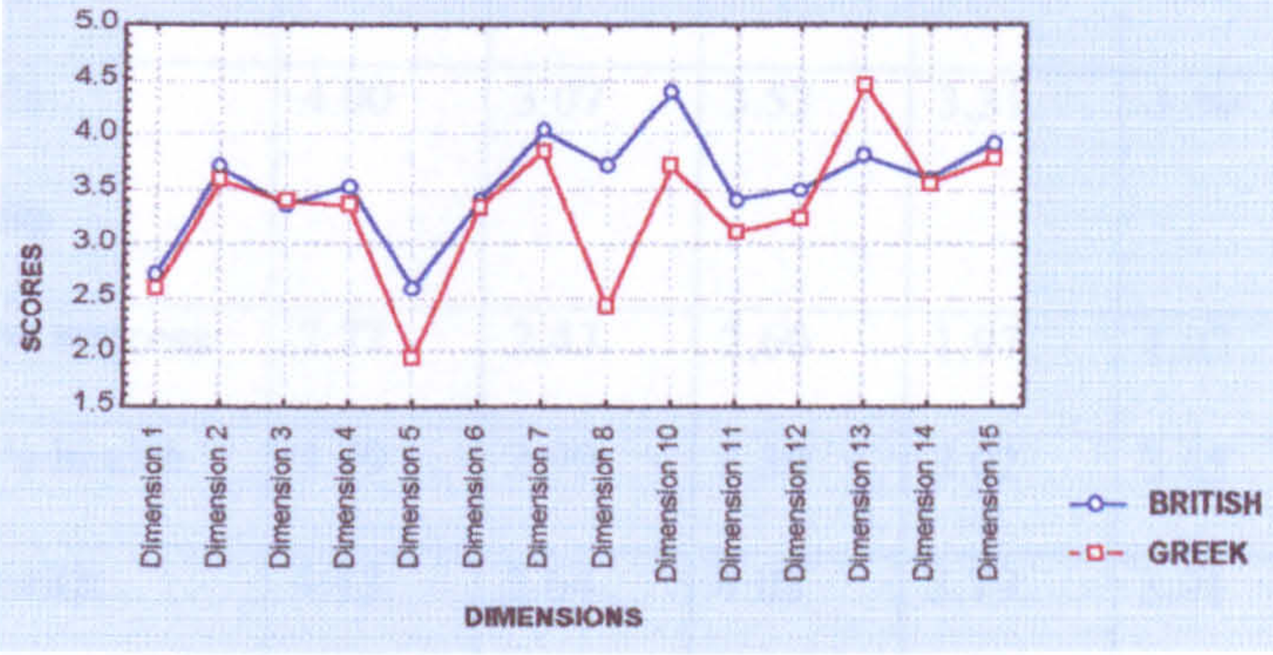
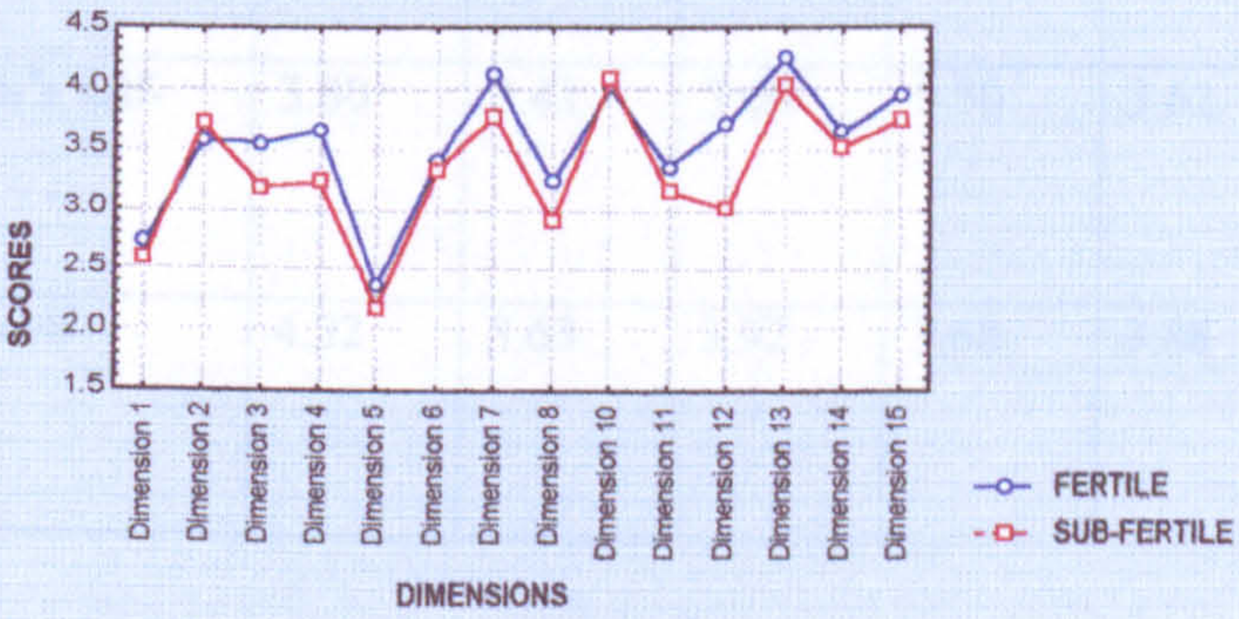



**Figure 5.7**

**Plot of Means (unweighted): two-way interaction between fertility and the 14 dimensions**

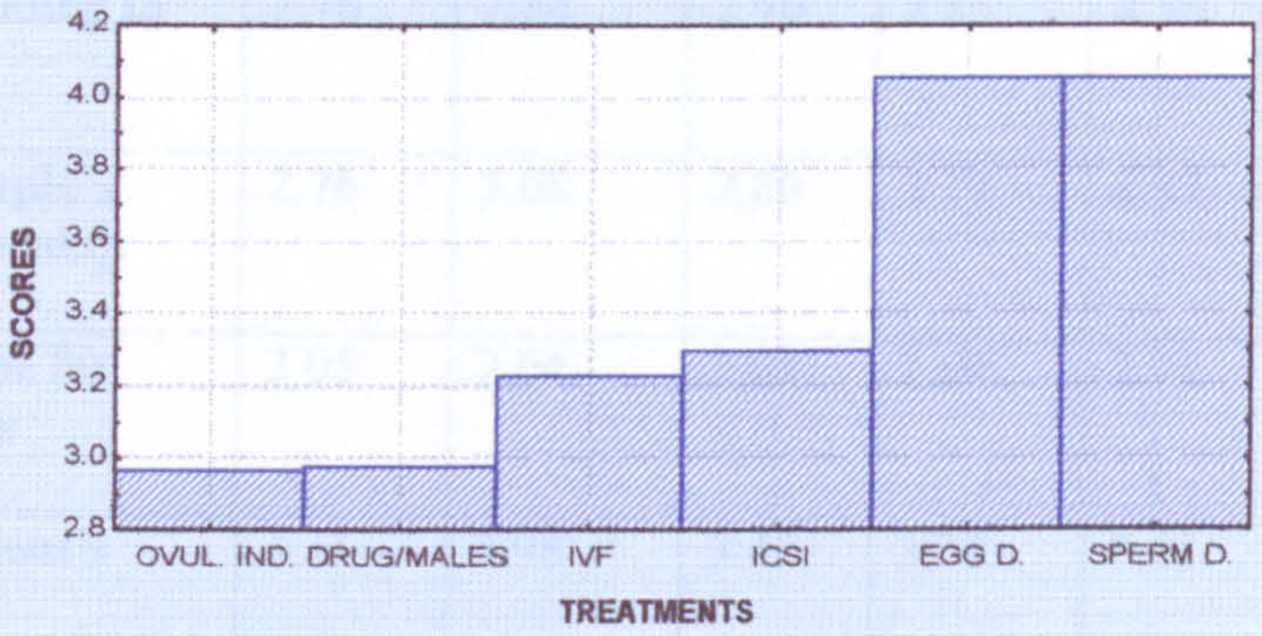


## Table 5.15: Means for nationality, fertility and dimensions

| Dimensions | British | | All British | Greek | | All Greeks | Total |
|---|---|---|---|---|---|---|---|
| | Fertile | Sub-fertile | | Fertile | Sub-fertile | | |
| 1) Social acceptability | 2.81 | 2.65 | 2.73 | 2.63 | 2.55 | 2.59 | 2.66 |
| 2) Physical pain | 3.84 | 3.56 | 3.70 | 3.31 | 3.85 | 3.58 | 3.64 |
| 3) Bonding to child | 3.65 | 3.07 | 3.36 | 3.46 | 3.32 | 3.39 | 3.37 |
| 4) Couple's relationship | 4.00 | 3.07 | 3.53 | 3.31 | 3.39 | 3.35 | 3.44 |
| 5) Hope for success | 2.77 | 2.43 | 2.60 | 1.97 | 1.93 | 1.95 | 2.28 |
| 6) Patient's health | 3.79 | 2.99 | 3.39 | 3.02 | 3.65 | 3.33 | 3.36 |
| 7) Fetal health | 4.43 | 3.64 | 4.03 | 3.79 | 3.91 | 3.85 | 3.94 |
| 8) Humiliation | 4.05 | 3.39 | 3.72 | 2.42 | 2.44 | 2.43 | 3.07 |
| 10) Sexual life | 4.42 | 4.37 | 4.40 | 3.62 | 3.79 | 3.70 | 4.05 |
| 11) Social exposure | 3.64 | 3.18 | 3.41 | 3.09 | 3.13 | 3.11 | 3.26 |
| 12) Moral dilemma | 3.96 | 3.04 | 3.50 | 3.49 | 2.99 | 3.24 | 3.37 |
| 13) Artificiality | 4.07 | 3.53 | 3.80 | 4.41 | 4.51 | 4.46 | 4.13 |
| 14) Woman's self-esteem | 3.80 | 3.41 | 3.60 | 3.50 | 3.62 | 3.56 | 3.58 |
| 15) Man's self-esteem | 4.22 | 3.63 | 3.92 | 3.68 | 3.86 | 3.77 | 3.85 |

Also, a main effect was found for the 14 bipolar dimensions, $F(13, 4745)=91.33$, $p<.001$ – (see Table 5.15 for mean values). The lowest (most positive) scores were given for items 5 and 1 (hope for success and social acceptability). The highest scores were given for items 13, 10, 7 and 15 (interference with the natural process, sexual life, fetal physical health and a man's self-esteem).

**Figure 5.8**
**Plot of Means: Main Effect**
**for the six fertility treatments**




Moreover, significant differences in attitudes were found for the fertility treatments, $F(5,1825)= 247.39$, $p<.0001$ – (see Table 5.13 for means). As is obvious, from Figure 5.8 above, participants scored the lowest (most positive) on ovulation induction and drug treatment for males. They scored somewhat higher on IVF and ICSI than on the above treatments. The highest scores were given for the sperm and egg donor treatments. The employment of Scheffé tests showed that the above effects were significant at .001. However, as it is obvious from Figure 5.8, the big effect has to do with the donor treatments, which have higher scores for all items than the rest of the treatments, particularly for items 1, 3, 4 and 12 (social acceptability, bonding to child, couple's relationship and moral dilemma) – (see Figure 5.9). The above differences

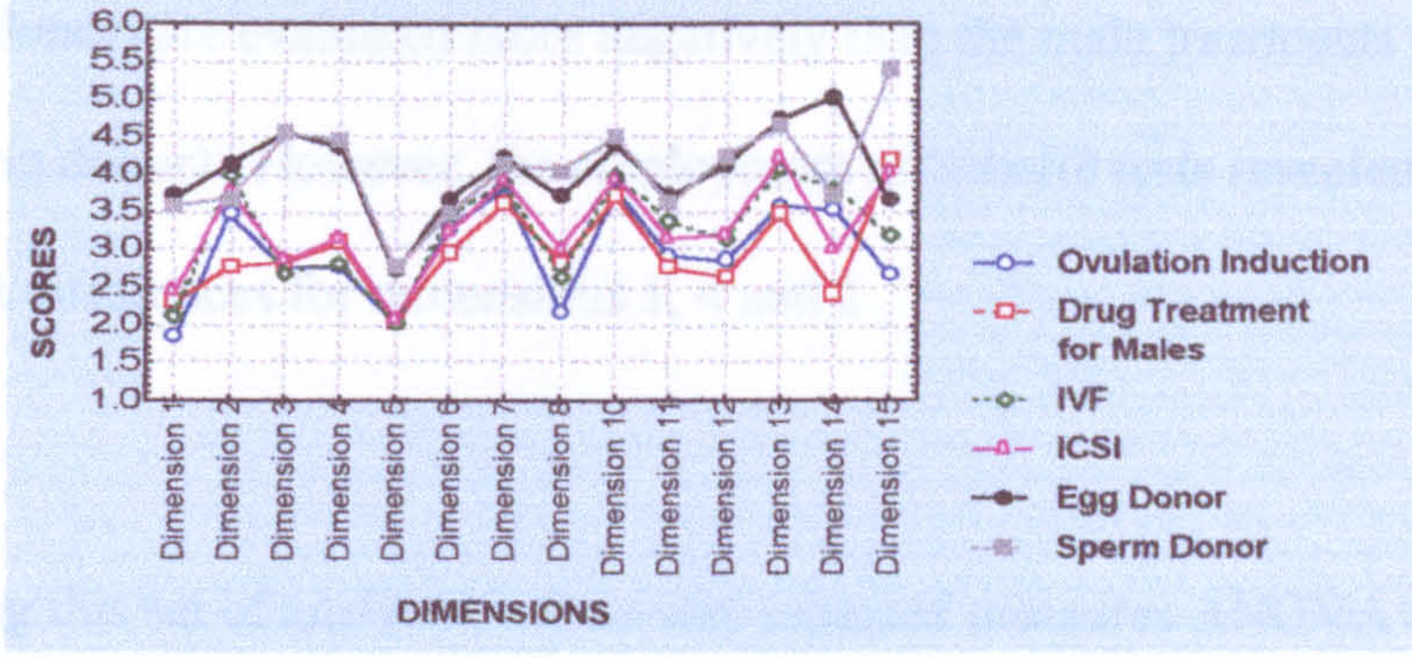
were confirmed by the employment of Scheffé tests for all the items across the treatments.

**Table 5.16: Means for treatments and dimensions**

| Dimensions | Ovul. Induc. | Drugs for men | I.V.F. | I.C.S.I. | Egg Donor | Sperm Donor | Total |
|---|---|---|---|---|---|---|---|
| 1) Social acceptability | 1.82 | 2.32 | 2.11 | 2.45 | 3.69 | 3.59 | 2.66 |
| 2) Physical pain | 3.46 | 2.77 | 4.00 | 3.78 | 4.15 | 3.68 | 3.64 |
| 3) Bonding to child | 2.76 | 2.84 | 2.70 | 2.85 | 4.56 | 4.54 | 3.37 |
| 4) Couple's relationship | 2.76 | 3.08 | 2.80 | 3.17 | 4.37 | 4.47 | 3.44 |
| 5) Hope for success | 2.05 | 2.04 | 2.01 | 2.09 | 2.71 | 2.76 | 2.28 |
| 6) Patient's health | 3.31 | 2.98 | 3.48 | 3.24 | 3.68 | 3.48 | 3.36 |
| 7) Fetal health | 3.83 | 3.63 | 3.91 | 3.93 | 4.24 | 4.12 | 3.94 |
| 8) Humiliation | 2.17 | 2.83 | 2.65 | 3.03 | 3.70 | 4.06 | 3.07 |
| 10) Sexual life | 3.78 | 3.69 | 3.98 | 3.96 | 4.40 | 4.50 | 4.05 |
| 11) Social exposure | 2.93 | 2.76 | 3.38 | 3.15 | 3.70 | 3.62 | 3.26 |
| 12) Moral dilemma | 2.85 | 2.63 | 3.16 | 3.19 | 4.13 | 4.25 | 3.37 |
| 13) Artificiality | 3.59 | 3.49 | 4.09 | 4.24 | 4.74 | 4.64 | 4.13 |
| 14) Woman's self-esteem | 3.51 | 2.41 | 3.80 | 3.01 | 5.04 | 3.72 | 3.58 |
| 15) Man's self-esteem | 2.68 | 4.17 | 3.18 | 4.02 | 3.65 | 5.39 | 3.85 |
| Total | 2.96 | 2.97 | 3.23 | 3.29 | 4.05 | 4.06 | 3.43 |

Figure 5.9

Plot of Means (unweighted): two-way interaction between the six fertility treatments and the 14 dimensions




Some interesting patterns in relation to male and female infertility become apparent by looking at Table 5.16. For example, with dimension 14 (woman's self-esteem), participants evaluated more negatively the treatments corresponding to female infertility (ovulation induction, IVF, egg donor) than they did for the treatments corresponding to male infertility (drug treatment for males, ICSI, sperm donor). Alternatively, for dimension 15 (man's self-esteem) participants had a more negative attitude towards the treatments due to male infertility than towards the treatments referring to female infertility. Overall, participants gave higher ratings for treatments referring to male infertility than they did for treatments due to female infertility. The employment of Scheffé tests revealed significant differences between ovulation induction and drug treatment for males and between egg and sperm donor treatments for both 14 and 15 dimensions ($p$=.0001).

This tendency for seeing the male treatments more negatively than the female treatments was apparent also for dimensions 1 and 4 (social acceptability and couple's

emotional relationship. On the contrary, for dimension 2 (physical pain) it seems by looking at Table 5.16 that the female-based treatments (i.e., ovulation induction, IVF, egg donor) are evaluated more negatively than the male treatments (i.e., drug, ICSI, sperm donor). However, the employment of Scheffé tests revealed no significant differences for dimensions 1, 4 and 2.

Completing this set of analyses, a four-way repeated measures ANOVA was performed using the 9$^{th}$ bipolar dimension (medical sophistication) and the six fertility treatments as a within subjects factor. Nationality, fertility and gender were the between subjects factors. The analysis revealed main effects for nationality, fertility, the treatments and several interactions (see Appendix 31b for effect size).

Specifically, the main effect for nationality, $F(1,381)=23.30$, $p<.001$, indicated that the British participants in general perceived the six fertility treatments as less sophisticated (scored higher) than did the Greek participants. Also, the main effect for fertility showed, $F(1,381)=5.88$, $p<.016$, that the fertile participants overall perceived the six treatments to be less sophisticated than did the subfertile ones. However, the interaction between nationality and fertility suggested that these effects were mainly due to the British fertile group, $F(1,381)=14.95$, $p<.001$ – (see Figure 5.10), which scored significantly higher than the other sub-groups. No significant differences were found between the other three sub-groups.

**Figure 5.10**

**Plot of Means (unweighted): two-way interaction between nationality and fertility for the treatments**

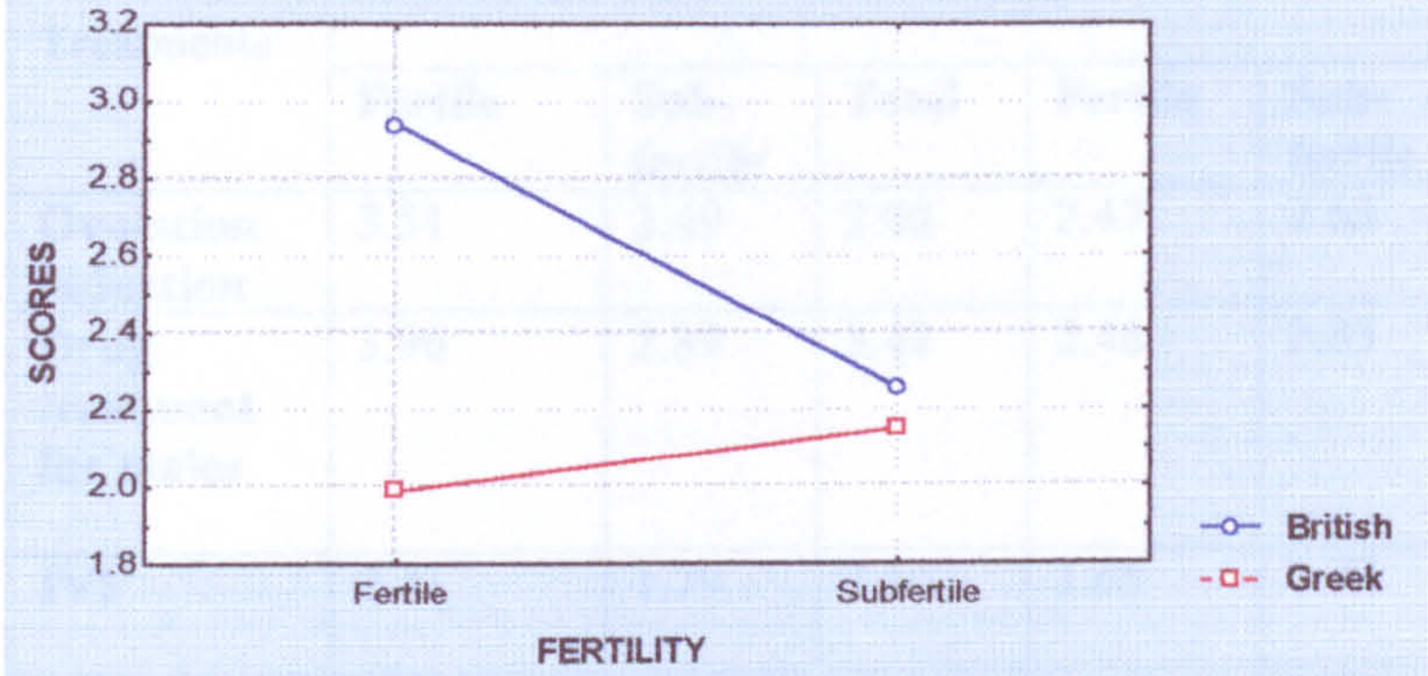



**Figure 5.11**

**Plot of Means (unweighted): three-way interaction between nationality, fertility and the six treatments**

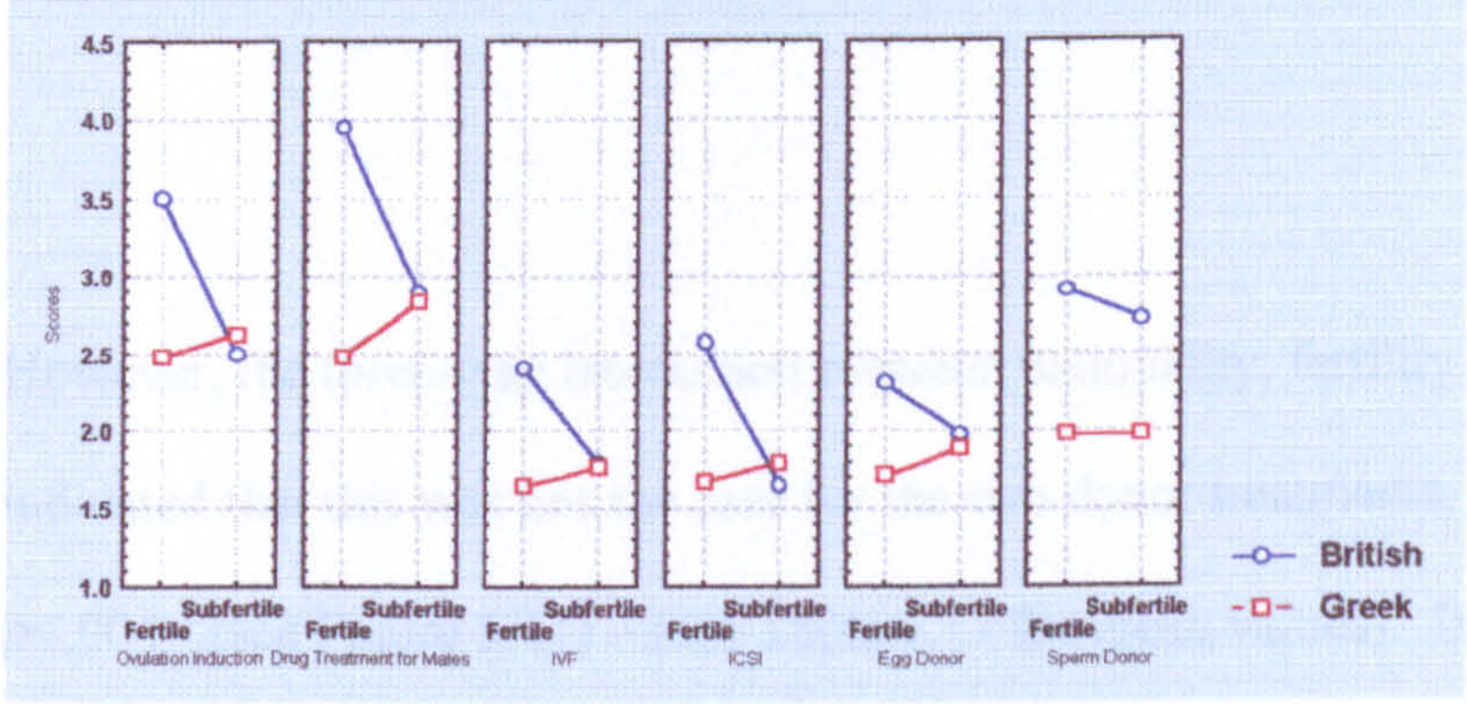


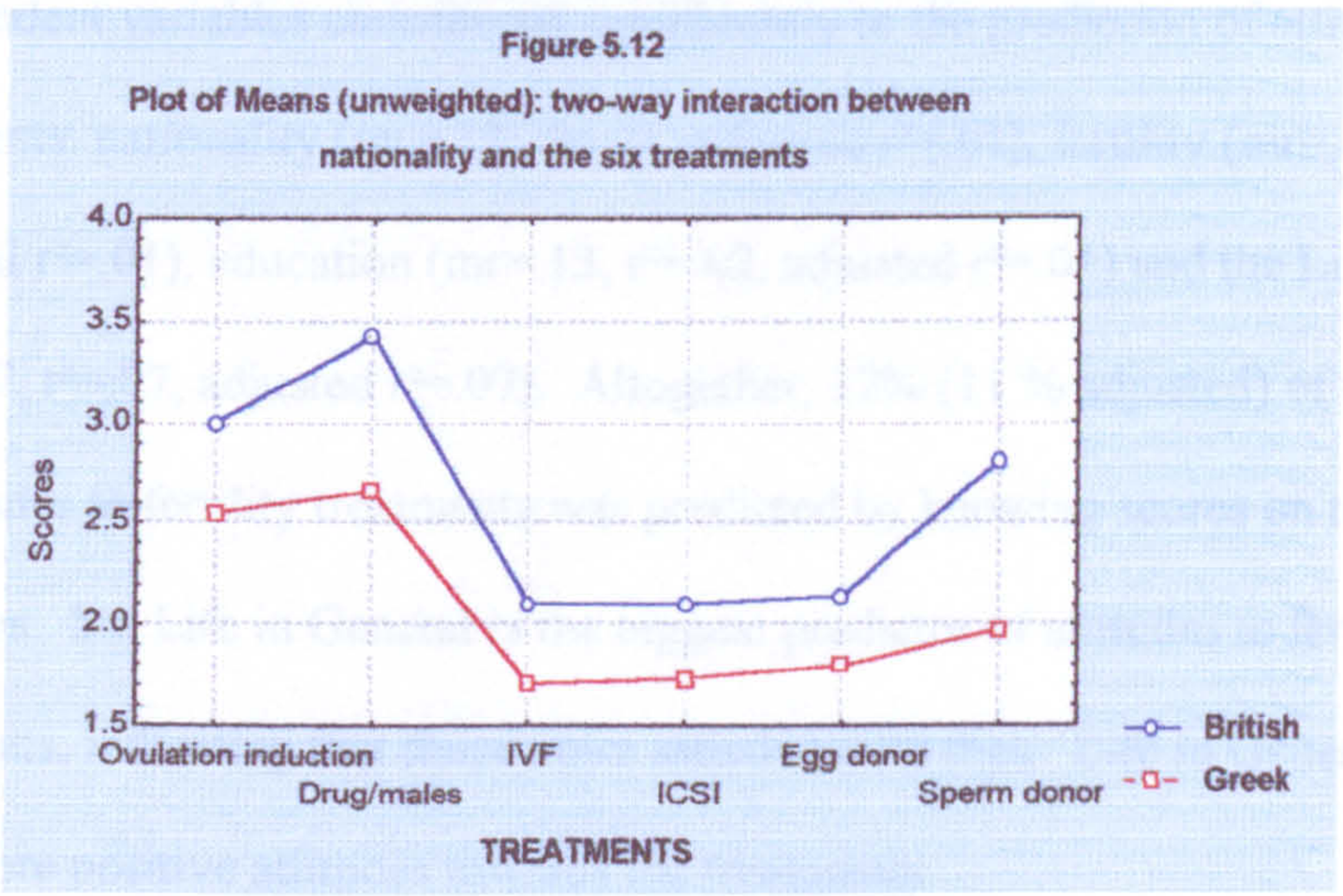
**Table 5.17: Means for medical sophistication for the six fertility treatments in relation to nationality and fertility**

| Treatments | British | | | Greek | | | All Partici--pants |
|---|---|---|---|---|---|---|---|
| | Fertile | Sub-fertile | Total | Fertile | Sub-fertile | Total | |
| **Ovulation induction** | 3.51 | 2.49 | 3.00 | 2.47 | 2.63 | 2.55 | 2.78 |
| **Drug treatment for males** | 3.96 | 2.89 | 3.42 | 2.48 | 2.83 | 2.66 | 3.04 |
| **IVF** | 2.41 | 1.79 | 2.10 | 1.65 | 1.77 | 1.71 | 1.90 |
| **ICSI** | 2.56 | 1.65 | 2.10 | 1.67 | 1.79 | 1.73 | 1.92 |
| **Egg donor** | 2.31 | 1.98 | 2.14 | 1.71 | 1.89 | 1.80 | 1.97 |
| **Sperm donor** | 2.91 | 2.72 | 2.82 | 1.97 | 1.98 | 1.97 | 2.40 |
| **All treatments** | 2.94 | 2.25 | 2.60 | 1.99 | 2.15 | 2.07 | 2.34 |

However, the three-way interaction between nationality, fertility and the treatments indicated that this was not the case for the two donor treatments, $F(5,1905)=3.52$, $p<.004$ - (see Figure 5.11) – (see Table 5.17 for mean values). In particular, the British fertile and subfertile participants did not differ in their evaluations for the donor sperm treatment, scoring higher than did the Greek participants. Furthermore, no significant differences were found between the four sub-groups for the egg donor treatment. Although the effect size for this interaction is very small (0,009), the effect is quite obvious in Figure 5.11. Thus, it is mentioned.

Finally, the main effect for the fertility treatments showed that the drug treatment for males was perceived as the least sophisticated treatment, whereas IVF, ICSI and the egg donor treatment were perceived as the most sophisticated ones, $F(5,1905)=65.79$, $p<.001$ – (see Table 5.17). However, the employment of Scheffé tests revealed that the interaction between nationality and the treatments, $F(5,1905)=3.23$, $p<.007$ , was attributable mainly to drug treatment for males and the sperm donor treatment (see Figure 5.12). The Greek participants perceived drug treatment for males and the sperm donor treatment as more medically sophisticated than did the British participants at .001 level of significance.

**Figure 5.12**
**Plot of Means (unweighted): two-way interaction between nationality and the six treatments**



### 5.3.2 Prediction of attitudes to fertility treatments.

A standard multiple regression was performed using attitudes to fertility treatments as the dependent variable and nationality, fertility, gender, education and the four well being variables as independent variables. The aim of the analysis was to identify the most powerful predictors of attitudes to fertility treatments. The rest of the demographic variables were not included in this analysis because they were not found to correlate with the dependent variable.

All the variables entered in the analysis were found to predict 13% of the dependent variable (11% adjusted) – (see Table 5.18 for regression summary). Only four of the independent variables contributed significantly to the prediction of attitudes to fertility treatments: nationality (mr=.12, $r^2$=.01, adjusted $r^2$=.01), fertility (mr=.12, $r^2$=.02, adjusted $r^2$=.01), education (mr=.13, $r^2$=.02, adjusted $r^2$=.01) and the Life in General (mr=.27, $r^2$=.07, adjusted $r^2$=.07). Altogether, 12% (11 % adjusted) of the variability in attitudes to fertility treatments was predicted by knowing scores on these four variables. So, Life in General is the biggest predictor of attitudes to fertility treatments, indicating that those more satisfied with their 'Life in General' (low score) have more positive attitudes towards the treatments.

| Table 5.18: Multiple regression results for predicting attitudes to fertility treatments | | |
|---|---|---|
| N=376 | $r^2$=.13, adjusted $r^2$=.11<br>std. error=.96 | F(8,367) = 6.7; p=.000<br>t(367)=12.09 p<0.00 |
| **nationality: beta=-.14, t(367)=-2.75, p=.006**<br>**fertility: beta= -.12, t(367)=-2.41, p= .016**<br>gender: beta=-.003, t(367)=-.064, p= .949<br>**education: beta= -.13, t(367)=-2.54, p= .011**<br>total GHQ: beta=.01, t(367)=.15, p= .879<br>**life in general: beta= .24, t(367)=3.59, p= .001**<br>easy - hard: beta=.04, t(367)=.76, p= .449<br>free - tied down: beta=.05, t(367)=.90, p= .371<br><br>***significant results in bold** | | |

### 5.3.3 Overview

Results indicated that the British had a more negative attitude overall towards the treatments than did the Greeks. Furthermore, whereas fertility was not a factor in the attitudes of Greeks, the British fertile group gave more negative evaluations than did the British subfertile couples. No main effect or interaction was found for gender.

Participants were also found to have a more positive attitude for drug and hormone treatments for males and females. They had a less positive attitude towards IVF and

ICSI and the least positive attitude for the two donor treatments. The big effect though was for the two donor treatments. The variety of effects reveals the particular issues underlying attitudes to treatments and dimensions between different groups. Also, it becomes evident that respondents were quite realistic and understanding of the treatments.

The separate analysis for the 9th bipolar dimension (medical sophistication) revealed similar effects as for the other 14 dimensions. British fertile participants in general perceived the six treatments as less sophisticated than the other three sub-groups did. ICSI and the egg donor treatments were perceived as the most medically sophisticated by both national groups. However, this dimension is difficult to interpret in terms of positive and negative evaluations. This may be the explanation for the low reliability of this item in the scale.

Quality of Life in general was the most important variable in predicting attitudes to fertility treatments.

# Chapter 6

# Discourses on parenthood

## 6.1 Introductory notes

The aim of this analysis was to identify the main discourses that participants facing subfertility problems used, including the content and the function of these discourses. Special attention was given to the cultural aspects of discourse. The specific results present the participants' social life and its problems in the specific moment with all its particularities. A generalization to other times or other individuals would be out of context and thus inappropriate.

The themes identified for the separate issues (i.e., parenthood, the fertility problem and the fertility treatments) can also be found in the discourses relating to the other issues. However, for reasons of clarity in presentation and because each theme is mostly mentioned in one of the above contexts, it is presented there. All these themes can be found throughout the interviews. Furthermore, it has to be emphasized once more that the discourses identified by this analysis did not just emerge. A lot of time was spent 'living' with the data, first in order to successfully code the material and then focusing on the content and the function of the categories for identifying the main discourses. The coding was perceived to be successful only when it managed to account for all the interview material. The categories that were extracted and helped in analyzing the interview data are presented in Appendix 32. Since these were just a piloting instrument to help in the analysis and were not part of the actual analysis, they

are not presented in the main text. Moreover, for the presentation of the qualitative results extended extracts from the interviews are used to give the reader the opportunity to check – partially of course – the researcher's understanding of the participants' presented reality. Also, names and any information that could identify the participants have been altered or omitted. Finally, it has to be mentioned that the analysis focused on the original Greek transcripts.

In this chapter, interviewees' perspectives in relation to parenthood are explored. Four main discourses were identified. These were parenthood as: a) sacred, b) normative, c) sacrifice and d) choice.

## 6.2 Parenthood as sacred, as the ultimate

The sacred quality of parenthood was evident in a variety of accounts. It was a powerful theme, representative of the dominant pronatalistic ideology. Parenthood was placed on a pedestal where nothing could touch it. Having children was above all, was the ultimate.

An important strand in this theme was the implication of adult identity. This dimension of parenthood was reflected best in women's accounts. Motherhood was constructed as sacred in the extract below. Nothing could be compared to motherhood since the latter was above all.

*Interviewer: In what ways do you think that having a child will change your relationship with other people?*

*Respondent: Firstly the relationship with myself will change, then with my husband and then with the others. I don't consider much the others. But simply I will feel more complete as a woman, like, I think that motherhood is above all. And from education, and from marriage, and from matrimony and from all. This is why there are so many unmarried mothers. They're not looking either at career, neither, and from every social level. It has no significance neither the level, neither the money, nothing. To be a mother, I think that it is above all.* (GF9)[6]

Also according to a British female interviewee (BF2) in order to be a woman one had to be a mother. Thus, when she was asked what did having a child mean personally to her among the things she mentioned was "experience in womanhood".

The professionalization of motherhood was evident in the account that follows. Being a mother was perceived as the most important occupation for this Greek woman.

*I: Why? What does a child mean to you and why do you want it so much?*

*R: Em why? Because (laughter) I don't know, I don't, I think that from now on this is the meaning of life for me. That is, I want to be occupied with the child, there let's say I want (it) to be the center of all (laughter)*

---

[6] GF: Greek female, GM: Greek male, BF: British female and BM: British male.

*I: Of interest*

*R: Yes*

*I: In your life*

*R: Yes, in other words neither the employment and because I don't work anyhow and thus, I don't have something, O.K. with my husband we are fine but (laughter) the child.*

*I: Meaning it is, it will be an occupation and the most important one for you.*

*R: Em yes.*

*I: The child.* (GF1)

A milder opinion was offered by BM10 regarding fatherhood.

*I: What does having a child mean personally to you?*

R: *[...] Erm, so the actual, erm being a father is very, very important to me although I had em for some time accepted that it may well not be the case [...].*

Children were not constructed as sacred for parents only. It was also reported that grandparents viewed children as the ultimate. However, this was not that important for participants themselves.

*I: In what ways do you think that having a child will change your relationship with other people, meaning in what ways do you think that your relations with your husband, your friends, your relatives will be affected? =*

*R: = With friends and relatives I am indifferent because I really do not believe that something will change. Simply for our parents, this dream for a grandchild, which neither neither my parents, nor my parents in law have. But sincerely I don't care and this [fulfilling parents' need for a grandchild] is the last thing for me.* (GF10)

Also, having children was described as the best thing that could happen to a couple's relationship, although it was not considered essential for the vitality of this relationship.

*I: How would you feel em if you couldn't have children in your life and why?*

*R: For sure it would be very hard for me, but not that it is and the that is I believe I started my life with Strato because I wanna be with Strato, if we can have children it will be the best, but not let's say that it will be the a and the z, (meaning to our relationship), not that our relationship will end or that we must necessarily have a child let's say for being together furthermore.* (GF8)

A more romantic account regarding parenthood was given by BM2:

*R: If we had a child it (laughter) how can I say this? Would put the icing on the cake, you know it must be the absolute dream we've been looking for. (laughter)*

The ultimate aspect of having children in one's life was evident in accounts mentioning love, happiness and feelings of joy. Such accounts were typical responses justifying participants' motivation to parenthood. The power of the emotional benefits of parenthood was evident in accounts like the ones that follow.

*I: What does having a child mean to you personally?*

*R: Joy, creation. (laughter) What else? I believe that in this way with a smile let's say it can overthrow your whole psychology, the bad mood you might have. Just with a smile let's say. I like generally children, (laughter) in small ages more than in bigger (laughter) because of problems.* (GF2)

Having children was also expected to bring happiness to individuals who have the need to love.

*I: And about your relationship with your husband, how do you think having children would affect this?*

*RI: I don't think that would change it a lot really, it would make us both happy because we've both got a lot of love to give. But I don't think, I don't think it would change much else.* (BF2)

*I: At first I would like you to tell me, now at the beginning of the interview for your feelings and thoughts regarding children. What does it mean to you personally having a child in your life?*

*R2: [...] You want a child because I believe that a child you have love to give to the child and the child is the warmest hug that can give you the most disinterested and sweet love. Beyond all these when a couple is O.K. with each other, they are beloved and it [the couple] is looking for this, from which it has to offer, it looks howsoever for having a child. When you have to give you are looking for it. Because only then you will be able to to to to be completed. From the spare of your love, you wanna give it somewhere. You give it of course to your partner and he correspondingly to you, but only this isn't enough.* (GF7)

Parenthood as the ultimate was highly connected with the biological aspect of parenthood. Although, the importance of the genetic tie was very important to all participants, it seemed to be of most importance to male participants regardless of nationality. One of the British male participants stated the above relationship clearly when he was asked what did having a child mean to him personally.

*R: Em. Mm, well there are several devils to this I think. Em you got that? That there's the sort of feelings you pass on your own genes. There's also activities you do with children and the basic, obviously the biological one is ultimately, everyone feels they should pass on their own genes [...].* (6BM)

Additionally, having children was perceived as a common creation between the partners.

*I: How do you think that your relationship with Thomas will change?*

*R: Em it will take O.K., it will take in this way another meaning don't know, not that the feelings will change simply that em em it will enter something that is ours let's say that we've created it in our lives [...]* (GF1)

In the two extracts that follow can be seen again that the genetic connection was of special importance for a couple. Thus, an adopted child could not substitute for a biological one.

*I: Would you feel differently if you couldn't have children, do you feel differently towards your wife? But you said this earlier too.*

*R1: Yes I would feel different, it is different, yes. It is different. It' s different, it wants the wife's subject is O.K., I believe that neither with adoption this is substituted let's say, because it is like a gift, meaning that it is considered the woman's gift to the man and the man's to the woman. Now adoption can fill the gap of the child let's say not the voices to be heard, the weep inside the house but gift will not exist, meaning that it isn' t that my wife gave me an adopted child as a gift or that I gave her as a gift an adopted child let's say.* (GM7)

*I: Would you feel differently if you couldn't have children in this relationship?*

*R2: [...] But as for the relationship, I think we'd stick, we're good and strong anyway. It would really make us both the happiest in the world if we did have a child together really. That's why we could never, I don't think we could consider any other way, I wouldn't adopt, I wouldn't no try to adopt because I think we wanted it between us, he or she between us. I think that's about it now.* (BM8)

### 6.3 Parenthood as normative, taken for granted

This theme refers to the mandatory, normative or taken for granted properties of parenthood. This was a central theme in the accounts produced by both the British and the Greek participants. Although, some participants had a difficulty in explaining their personal feelings and thoughts regarding parenthood, all of them made references to the discourses about the mandatory and normative dimensions of parenthood.

Having children was also perceived as an urgent biological need. A physiological dimension was given to this participant's motive to parenthood after she was asked what did having a child mean personally to her.

*R: That's a difficult question to answer. Erm, for me it's a fulfillment of a natural urge.* (BF13)

The perception of parenthood as mandatory was linked with time.

*R: As years pass by, let's be truthful, the need to have a child becomes more mandatory.* (GM6)

A typical response of some of the participants was that children fulfil their relationship with their partners.

*I: In what ways do you think that your life, your relationship with others would change if you had a child?*

*R: In what ways would it change?*

*I: your relationship with others =*

*R: = Basically a couple's life would be filled in that case for me my life would would be completed. As regards the others, either in the close family circle either with friends, meaning socially I believe that a couple's presupposition is em and the birth of a child. For the couple to be considered as worthy in some way socially into life.* (GM3)

Additionally, in the extract below can be seen that the mandatory aspect of having children in a marriage was attributed to social norms.

*I: What does having a child mean to you personally?*

*R: Me, personally, it's I think it would bring me and my wife closer together, and it's like em, it's something we've always wanted, from like, being married and it just bonds the marriage eventually, you know and it's it's things like in the future, like, I'm a care worker and I see childless couples there and they have got no other people to look after them when they're older and that, you know and sometimes it hits home like that. If I ever lost Julie and I had to go in a care home I would be there on my own, no family you know. Em it's just like it would bond me and Julie more together where at the moment we seem to be chasing it and not getting anywhere. I just think it would be quite nice, I'm not very good at this (laughter) em I think it's normal as well, people expect you be be normal, and to have children during a marriage, and it's the way you're brought up as well. Em that's about it on that one. (laughter)* (BM2)

A powerful association exists between marriage and parenthood, which can be evident in the accounts that follow. There were many that offered absolute opinions regarding the latter.

*I: What do you think about couples who choose not to have children in their lives?*

*R1: I don't agree, of course. Especially, when they are married individuals let's say. For what reason did they get married?* (GM9)

*I: What does having a child mean personally to you?*

*R2: [...] I think it's very hard to live without children especially if you're married you know, and can we move on to another one? (laughter) – (laughter relieves tension of uncomfortable situations)* (BM3)

Furthermore, one participant made explicit that having children forms the family, because as he said "family without a child can't be" (GM9).

*I: How would you feel if you could not have children in your life and why?*

*R: I think that it would be like doing nothing in my life if I hadn't had a child I believe that I would be empty, I believe empty thus, it would make me think deeply, I would think about it all the time, let's say I would be generally very sad at first I believe that I would be for instance like not that I got married meaning that I haven't achieved anything. Nothing else.* (GM8)

As it became evident for some of the participants, having children was not only fulfilling for a marriage, it was the very essence of it. This was the case for most of the Greek participants, regardless of gender. For the majority of the British participants having children was seen as the completion of their relationship and not so much as an essential component of marriage.

Furthermore, for some of the British participants marriage was not important for having children. Below are presented two accounts supporting the latter. The first account came from a participant who was in a stable relationship, but who was not married to his partner. The second account came from a participant who was married at that time.

*I: Erm, how do you think your relationship with others would change if you had children, erm with Kay, would it change the relationship with Kay with your friends, relatives?*

*R: Erm, I, I could, I can't really see it changing our relationship, erm, all I think is it would probably make it better than what it is now, we've got a, I think, I don't know about Kay, but, I think we've got a really good relationship although we aren't married, we're as, I think, I mean I have been married, I've been married for a number of years, I think Kay and me are probably closer now than what I was with my ex wife who I was married to for a number of years. We erm, it's not just a man and wife thing it's, we've got a good friendship as well, erm, I think having a child would probably even make it better probably. I'm saying that now, you don't know do you until it actually happens, but that's what I think.*

*I: Yes, yes.*

*R: It could probably make it better, even though we wasn't married, I don't think marriage comes into it myself, that's my personal view.* (BM3)

A British female participant (BF6) also expressed her disagreement with the opinion that having children is the completion of marriage. She supported her view by minimizing the power of the latter opinion. This was attempted by attributing the counter-opinion to societal conditioning.

*R: I wouldn't say it would complete our union because, because, because the union is with my husband, the agreement, the marriage, our partnership is with Bill it's not really with the child, they're actually, he or she would be additional, it wouldn't make me any necessarily happier I don't think, I think, and I think that's because of our strength together, so so my feelings and thoughts, I feel as though that we're very conditioned by society, that it is part of, sort of like our culture any part of union that's come together through marriage that you have to have a child to complete that, I don't believe that at all, and I'm just very much like a sort of visual person I have to be able to to, I suppose, see the product in a sense before.*

Participants also made references to the 'taken for granted' properties of being able to parent their own children.

*I: Why did you tell some people? I mean you couldn't know who'd listen or not, but you've chosen =*

*R1: = Because, being infertile is that upsetting, the stress just builds and builds and builds, when you're trying to do something that most people can take for granted, but*

*you can't do that, and the stress just builds and builds and you've got to talk to someone eventually.* (BF2)

*I: What does your wife think about this fertility problem? What do you think?*

*R2: Em, what does she think about it? We are I suppose we are both a little naïve. We were shocked that we' re having to go down this route really. We didn't expect this, while we were totally aware of IVF treatment and why there is such a treatment, we never expected it to happen to us. Em, so we were disappointed that we couldn't have a family or we don't appear to be able to have a family naturally.* (BM5)

*I: What are your feelings and thoughts regarding em this fertility problem at the moment?*

*R3: [...] Can actually happen to anybody, but I think nobody prepares you for that thought, you know, nobody prepares you for actually em being infertile you know not having the capacity to produce children and it's like because we live in a culture where you know, children are nor you know, to have children is normal.* (BF6)

## 6.4 Overview of Sections 6.2 and 6.3

So far two out of the four major themes of the analysis have been presented. Both these themes are part mainly of what could be called the conventional repertoire. The aim of this broader discourse is to justify the importance of parenthood and procreation, based on dominant pronatalistic ideologies. The 'ultimate' theme was the

first one presented, having to do mainly with one's identity, the biological tie and the emotional aspects regarding parenthood. The second theme concerned the mandatory, the normative and the taken for granted properties of having children. As was evident, there were some resisting voices to these powerful societal discourses. Such voices consist of the emancipating repertoire, which will be presented explicitly in Section 6.6.

### 6.5 Parenthood as a sacrifice

The British participants in comparison to the Greeks made the most references to this theme. This theme reflected the participants' awareness regarding the 'sacrifices' linked with parenthood. Participants mentioning this theme had a realistic attitude regarding the demanding aspect of parenthood.

Both of the accounts that follow showed that changes at the interpersonal level were not expected due to parenthood. However, important changes were connected with the practical aspects of life for which these participants were well prepared.

*I: Alright. In what ways do you think that having a child will change your relationship with others?*

*R1: With others, meaning my wife, maybe colleagues, maybe friends?*

*I: Yes*

*R1: Em I would have thought priorities would change quite a lot especially outside the family, outside this family as it were. Em I probably, I might work a little less hard (laughter) on colleagues and work and so on. As far as with my wife, I would hope that it would be, it doesn't it doesn't seem to me as though it would necessarily move one way or the other, I mean I'm not too worried whether it would move, I don't think it will necessarily make us closer or less close, and, so em I can't see it being, it will obviously change us in terms of what we do and how we do it, you know, we will have to have a different style of life in lots of ways, in fact I think we're pretty well ready for that, but I'm not sure it will change us very much between ourselves.* (BM6)

*I: Erm, how would you feel, how do you feel it would change your relationship with your partner by having a child?*

*R2: Yeah, erm, well we're going to have somebody else instead of the two of us there' ll be three, so obviously [our relationship will change], but I think again, because we've had a lot more time than most couples to think about it we've sort of looked into that so I don't think it'll be as drastic a change as it is, or as much a shock shall we say, as it is for some people because, because we want it so much, I think that although you get the ten hours screaming baby, the realities of it, and I mean I've never changed a nappy or anything, so I mean we'd have complete and utter chaos in that way, coping with it, because now we want it so much and we've waited, I think it will make us closer, although if we don't have a baby then that also has made us close because we're the only two who's gone through it, so either way it'll strengthen I think.* (BF15)

The demanding realities of parenthood did not seem to affect these participants' attitudes to having their child. Similarly, a Greek female participant after being asked how she thought her relationship with her husband will change replied:

*R: I believe that it will be better because we are conscientious of wanting a child, from there on we'll loose some mini enjoyments, after lunch let's say to lie down and all these, these will be lost (laughter), but I believe that we'll function well.* (GF2)

In the extracts that follow having a child is seen as a common responsibility for both partners, too. In the account below the obligations of being a parent are presented in greater detail. Specifically, as was reported the responsibilities were expected to be more when the child was a baby.

*I: OK. In what ways do you think that having a child will change your relationship with others?*

*R: And with everything else, your life at home would revolve round the child because basically they are helpless, they can't do anything for themselves, we've got to do everything for them, and we've got to do it together so, eem the responsibility for the child becomes the most important thing, I think, and our relationship with each other would have to change because obviously if there's a baby, one of us will be getting up*

*during the night and or both of us even, but you sort of take it in turns and you don't have as much time for each other.*

*I: Hmm*

*R: All your time is channelled towards the child and I think that's like that right the way through, I don' think that changes at all, it just gets a little bit easier when they get older, the child's able to look after him or herself I think. But our lives would change in a massive way. Family wise, em relatives, they'd always be there for us if we needed them, baby-sitters or things like that, but that changes as well. Social times change completely, I think. I think that's about it, it's a massive change.* (BM8)

The routine having to do with childcare and the constant responsibility of it was expected to have a great effect on the social life of the couple. This was expected to be more intense, when help by a third party was not available.

*I: Fine. In what ways do you think that your life would change if you had a child regarding you relationship with others?*

*R: With those around me?*

*I: With those around you, meaning your parents? Your friends? Your husband?*

*R: Simply I wouldn't see my friends so often, I wouldn't go out (laughter) I wouldn't go out so often because we don't have the parents let's say to help in some outings etcetera.* (GF2)

It is remarkable that in the Greek man's account below the changes in his wife's life and not so much his own were highlighted. It seems that the link between women and childcare was stronger in the Greek culture than the British.

*I: In what ways will your relationship with other people change when you have a child? In other words will your relationship with your wife change with having a child?*

*R: No, I don't think so. Simply there must be different distribution of hours I believe and on the expense of the wife always like that (laughter)*

*I: Right.*

*R: To be honest*

*I: Will your relationship with your friends change?*

*R: No, in relation to time nothing else, in interpersonal level no.*

*I: In relation to time how do you think will it affect?*

*R: It will affect, for sure, because now we do whatever we want.*

*I: Hmm.*

*R: We leave whatever time we want, whatever time we want we come (laughter)*

*I: Some restriction let's say.*

*R: Em for sure. Not some, the restriction. This is why I disagree with the wife working.*

*I: Hm.*

*R: She 's not working, neither will she ever. But I believe that when a child will come I' ll have to go through what I did not want to go through in case she was employed that she would be tied down. I want her [to be] under no obligation. For instance, to give her a call at 11.00 o'clock in the night [and tell her] «come to meet me in that town». This thing about the child, not that it would be negative, but O.K. we 'll adjust accordingly.* (GM6)

It was evident by the accounts offered by most of the British participants mentioning this theme that parenthood was expected to be shared by both partners. However, one British female participant offered a different view regarding the role of parenthood in a woman's life. She was dissatisfied with the demands placed on mothers.

*I: In what ways do you think that having a child will change your relationship with others? With your husband, family, friends?*

*R: [...] I can't really see any impact, I mean the functional things I can, like you know feeding baby all those sorts of things but no I hope it wouldn't have a great impact on us as people, I hope it would enhance, that I see it, as a woman I think a child would have, would have influence over me when it came to my career. [...] But as as a, I work in a culture where it's not advantageous for women to have children in the actual sense my career break, it was eight years and now it's gone down to five years, yes I job share but there's no child care, well there is lots of child care provision but you have to pay for that so from an economical point of view I think it will have a great impact and I think it will also have an impact on the decisions I make about my*

*career, whether I actually, it was my career in a sense where I am, maybe will stop in the sense of I think my husband and I have actually decided about not who would necessarily give up but who maybe would have to do that little bit more in the sense of sort of like, looking after during the day and things like that, so I'm very, I'm very conscious about how my life would change and from my husband's point of view he's the main wage earner at the moment and I'm sure that I could be the main wage earner, but it hasn't worked out like that because things you know, things have happened. Em I, yeah, I suppose we've come to some sort of agreement but it doesn't make any easier for women who have children, you know, people don't understand you know, a typical example is that although people are understanding of how the treatment you actually have to go through they don't necessarily understand the concept of it and how they support you, you know like in other countries I'm thinking like Sweden and the other European countries who are much more further thinking about women women and also about em about em leave, absence from work which would also include the man as well as the woman. Em so I feel as though that we're very you know, work culture is very naive towards women and I think that, so it's going to have a really great impact on me. (laughter) I don't know whether I've answered that question.*

*I: Yes*

*R: Is that yes? Right, oh yes. So really husband, family and friends I don't really have a problem with that, I can't see any impact, it's going to be the functional things but where the impact is going to hit me most is in my career*

*I: Right*

*R: and in my ambitions and my dreams.* (BF6)

The latter account is of great interest because of its powerful resistance to the dominant societal discourse constructing women as selfless Madonnas, who can take better care of a child than men. The main care of a prospective child was a common decision made by her husband and her, based on rational thinking, unbiased from the dominant gender discourses. Life circumstances wanted her husband to be the main wage earner, and thus the couple thought it best for the wife to take up most of the childcare. According to this participant, this obligation was expected to negatively affect her ambitions and dreams regarding her career. She attributed a lot of blame to cultural naivety.

The participants who brought forward this aspect of parenthood did not seem to attribute more importance to it than they did to the "ultimate" and the "normative" themes. The power of these themes in comparison to the "sacrifice" theme can be seen in the extracts that follow.

*R: Oh, well it's something that I always thought would happen, it was the only thing I ever knew I really wanted so it was like, not everything because I always wanted to work, well you know, but I always wanted at least six children so, and it was probably from watching the Waltons (laughter), you know when I was younger. Now I've just it never crossed my mind not to have any, it was just like what I was here for, just like the ultimate, do you know what I mean it was just [...] I know it's not easy, I know*

*it's, you know, there will be days when you think, you know, what am I doing with all these, but really it was the only thing I ever wanted (voice softens, sweetens). So [...] I don't know how else to describe it. It makes you question everything because it's been like years of wanting them so, you go through everything. That's that. Yes (laughter).* (BF8)

Although, the respondent's discourse is arguing for the mandatory and the sacred aspects of having children in one's life, it also contains implicit meaning which could be taken as an explicit argument for the counter-point. The respondent's words imply that it could have crossed her mind not to have any children because she is aware of the difficulties involved in having children. She made a reference to the 'sacrifice' theme. However, by using the technique of particularization (Billig, 1987), since it will only be some days that thoughts like these appear, the counter-argument is presented as inferior to the main argument.

*I: In what ways do you think that having a child has changed the way your life?*

*R: Oh, totally. I mean it, nobody could ever prepare you for having children, I mean you read books and you listen to people, and think em it won't be like that, it won't alter me, I mean from being full time at work, I went back, a case of having to because of paying the bills, I've gone back part time, and you are so reliant on other people, I mean namely, my mum looks after him, and it's like she's got this hold on me because she knows that I need her to look after John*

*I: Hm*

*R: And in that respect, your independence, well it has for me, it's it's virtually non existent (laughter) because you are beholden to everybody else, sort of, help you going to work or if you, I mean we don't go out, the last time we went out was Philip's fortieth which was 9th January (laughter). So I mean, it's changed in that respect but I feel that the fact that we've got John, it outweighs it all and you don't, you don't mind.* (BF3)

The participant above had a child after a successful sperm donor insemination. As was suggested by this participant, the negative aspects of having a child were outweighed by the existence of the child in her life. At this point, it can be assumed that having a child was strongly connected with some of the dominant pronatalistic discourses.

The power of the pronatalistic discourses is so great that they can coexist with the 'sacrifice' theme without posing any great problems to their superiority.

*I: (laughter) Well, at the beginning of the interview I would like to talk about your thoughts and feelings regarding parenthood. What does having a child mean personally to you?*

*R: To me personally?*

*I: Yes*

*R: Well I've got two children already from my first marriage so I've been a parent, but for Tracy and myself, we're happy together, we're a happy couple and a child would be perfect not only for me, my own personal feelings for it would be for Tracy to be happy, because she really is made for children, children love her, kids love her and I think that would, that's my main aim but em just for the pair of us, really to have a child would be, it would make us happy, happier than we are even now. I think that's all I can really say. There's nothing to and I know all about bringing a child, and I know what the, everything that goes with it, but it will mainly to, it would make us both happy, I know that, it would make me happy. I just want that. That's all I can really say about that because I mean children are great aren't they?*

*I: Hm*

*R: Really, I love them. I think that's about it really.*

*I: O.K.*

*R: That's what it would mean to me most it would make the pair of us to be parents.*

(BM8)

In the two extracts below, a combination of positive and negative effects of having children was attempted. However, because the participant that offered the first account was not 100 per cent certain about his claims, he used the 'time will tell' device to bring an end to any further claims at least for the time being. In the second extract, the participant tries to establish his claims by mentioning that he had learned them from other people.

*R1: Em, em about my friends, I wouldn't be able to see them as much, but em no, if anything I think children fetch you closer together with your family, not create any problems, don't think so anyway. Time will tell.* (BM11)

*I: = What does having a child mean to you personally?*

*R2: Em, well experience in womanhood, being part of a family, and it means a lot of pain, I know that (laughter). I've learned that from other people. It means a lot of heartache sometimes, I've learned that from other people as well. (laughter) I think that's about all.* (BF2)

Of particular interest was the account offered by a Greek male participant where the 'sacrifice' theme was not simply embedded in the 'ultimacy' theme, but it was very successfully presented as an actual part of it.

*I: How would you feel if you couldn't have children in your life and why?*

*R: Certainly I wouldn't feel nice. At that point it would hurt me. And why? Exactly because it's the result of a marriage, firstly you want it and secondly you wanna feel the sense of a child to bring it up, to feel joys and sorrows, anything that a child brings, em and to tell you the truth to feel and the sense of a father, for sure.*

*I: Good. May I ask you what do you feel about the couples who choose not to have children, meaning that there isn't some organic problem?*

*R: Yes. That's one of the best questions. And afterwards this kind of life wants to try enjoying everything. Why not to enjoy the happiness, even and the sorrow, because even sorrow is enjoyment, of a child.* (GM10)

### 6.5.1 Overview

The sacrifice theme concerned to a great extent the practical aspects of parenthood. The demanding lifestyle of a parent was embedded in the dominant conventional repertoire having to do with parenthood. This theme was mainly referred to by British participants. The participants who had mentioned this aspect of having a child proved that their desire for having a child was not based on unrealistic expectations about it. Of course, one cannot be sure about the standing of the participants who did not mention this theme. It could be that they were not aware of the sacrifices involved, or more possibly that at the time their strong desire for having a child overshadowed the demanding nature of being a parent.

## 6.6 Parenthood as a choice

Parenthood was constructed as a matter of 'choice' in accounts produced both by Greek and British participants. There were though great differences revealed between the two cultural contexts. British participants mentioned this theme in a variety of accounts. The Greek participants mainly made references to this theme after this was introduced by the interviewer.

Parenthood as a choice for a couple was quite acceptable in both cultures in relation to time. Some participants referred to parenthood as a decision taken later in their lives. Others left open the possibility that people who decide not to have children or who feel they do not want children might change their minds later.

*I: What do you feel about couples who choose not to have children, that is they decide that «we don't want children in our lives»? What do you feel about them?*

*R1: I have the example, Peter and me experience this [attitude]. Many times we scold them but, at some point we say that it is their own choice. But to stay alone for a life and as years pass by, life becomes to be spoilt, because you start scolding for the smallest thing in order to have something going on in the house, certainly this isn't the best for a couple. I might choose to be with him, to start travelling, going on excursions, having a good time, but after some years becomes a bit difficult I believe. Ruin will start between the couple, while if you have some kids you will be occupied with the kids, like I listen to my mother and my father (that all the time) [they say] «we don't have anything going on in our lives and we quarrel about you». Be it so this is a life, too.* (GF4)

*I: Right. What do you feel about couples who choose not to have children?*

*R2: Well obviously they choose their own way of living. I'm not sure you can necessarily always make an absolute choice in these things, I don't know. Em, you always seem to make a you can make a choice at the time, but you may change your*

*mind later, that's the thing, you may, it may not it may not arise again you know come up, (it may not feel important later). I've not come across anyone who's chosen not to have children I must admit.*

*I: Hm*

*R: Any couples that is, that's their choice. Is that a reasonable answer? [(laughter)*

*R: Yes (laughter)]* (BM6)

Some participants expressed their disagreement with absolute choices. In the two following extracts taking away the option of having children was disapproved of and judged negatively.

*I: Em what do you feel about couples who choose not to have children?*

*R: I think it's personal choice, you know, if they choose not to. I think if they get sterilized at an early age I think they are silly, because I think you could easily change, you don't know, you know if your feelings are going to change or not, and if you've got everything there that works, you know, you could just try and prevent it from happening rather than take it away (with sorrow), but again it's, you know, it's their own choice.* (BF8)

Rejection of parenthood was constructed as an acceptable personal decision in both cultures for child-centered reasons. Specifically, when there were indications of possible health or emotional risks to the child such a choice was judged positively.

*I: What do you feel about couples who choose not to have children? Who don't want children in their lives?*

*R1: According to what reason now if it's a matter of health. Now I know a child, it is a couple that had Mediterranean anaemia, the wife [had it]. A couple where the wife has problem with her eyes and it is a health problem let's say. There O.K. because when you know that you'll bring into the world an unhappy creature em somewhere this is let's say a little bit heavy and it seems to me that this is a good choice.* (GM7)

*I: How do you feel about couples who choose not to have children?*

*R2: Like everybody's to their own, like I keep saying about my friend Mary, I mean she always said if ever she got pregnant, she would have had an abortion because it wouldn't be fair to the child because she would resent it, because it would stop her from doing what she wants. Everybody's different, I mean, I don't think there's anything wrong with them, the fact that they don't want them.* (BF3)

In the accounts produced by the British participants, childlessness was often assumed to be a conscious choice, while in accounts offered by Greek participants this was perceived as suspicious, even unbelievable.

*I: What do you think that people that know about this problem, what do you think they think about it?*

*R1: Erm, my sister, I think most people are very sympathetic, the majority probably have children, no, they're mixed. I mean, I think again, most people just think we're really unlucky and are very sympathetic and hope that it works. I think my manager that I told is probably really shocked because I think some people it doesn't cross their mind, they just think again, it's a conscious choice, and she hasn't got a family either so she is, she's been quite a career person, so I presume she just thinks that it was a choice, I don't know, because I've not spoken to her again since, I know I could tell by her face she was like, oh, blimey. Other people I think just for my sake hope it, hope it works.* (BM15)

*I: What do you feel about couples who choose not to have children in their lives?*

*R2: I really respect them and I wish I could be like them. We have a lady at work who, erm, I work for a bank and she works at a different branch but for the last fortnight she spent time at my branch, and she's, I think she's about thirty six, thirty seven, and erm, she like has chosen not to have children and she goes away twice a year to America and Canada and you know, places like that, and I wish I could be like that, but and then, you know, it would be so simple, we wouldn't have to go through the treatment we could, we're both working so we'd have lots of money and move to a big house, but I don't want that, we like want a child.*

*I: Hm*

*R2: So I, you know, I don't think that they 're odd that they don't want children but in a way I wish I could be like that because then, you know, the questions would be*

*answered, we wouldn't have to go through any treatment if I could be that way, but I do want one, so I can't. (laughter)* (BF9)

*I: What do you feel about couples who choose not to have children, that is there is no problem em organic let's say and they decide that they do not want children in their lives?*

*R3: I can't understand this. It seems to me that is unthinkable. Not to want children or many that I hear who want only one child let's say because of cost let's say of financial, «I won't have», «I won't do». I believe that these are silly and I can't understand this, that is I think that there are other reasons. I can't undestand that is a human being that doesn't want to have children that is a couple. (I don't, I don't) I believe that I consider them on this topic as very stupid.* (GM8)

*I: What do you feel about couples who choose not to have children?*

*R4: Eem who choose, that is regularly married?*

*I: Yes, married and they say that they do not want to have children and they never have children, they don't want children in their lives. How do you feel for them, for this attitude of theirs?*

*R4: I don't know what problems can somebody have, how does he think about it and he says this but it might, I believe the most that he is lying, when they say so.* (GM1)

For the majority of the Greeks deciding not to have children was perceived to be wrong. They only accepted such a choice when there was a potential danger to the child or to the woman. Some of them had quite strong views on this matter. Career or finances were not acceptable reasons for such a choice against having children. Voluntary childlessness was constructed as problematic and stupid.

*I: What is your opinion, what do you feel about couples who choose not to have children?*

*R: I don't think that they are very many and I don't know what reason do they have, possibly I told you their problem is intellectual. It has to to go to another let's say, to another psychological confronting, sanitarium, insane asylum (laughter), electric shock. Anyway, something is not going very well. Except if they have some serious health problem. Some heart problem, that I know couples, diabetes, that is people are obliged to be deprived of it for saving their own lives. Yes only then for health reasons I accept it. For reasons of beliefs and these and to tell you something? If by chance they feel that they are unworthy for parents they do well and they don't have a child. Because some feel that they are not, they might have their reasons, (they might) have some personal peculiarities where if they have a child they will harm it and this. So, they do well and they don't have (a child). Only not to have a child, for not loosing a walk, a feast, party, this is something I do not accept. Like when very many stay with only one child for this reason, I think this is unacceptable since they can have another one.*

*I: Yes (xxx)*

*R: Since they can. Because and I might stay with one child since there is a serious problem. If they can, [but they don't have children] for reasons of fun and daily way of living, no I do not agree.* (GF9)

The latter participant offered very strong views against couples who choose not to have children. They were constructed even as insane. Once more, only for health reasons such couples were not blamed. If one preferred being childless because s/he did not want to miss going out, having fun, this was unacceptable. For the Greeks it seems that 'self-sacrifice' was the norm. The two accounts presented below were the only ones given by Greek participants that constructed voluntary childless couples with positive terms. Expressing admiration and praising the voluntary childless were not common responses.

*I: What do you believe about couples who choose not to have children?*

*R1: I believe that they have a very good relationship and that they are capable of confronting everything together and not necessarily with some third person let's say, with help from a third person because a child on the one hand it might has its problems and its anxieties, but on the other hand it certainly is let's say joy that makes you to want it and not as a continuation of the species let's say, thus I believe that these couples are very strong.*

*I: That is you've got positive feelings towards them?*

*R1: = Yes =*

*I: = What are you feeling?*

*R1: Positive feelings. Especially, when I see like that beloved couples that are in the old age and they don't have children I am very glad about them. Because I believe that they have a very good relationship.* (GF2)

*I: What do you feel about couples who choose not to have children, that is there is no organic problem, they simply decide that they do not want children in their lives?*

*R2: What do I feel? I accept it. The same way I decide that I want a child, or that I want some things in my life, similarly they decide some things for their lives, too. I am not the one to judge them. I do not accept judgement for me judgement meaning to tell me what to do, this is what I mean by judgement =*

*I: = Yes*

*R2: Thus, I am not the one to tell them what to do, if their decision is right or not. They are fine couples, fine people.* (GF1)

On the other hand, the account that follows is a typical response offered by the British participants.

*I: How do you feel about couples who choose not to have children?*

*R: Everybody's different, everybody wants different things from life, people want careers, they have careers, if people want a family they have a family. It's individual choice. If they don't want them, that's alright, I can understand why they don't want*

*them, I can understand people who do want them, you know, em everybody's different, everybody's got their own life to lead.* (BM11)

Contrary to the accounts produced by the Greeks, when the choice element was introduced by the interviewer, only two accounts were produced by the British who could not understand voluntary childlessness. However, even these accounts showed respect towards such a choice and to the individuals concerned.

*I: Erm, what do you feel about couples who decide, who chose not to have children in their lives?*

*R1: Erm, one of my friends at the old place I used to work to, em he always said that he didn't didn't want children. Erm, I thought it was strange because I mean, obviously if he wasn't a child in the first place, he wouldn't be in the position he was now. Erm, but I'm, I don't think any less of them. Em I find it like fairly strange, but not erm, I don't hold it against them in an any any way at all. Just a bit different to my way of thinking really.* (BM9)

*R2: Erm, I can't understand it. I can't understand why people don't want children. I just can't because I'd feel empty, really empty if I couldn't have children. So I just can't understand people why they don't want children.*

*I: Can't you think of any reasons?*

*R2: Well, I think it's nice to have them when you get old and there's somebody there to fall back on, your children. And I think it's nice to know that they're there for you. Hmm.* (BF10)

The power of the 'choice' theme in the British culture is profound in the extract that follows:

*I: Hm. What do you think about couples who choose not to have children?*

*R: That's fine, it's their choice isn't it? It's a very populated world, if you choose not to then you know, that's your choice isn't it? It doesn't, doesn't really bother me. I mean I personally I was quite sure for a long time that I didn't really want children and it was only really when I found out that I couldn't naturally have them that it kicked up a feeling, an emotion inside me to say "Oh wow, you know, I can never have them." so that brought a lot of it in to me to want them. And of course seeing friends and other families having young children and enjoying their children and enjoying seeing what they have, it's made me change my perception from possibly not wanting children to yes definitely very much.* (BM15)

This participant started to want to have children when he could not have them. Such an attitude was judged negatively by a Greek participant (GM4). His account offered below reflected the negative construction of individualism and selfishness for the Greek culture.

*I: At first I would like to ask you about your feelings and thoughts regarding children. What does having a child mean to you personally?*

*R: Em look to see I think that it is the completion of family. You could say in other words that it is the completion of family. But and of course I would like very much to have a child and indeed this is not selfish. There are I think some who say that you know I would like a child just because they have the problem or they lack the possibility to have a child and the more they lack the more intense becomes the mood. I personally, to tell you the truth, I felt the need for a child about two years maybe from when I got married, just before I got married. Till then, I didn't maybe I didn't consider myself ready to have and to bring up a child, but now I think that I want it. (Because) I don't think that there is a human being who doesn't want a child. Isn't it like that? Next.* (GM4)

Similarly, in the account that follows parenthood is constructed as something very beautiful that is however, led by a selfish motive.

*I: At first I would like to ask you about your feelings and thoughts regarding children. What does it mean to you personally to have a child?*

*R: It is in this way an odd question this one, it's a question that you can't say anything and very much. What does a child mean? At first it's something very selfish, to have a child. We become selfish with demanding and wanting a child really. Like a continuation of ours, like a support to our old age, like a bond with your husband, I believe that we become very selfish with this subject. I sincerely believe this thing.*

*That we want it for us. I consider this very selfish indeed. And of course that it's very beautiful over this, over selfishness, to create life, to bring up a child, to see all these stages of human growth. We have passed through all these but also to look upon them and as adults, these stages.* (GF10)

### 6.6.1 Overview

The choice theme was a dominant one for the British participants. However, this was not the case for the Greeks, of whom parenthood was seen as a matter of choice only in cases of health problems or in terms of time. Not choosing to become a parent for whatever reason was criticized heavily. On the contrary, for most of the British interviewees, choosing to become a parent or to stay childless was an accepted reality. Voluntary childlessness was seen as a respectable option.

## 6.7 The conventional and the emancipating repertoires.

Two main contradictory discourses (repertoires) were revealed by this analysis; the conventional and the emancipating. The first was apparent for both the British and the Greek participants. However, in the Greek culture the conventional repertoire was the dominant one. Even when the emancipating repertoire (e.g., discourse on choice) was introduced by the interviewer, the majority of the Greek interviewees either did not acknowledge it or they tried to disempower it. Although, the conventional repertoire was the powerful one and the accounts produced by the Greeks were more absolute and one-directional, there was a lot of ambivalence in the Greek participants'

accounts. In some occasions, as it is shown below, even the same person was found to endorse opposed positions.

*I: How would you feel if you couldn't have children in your life and why?*

*R: [...] If it's like that, if it's in other words the child the purpose of your life you could do it with a thousand and two ways, it's not necessary to get married in order to have it in a marriage. In other words, I would be annoyed meaning if I want to have a child I would have it outside of marriage, I wouldn't [need to] have it within a marriage. I got married for other reasons not only in order to have a child. These.* (GM4)

*I: What do you feel about couples who choose not to have children?*

*R: [...] Isn't it? To say someone that "I don't care. The woman is a career woman, I' ll make my career I don't want a child for the moment, the man "I' ve got my business worries, or I' ll have a career and I don' t want a child for the moment", therefore they choose their careers, meaning I think so, I find this very selfish. They would have better not to get married since they wanted to have careers.* (GM4)

The specific participant had very strong views regarding parenthood. However, as it became evident he offered contradictory opinions regarding the functions of procreation in marriage. In the first instance, he attempted boosting his self-esteem by supporting the value of his marriage. According to his claims, his marriage with his

wife was not about having a child. It was a lot more. The emancipating repertoire was used to distinguish procreation from marriage. In the second account, the conventional discourse was used in order to put the blame on the group of voluntary childless by criticizing negatively persons who get married without desiring to procreate within their marriage.

The emancipating repertoire was strongly embedded in the British culture. It aimed at justifying all situations; having children, voluntary and involuntary childlessness. Of course, the conventional discourse was dominant, too. Its aim was to justify only the pronatalistic views. Consequently, since both discourses were of great power in the specific context, there was greater pressure on the British participants, greater conflict and need for finding ways to allow both repertoires to coexist meaningfully. Thus, the British used more interpretational devices[7] because they often used a lot the two contrasting discourses. In Table 6.1 below can be found a list with these interpretational devices used by the British and the Greek participants.

[7] Interpretational devices (discourses), discursive solutions, resolution devices and rhetorical devices are all synonymous. Different analysts prefer using one or more of them.

| **Table 6.1: Interpretational devices (discursive solutions) used by the British and the Greek participants regarding opinions about parenthood.** |
|---|
| **Discursive solutions coming from the conventional discourse** |
| - Children are great, aren't they?<br>- We all want children. Isn't it like that?<br>- I don't think there is a human being who does not want children. Isn't it so? |
| **Discursive solutions coming from the emancipating discourse** |
| - Everybody's different.<br>- Just a bit different to my way of thinking.<br>- I don't think that counts these days any more. I think life's changed, times have changed. I think that more of life is geared towards not having children than it is towards having them.<br>- I think nowadays it doesn't matter either way. |

An example of a rhetorical device used by the conventional repertoire is presented below. In this extract, both contrasting repertoires were used. The emancipating repertoire though was implicitly used in order to empower the conventional repertoire.

*R: Because if I didn't love them I wouldn't be bothered, like there are others who don't love them and they have no problem. Rare of course these people. Because many cover the weakness to have children [by acting] as if they don't want. Very many very many people. "Oh we don't want, we want to enjoy our life, till 35 – 40",*

*which is a lie. A very beautiful covered lie. Or we have money what do we need children? We all want children. Isn't it like that?* (GF9)

The "We all want children. Isn't it like that?" was used to resolve any interpretative difficulties arising from the participant's use of the conventional as well as the emancipating repertoires. Such a rhetorical device cut any further arguments and established the conventional repertoire. Discursive solutions coming from the conventional discourse were used by both British and Greek participants.

However, this was not the case for discursive solutions coming from the emancipating repertoire. These were used mostly by the British participants, where both opposed repertoires were of great power. Some examples are offered below:

*I: I would like to ask you about your personal feelings towards parenthood. What does having a child mean to you?*

*R: Everybody's different aren't they? It's it's a wanting that you can't explain. It's a fulfillment (smiling) as you might say. I don't know what I mean. I have a friend who, she's never wanted any family and she's never altered, she's never changed her views, but I went through sort of, we knew from the onset that we had a problem anyway.*

(BF3)

In the above extract, the participant is using the "everybody's different" device in order to justify her desire for having a child and to overcome her difficulty to explain her personal meaning attached to parenthood. The specific device gives the solution to problems arising from the co-existence of views for and against parenthood. The appearance of resolution devices are typically found towards the end of an argument, after the contrasting repertoires have been revealed. In this case though a reverse pattern was followed without posing any problems.

In the two extracts that follow, modernity was used as a common rhetorical device. Phrases like "life's changes", "times have changed", "nowadays it doesn't matter either way" were the solutions to arguments between conventional and emancipating repertoires. However, their final use by the subfertile participants managed to re-establish the importance of the conventional repertoire.

*I: What do you feel about couples who choose not to have children?*

*RI: Em I think that's their choice. I think if they choose not to have them then I think that's their choice, they can't have the feeling inside them that they want to have children, I don't think that em you can convince anyone that they should have them. I don't think you can say it's right or wrong to have children. I know it's a natural process and they're keeping the line going we'll say, you know your family name going, I don't think that counts these days any more.*

*I: Hm*

*R1: I think life's changed, times have changed, I think that more of life is geared towards not having children than it is towards having children. I think that if they're a couple who choose to do that then, that's their choice. I think they'll feel later in life maybe like changing their mind, I think that does happen. But that's not really a question I think a lot about I just think it's their choice.* (BM8)

*I: What do you think about couples who choose not to have children?*

*R2: I find that easier because obviously I've been with John, I was, I was married, I've been divorced, I was married and then erm, I've been with John, and during that time I, we chose not to have children, so I really didn't have a desire to have a child until I was about 32, so I understand people who never want children, I think for some people that's why, that's why it was strange when I started to. My life was quite, I was quite happy with what I'd got, so I think it's, people should have the right, I don't think people need to have a child to be happy, I need one now, so I have no problems with that and I don't resent them and think "Well you could" so no, I think nowadays it doesn't matter either way. But I used to think everybody chose not to and what I've learned now is maybe some of them didn't choose, they just couldn't and that, and that way I've changed my outlook and I tend not to say to people either "Didn't you ever want a family?" or you know "Would you like to have a family?" because you don't know what goes on behind closed doors. So I think my eyes have opened, until you experience childlessness you don't think of it, you think it is a conscious decision and sometimes it's not, they just pretend it is. So.* (BF15)

## 6.8 Conclusion

Four main discourses were identified in relation to parenthood. Parenthood as sacred and as mandatory are two of the themes that were prominent in both British and Greek cultures. Another theme was the sacrifice theme, which was mainly used by British participants. Last, the choice theme was a dominant one in the British culture, while it was either not accepted or was heavily criticized by the Greek participants. Although there were cultural differences between the British and the Greeks, there was a common goal being served by all the accounts offered. That was the justification of the individual's desire for parenthood.

These four themes were parts of two broader discourses; the conventional and the emancipating. The first one was powerful in both cultural contexts. Its aim was to justify only the pronatalistic views. The emancipating discourse was dominant only in the British culture. Its use accomplished the justification of all situations; having children, voluntary and involuntary childlessness. Although, the majority of Greek accounts were more absolute and one-directional, there was much ambivalence in them. In the British context, since both conventional and emancipating repertoires were used, there was great conflict for British participants in managing their harmonic co-existence. A variety of discursive solutions were used for solving any such arguments.

# Chapter 7

# Accounts on fertility problems

## 7.1 Introduction

Three main themes were identified in relation to subfertility from the analysis. Participants viewed their fertility problem as: a) a health problem, b) a personal issue and c) a threat to their identity. These themes are presented in this chapter, giving emphasis as was stated earlier (Section 4.2.2), in both similarities and differences between the accounts produced by the British and the Greek participants. The content, as well as the function of the discourses were explored.

## 7.2 Subfertility as a health problem

Interviewees viewed their fertility problem as a 'health problem'. They focused largely on the organic dimensions of subfertility. This theme was directly embedded with the medical discourses. This connection became more evident when participants were asked about their fertility problem and they replied referring to their fertility treatment. It seems that their problem was directly connected with the area of reproductive technologies. This of course, is of no surprise, since all the subfertile interviewees were treatment-oriented.

*Interviewer: About your fertility problem, what are your thoughts and feelings at the moment?*

*Respondent1: At the moment? Hm. Can't tell to be honest. At the moment I'm just myself actually just starting the treatment and getting on with it, because I've been waiting a long time, so just looking forward to moving on. Yes.* (11BF)

*Respondent2: [...] I am terribly stressed. Of course, I try not to show it to Stratos, but, you know, surely I get upset, stressed, feel bad with myself. On the other hand, I think that the science has done great steps, and that we are finally going to make it, and I would say that, this is a rather comforting thought, which makes me think more positively than at the beginning, when they had just told us [very simply, just] like that.* (8GF)

In the extract that follows, it is quite interesting to note that a part of the participant's body, her womb, was being personified and seen as responsible for her anguish.

*I: Now I would like you to tell me about your feelings and thoughts regarding the fertility problem at the moment.*

*R: I've just been talking to my husband about this, this is has been my second IVF attempt that's been unsuccessful and at the moment I feel as though I don't want to have another IVF attempt, I just want to have a hysterectomy and have my womb*

*taken away because it's caused me that much pain and heartache in the past, but I mean my feelings will probably change within a few weeks.*

*I: Do you have any positive feelings at all?*

*R: Em not really. No I don't think so.* (2BF)

Again, in the two accounts below the connection between fertility problem and fertility treatment was clearly evident.

*I: Now I would like to ask you about your thoughts and feelings regarding this fertility problem. What are your thoughts and feelings at the moment?*

*R1: Well, em it's a problem with Joan's tubes, that we can't have children, we have to go through this treatment, there's no way of conceiving naturally I don't think, or a very slim chance. Em it's something that we've got to go through, or we've got to try. We've had the procedure explained to us so it's pretty straightforward what we have to do and just get on with it.*

*I: Do you have any negative feelings?*

*R1: Em, apart from paying for it, no (laughter). No not really. It's exciting time for us, because we're moving house, going through this IVF treatment, just come back from Florida, so we're on a roll at the moment and, so's going to be good for us, the whole thing.* (11BM)

*I: Now I would like you to tell me about your feelings and thoughts regarding your fertility problem at the moment. What are you feeling and thinking at the moment?*

*R2: You mean about the IVF?*

*I: About the whole problem, let's leave the treatment out.*

*R2: Yes*

*I: Concerning the problem that already exists that you can't have children? What are your thoughts=*

*R2: = I feel depressed, melancholic, my mind has stuck there, and it really affects me a lot. Very much. Whatever I do, wherever I am, it's in my mind all the time.*

*I: Is there anything positive or a positive thought regarding this matter?*

*R2: None.* (3GF)

The account that follows came from a British male participant who was incapable of having his biological child. However, he became a father, after the successful outcome of donor insemination. His view was used to support the normality of infertility. In the specific case, such a claim was easier to be accepted since the participant- although infertile- had become a father.

*I: What are your concerns, what are your feelings and thoughts at the moment about this problem of yours?*

*R: Not a lot really, it's just one of those things, isn't it? I've got a low sperm count, you know I suppose it means other blokes have got a low sperm count. [...] I don't get up in the morning thinking "oh, I've got a low sperm count what am I going to do?" I don't, no, nothing like that.*

*I: So, you don't have any*

*R: No it doesn't bother me. Just one of them things I think. I've got it, millions of other blokes have got it.* (3BM)

This medical reality was not always though accepted. In the following case, it was doubted by other people. The male subfertile participant did not agree with others' standing, which he excused because of their ignorance. This point indicated indirectly the interviewee's medical superiority towards others (the fertile).

*I: But family wise I've told all [of] them, they understand roughly what, the reason why. I mean a lot of them do come out with silly comments, (laughter) but that's because I don't think they understand the exact reason why we can't have children medically terms, you know.*

*R: Although you have explained to them?*

*I: Yes, yes, they think we can still do it naturally.* (2BM)

Similarly in the following extract the medical reality was mistrusted not only by others, but also by the subfertile participant herself. In this case the reality presented

by the medics to this participant was unpleasant, thus her denial towards this and her agreement with others' opinions that were more hopeful are totally understandable. It's quite interesting that although she explained her reasons for not believing the medics' diagnosis, there were resisting voices to her denial indicating that her justified views could also be false hopes.

*I: Em now I would like to ask you about your feelings and thoughts regarding your fertility problem. What are you thinking and feeling at the moment about this situation?*

*R: Yeah. Well although we're told we only have a one in a hundred chance of having a child naturally, I don't believe it. I just can't see how anybody would know that and I still think every month it will probably work. I mean I'm probably just being foolish, but, and also friends and family they don't believe it either, and they say "Oh, just relax and you know it will probably happen" and they all, you know, you get so much, I suppose it's false hopes of everybody because they think, oh you know, probably happen soon, it will happen soon, so I like believe that it will happen soon as well, even though we are still paying for the treatment. I keep thinking oh maybe before it [next attempt] will start, we'll like, you know get pregnant. [...] Because I think well what about all the other couples who've got the same problems as us, well they may have had children normally, you know, just naturally without any treatment but they may not have, you know, had any examinations or any tests done on them so I thought they could be, you know, thousands of couples the same as us who've you know, got lots of children, so in that way I think you know, I maybe don't believe that we've got a*

*problem, even though I've been told we have. I suppose it's just false hopes really.*(9BF)

Also, in some cases like the one that follows, the subfertility problem could not be identified by the medical science. This uncertainty regarding the organic dimensions of the problem made this participant hope that by appliance of science or by nature itself, conception would be accomplished. Thus this difficulty in having children was difficult to be described as a problem. For him it was just a matter of probabilities.

*I: Em, what are your feelings and thoughts in general about this fertility problem?*

*R: Well our basic problem is it's pretty unknown what, it does seem to be uncertain what it is, I mean there's no, doesn't seem to be any physiological problem, we've tried all the tests. Em the em we had we had decided to go for IVF earlier in the year, we've done one*

*I: Hmm*

*R: one test and we're trying another. Em my feeling is that I suppose I'm the optimist at the moment (laughter) we still have as good a chance of conceiving naturally as we ever had before we started the IVF*

*I: Yes*

*R: and so the, there's still as good a chance of conceiving as there ever was so. To describe it as a problem it's difficult to (laughter) difficult*

*I: OK.*

*R: difficult to describe as a problem*

*I: OK situation*

*R: situation*

*I: All right*

*R: So I see it as, something that we can possibly overcome through appliance of whatever science is available. I can't see any problem at all with that, and but I do recognize that em and em all we're doing is changing probabilities we're only judging the probabilities, we're not doing anything that's got any certainty about it. But then there's no certainty that we'll never actually conceive naturally anyway. (xxx)* (6BM)

Similarly, this British participant faced a difficulty accepting the word infertile and he attributed their fertility problem to luck. It has to be noted that nowhere in the interviews the interviewer mentioned the words infertility or infertile.

*R: As regards em the fertility part of it, I'm a bit confused at times because both of us are, I've been told that we're OK and sperm tests have been all right. Tracy's been tested and it was just em unexplainable which isn't a word either of us like, we've talked about it and we can't understand why anything can't be explained. They're sort of saying that we could be, we could have a child at any time, Tracy could become pregnant at any time and we just don't, we would like to know more why we can't, that's the main thing, we just wish we knew why we can't have children when everything's in working order you know, and it isn't like we don't like each other or*

*anything (laughter) like that, just everything works for us both, you know, we just can't understand that em and infertility, infertile's a difficult word as well, I don't like that because it describes you as being something, and puts you in a category and I don't really like that. It's that we're just unfortunate at the moment, it might happen next week.* (8BM)

This theme was embedded with discourses on fertility treatments. This is pretty understandable, since the interviewees were all treatment-oriented. What's more, fertility problems and wishes were viewed even as synonymous with the difficulties and hopes concerning fertility treatments.

### 7.2.1 Overview

The construction of participants' fertility problems as health problems was directly connected with the medical experiences and was part of the conventional repertoire. The predominant medical discourses though are presented in a greater extent in Chapter Eight of this work. Of great interest were the resisting voices to the power of the medical ideology. No differences were found between the accounts offered by the British and the Greek interviewees regarding this theme.

## 7.3 Fertility problem as a personal issue

This was the second theme revealed by the analysis. According to many participants' claims, their fertility problem was a private matter that they chose with whom they shared it. This theme was part of the emancipating repertoire and was used to empower subfertile persons' moves, no matter what they were. It was mostly used by the British interviewees.

In the extract that follows, the specific British female participant stated that keeping the fertility problem private was empowering, while revealing it to other people would make her be seen by others as underprivileged.

*R: [...] but you have to cope with that in life and you either decide to tell people, the world, and then they think "oh bless them, poor people" and they feel sorry for you, or you decide to keep it private and so you've got that choice to make and it's up to you, so I'd rather, I hate people being really overly sympathetic so I think personally I would rather not say to the wider world.* (13BF)

An opposing opinion came from the participant below. In particular, he was of the opinion not to tell other people about his problem, because others would laugh at him. In his case, a sperm donor was used for achieving parenthood. The social stigma though had not been overcome regarding the donor treatments. Thus, there was no reason for telling others about his and his wife's problem.

*I: Was there any specific reason why you didn't tell your friends, your relatives, other people in general?*

*R: Why should I, why should I go round publicizing my life to other people when they're going to turn round and laugh at you, saying, "oh we've got a jaffa here"? Goes on doesn't it?*

*I: Hmm*

*R: "Oh look at him, he can't have babies."*

*I: So this is why*

*R: It's just it's my life, I wouldn't go round publicizing anything that I didn't want anybody to know about you know, it's one if I had loads of money I wouldn't go round telling everybody that I had loads of money. Same with, I've got a problem, it's my problem, it's my wife's problem. It shouldn't be anybody else's problem, should it? Because it wouldn't be anybody else's problem, because they'd be laughing at you. Well, it's a known fact isn't it that people do laugh at other people with a stigma or problem, yes?* (3BM)

The above participant's attitude in keeping his fertility problem hidden, was supported by the account offered below by a Greek woman, who regretted revealing to special others her and her husband's fertility problem. This strong and negative view was given after this Greek woman was asked to whom she had told about the fertility problem.

*R: We have talked to few people and we have truly regretted it. No one should have ever learned about it. And we include our parents too. They don't talk to embitter you any more, they just worry too much, and it gets tiring. As for our friends, we said that they express some kind of sorrow - pity, even resentfulness. So, the fewer [persons] know about it [the better], maybe none [would be even better], the only person who knows, is my friend and maid of honor, who is a person that we have lots of things in common. She also puts herself into the procedure of IVF and so, we are people who face the same problems and understand each other totally, without irony, bitterness, or resentfulness. She is the only person who understands me, and the same thing goes for me. Nobody else. The other people move in different spheres. She is a friend that I included in my papers, too. [...]*

*I: Let me ask you, why didn't you tell it to others, I mean, did you tell it to some others, why you didn't?*

*R: Because we saw the reactions of these few people, not to mention that they were very close to us.*

*I: Yes*

*R: Let alone the others who are less close. They would have had a very different and worse attitude. Imagine that we have regretted telling it to the ones we have. They don't need to know. No, this issue is completely personal.* (9GF)

In the account above, friends and parents' reactions were perceived as non-supportive, while only one subfertile friend of hers was viewed positively. Thus, she argued that she shouldn't have talked about it to anybody and she used the 'personal issue' theme

in the end of her account for avoiding any further arguments.

Finally, in the account below it was stated clearly that the fertility problem was the couple's private issue. In this extract it was acknowledged that this problem was one that belonged to her and her husband. However, contrary to the two accounts above, she was presented as being comfortable in telling others about it. She was also presented as being in control of her social interactions with others regarding this matter, knowing how much information each one could take in order to have a balance between sharing with others and not letting them cross her personal, safety boundaries.

*I: Who have you told about this problem?*

*R: [...] so I think I've told I've told nearly all my support system but I've told them different depths of information and that to me is quite important because I don't want people to look after me, it belongs to Bill and I this presenting issue, it doesn't belong to other people, yes other people can help, but at the same time it's Bill and I who have to work through it, we've got to, and yes we can share, we can share, I think it's quite important to share, share the experiences and thoughts and feelings but Bill, it's it's Bill and I, you know, my husband and myself, we have to share completely, so with everyone I have actually shared with it, all my feelings and thoughts is is Bill and it's yeah, I think I've shared, I think I've shared quite a lot with people. But I've also known people and you know, all that sort of thing. [...] I don't like people who, to take on my presenting or Bill's presenting issues, I like people to value me as a person.*

(6BF)

According to the account offered by the Greek man below, fertility problem was a personal problem, but not a special one. Thus, he shared it with people who usually talked with about all his personal issues.

*R: [...] those who know the situation, I mean, I notice that they try to support me, in every way. Not all people are the same, you know. Someone will move you more with the things he has to say to you, someone else will be more absolute, and again I don't think that if someone comes and opens discussion, I am open, I mean if someone asks me seriously to talk about it, no, I won't have a problem, I think it's something that happens around us, I mean, what's the point in keeping it a secret and say "no, let's not say it, and they think that I am, (laughter) I don't know what" (mocking), as it used to happen in the villages [...] I mean it's not a special problem, at least I don't think it is, maybe I am not going to discuss with my friends and my people everything except that. Or you will discuss everything with them, because your personal life is at the same level, or you won't say a word and let's say that you stick to a typical discussion.* (4GM)

Similarly, in the extract that follows, the Greek female interviewee was very open in sharing the specific problem with others.

*R: I don't think there is a point in keeping it a secret, I mean, when you see that the other wants to know, and asks some things or he is interested, you know, is a friend and he's asking something, I mean it's stupid to say to him "no, I don't want to",*

*(mocking), I mean all right, when I sit and have a discussion with you about anything, why should I hide something from you? Even with persons I don't know, I don't have a problem to discuss it.*

*I: Yes*

*R: It's not something bad. It's something that is dealt with and what's more, it's socially acceptable, it's not.*

*I: Yes*

*R: I don't mind. Moreover, I like it, and not only with someone who doesn't have a problem, even with someone who has a problem and he is strange to me, I want to discuss it, either to help me with some problem of mine, or to help him let's say.*

*I: Yes*

*R: Like an examination, you know, I don't know what he hasn't done (laughter).*

*I: Are there any people to whom you haven't spoken on purpose?*

*R: No, there aren't.* (1GF)

### 7.3.1 Overview

The construction of fertility problem as a personal issue was part of the emancipating repertoire. It was used in order to justify participants' interactions with others regarding their subfertility. Revealing or not their fertility problem to others was a private matter and thus, none could criticize them, no matter how they were handling it. This theme was used in order to protect participants' dignity and their already

affected well being. Although it was a theme found in both cultural contexts, it was not found very often.

## 7.4 Subfertility as a threat

The third theme coming out of the analysis was 'threat'. The fertility problem was perceived as threatening to subfertile individuals' identity and self-esteem. This was evident in accounts like the ones presented below.

*I: At the beginning I would like to ask you what are your thoughts and feelings in relation to children. What does having a child mean personally to you?*

*R1: Yes. I love children very much. A child for me is the continuation of my life. If I don't have a child I think that my life stops somewhere, that I'm useless to the society. This.*

*I: That's a very tough thought.*

*R1: It sure is, but unfortunately, this is how we feel.* (9GF)

*I: Shall I ask you now what are your feelings and thoughts erm in relation to your fertility problem at the moment? What do you feel ant and think about it?*

*R2: Yeah, I mean it's not a nice thing to think that as a man, it's not a nice thing to think that erm, you can't fulfill your manly role. Erm, but at the end of the day we're not all perfect, erm, we all have good points and bad points, we all have problems*

*medically and psychologically and physically, and and if we were all perfect, fine, but it's a disappointment, nothing would make me happier, to be able to erm, click my fingers so to speak and have a child. But again it's part of life, I mean I'm disappointed but it's just, it's part of life, I mean, you know, just one of them things.* (10BM)

The accounts below came from a couple with unexplained infertility. When they were asked what their partner felt about this fertility problem, they replied:

*R1: Well, it made him feel at first as though he was not a full man, as though he was letting me down in some way. But I think, I think he's coming round to normal now. He felt as though he'd let me down, especially after I'd had, especially after my last, my first IVF attempt, after I'd had the ectopic pregnancy, he felt it was his fault that I had to go through that. But I think he's getting over that now.* (2BF)

*R2: She feels cheated, very cheated. I think she's, she feels an inadequate woman and these are feelings that she's been explaining to me that she can't she doesn't feel like a woman because she can't produce children. And some ones that I really don't want to say on that tape because they are quite distressing to feel, to see my wife go through that sort of emotion. Can we move onto the next one?* (2BM)

The threatening aspect of subfertility was also connected with other people's behaviour.

*I: How would you feel towards others if you couldn't, if you knew that you couldn't have children in your life and why?*

*R: Look, from the moment you want it, it's sure that you feel bad, cause I see my friends; everyone is married, having their children, you know, their families are complete. I sure feel a bit unwell. It's jealousy, in its positive meaning, you know, that you know they have managed something that we might not manage [to do]. But it's not that I will reach the point of jealousy where, hmm, you know, I will think badly of others, while by all means I am very glad seeing them like that.* (8GF)

In the account that follows, there was a major contradiction. This Greek woman when asked how she would feel towards others, if she couldn't have children and why, she replied:

*R: Very defectively. As if I have a terrible physical damage, which leaves me useless, you know, as if I am not able to walk, like being stuck on a wheelchair. As if I am seriously handicapped. And I told you before; I don't intend to do anything else in my life. I don't intend to create. I don't want to create. I'll enjoy the little things I own at present and we'll see from there.* (9GF)

When she was asked though if she thought that her relationship with her friends would change if she couldn't have children and how, she stated:

*R: I think it would, because we've said it to very few people, and although they are not many, still they are very close to us. They treat us a bit as if we are, not undervalued, but as inferior. They feel sorry for us. And I don't like that. It's not that they feel compassion, they feel sorry for me. I don't like this kind of treatment. I just told them that I don't have a disadvantage at anything.* (9GF)

The key point in the two accounts, claiming initially that she felt very defectively and useless and then that she didn't luck anywhere, was the function of these claims. In the first instance, the respondent used the conventional repertoire to justify directly her pain and sorrow towards the fertility problem and indirectly to show her commitment to parenthood. In the second instance, she denied her previous claim in order to protect herself from the threat others imposed on her and most importantly she put the blame on others – the outgroup.

On the same grounds, blame was attributed to others for their discriminatory behaviour.

*I: In what ways do you think that having a child will change your relationship with others?*

*R: In what way, what?*

*I: Do you think that having a child would change your relationship with others, like your wife, family, friends, extended family I mean?*

*R: I think we'd be accepted as part of the family, because at the moment we don't seem to all my sisters have had children and all Kathy's brothers, they've all had children and they all seem to be like a big part of a family but because we haven't, I haven't it seem to be put on the outside of the family, and not get involved. The family seem to like, shun us off a bit and like friends at work, they get a bit uneasy when they start talking about children, they think that they might hurt our feelings, they wouldn't, you know, I don't think they would.* (2BM)

A resisting voice to the threat imposed by fertile people on the subfertile ones came from a British male participant, who constructed fertility as a matter of luck.

*I: What did these people that know about your situation think about it?*

*R: [...] but em a couple of close friends who luckily have been successful in having a family, em only five six weeks ago because they know what we're going through and they just luckily had a child naturally em they and my sister as well who've got young children they are the most enthusiastic, the most supportive because I think they can relate to it. All the relatives (tend to be more on the elderly site) I think they are more a matter of fact about it really. Our closest friends I think they can appreciate the problems. They've been trying for children. They've been lucky and I think they appreciate that they've been lucky and and support us in that way so. Yes that's the only difference. I think they can one side can appreciate and the other side have long since passed that stage and they are a little bit matter of fact about it.* (5BM)

Blame attribution and having the responsibility for this problem were important strands of the 'threat' theme, too.

*I: What does your husband think regarding the fertility problem you are having?*

*R1: What does he think? The same thing as I do. I mean since it appeared as a problem by his behalf, at the beginning, at least until the point we visited Mr. X. [the doctor's name], I believe that he put the blame on himself. What we were saying previously too, was that men face this problem differently, hm. Although he's too modern as a person, but however, it hurts your ego. I believe that it has the same effect on a woman too, but on men maybe the effect is greater.* (2GF)

*I: Em what are your feelings and thoughts regarding em this fertility problem at the moment?*

*R2: Em I think it's very easy from the the female point of view to blame oneself and can you just repeat the question again?*

*I: Yes. What are your feelings and thoughts regarding this fertility problem?*

*[...]*

*R2: Right. So I have had negative thoughts, I mean definitely negative thoughts and the factors about blaming sort of whacked myself thinking it's my fault.* (6BF)

In the two previous extracts, the psychological burden put on the one responsible for the couple's fertility problem was obvious. Furthermore, two gender discourses made

their appearance. Particularly, in the first extract the stereotype that men's self esteem was affected more than women's due to infertility was supported. In the second extract, the view that the blame was usually put on women regarding infertility was brought forward.

An interesting account of a Greek woman is given below. According to her claims, she would prefer to be the one responsible for the fertility problem and not her husband because he would be more affected than she would. She thought that it was fortunate that both of them were responsible for their fertility problem and not only one of them.

*R: I wished I am the one who has the problem, you know, not Stratos, because I knew that Stratos is more, like, well, he gets everything too personally, he is very stressful too. So am I, but Stratos is even more and I knew that he would feel awful towards me, you know, if Stratos had the problem and we couldn't do something about it. Now, I would feel terrible towards Stratos if I had the problem, you know, if I was the reason that he couldn't have a child. Really bad. But since fortunately we face the same problem, luckily for the both of us, I feel fine. When I say OK, I mean that I am not the only one who is responsible for this situation, I mean, I don't know how Stratos would face the whole matter, and I would feel terrible to know that it's totally my fault. At least now, we are both in the same position (laughter). The truth is that it's a bit alleviating, even though I feel very bad with the current situation.* (8GF)

This theme was a major one. It was used by both British and Greek participants. However, the responsibility sub-theme was not found in Greek men's accounts. An exception was the extract presented below. Although this sub-theme was used by the specific interviewee, blame was attributed to the ingroup (infertile people), which was not common practice (Billig, 1976).

*I: What do you think those that know about this problem, what do you think they think about it?*

*R: Judging from what I've heard so far, because I haven't seen, I don't have a very close person to tell me, there must be various reactions. I mean, I've heard there we did the (xxx) that people have reached the point of blaming their women because they can't have a baby, or the opposite around. That's absurd, it's an exaggeration. I've heard from women before to consider this as their unique goal in their lives, as their unfulfilled dream, which want it to become true and I also think of it as an exaggeration, because at the same time they neglect other things, which are very important. For instance, they neglect a husband. Maybe they neglect their first child, because I've heard about this couple that had a baby by IVF and in their second attempt, just because they couldn't conceive, they went mad. Well, the wife lost her senses, I mean as far as I know, it was the wife that lost her senses. She resigned herself from everything, even from the first child. And that's an exaggeration.* (10GM)

### 7.4.1 Overview

The threatening quality of subfertility was a powerful theme that was found throughout the interviewees' talk. It can be perceived as the other side of the powerful pronatalistic discourses. Since having children was perceived as mandatory and normal, subfertility's threatening dimension was consequent. It was the power of the pronatalistic discourses that threatened subfertile persons' identity. Thus, there were many resisting voices that subfertile people used in order to cope with the threat imposed on them by the conventional repertoire.

## 7.5 Blame attribution, pronatalistic ideas and threatened identities.

By pushing the analysis further, it was revealed that participants who seemed to be affected more by their fertility problem were those who held strong pronatalistic views. It was also found that these participants were negatively positioned towards voluntary childless people and toward other fertile people. It seems that the bigger the threat imposed on one's identity, the more likely it was that this person would create a negative construction of others. Participants that were affected more at a personal level by subfertility were likely to be uncomfortable with others knowing their problem and were more likely to keep it a secret or at least to think that it would have been better if none knew about it. The above conclusions were drawn after a thorough examination of each one of the interviews and a careful comparison between different types of talks.

In the following extract, the relationship between blame attribution and self-esteem

was supported. According to this man's personal experience, he apportioned blame to his wife about the fertility problem when he was emotionally affected the most by it.

*I: Hm. Em now I would like you to tell me about your feelings and thoughts regarding em your fertility problem at the moment as a couple?*

*R: Yes*

*I: Have you had any positive or negative feelings or thoughts?*

*R: Yes, I think em because we're now going through a couple of treatments we've had two failures em we have all the mixed emotion. The first treatment seemed to be going so so well up until the last heardle and then we failed. Em unfortunately what happens at that stage, because it's such an emotional shock, human nature as it is, I think you want to start portioning blame or or the opposite to that is you want to think that you're not the guilty party, you're hoping that from my point of view that I'm OK and I hope that it wasn't my fault that it failed]*

*I: Hm*

*R: [so you while you don't want to apportion blame you don't want to feel that you are the guilty party em and I think with our two failures we have had an element of that. Em it has been em there have been times where em blame has started to be apportioned you know "I'm OK" you know "it's your problem" em none of us like to feel failures I mean we are going through this IVF because there are problems, things are not as straight forward as we hoped that they would be. Individually we are fairly selfish people em we don't want the problems to be ours, we want them to be the other*

*person's. We'll help and understand and whilst we don't particularly blame them generally, one of the low points of failure I think that does tend to creep in, you know you we think "oh I 'm all right" and you want to feel yourself that you're not the the party that's at fault but I think that that's just a selfish view really, but when when things are at a low point we've we've got the different views when when we're not emotionally (at a low point), we've got over the failures, that we're supportive of each other, no blame gets apportioned but when you really are at rock bottom just when the failure has occurred that's when I am the most vulnerable and that's I think when we start to hope that we're OK and the problem lies with the other person cause I think it makes us feel better if we are OK, maybe they' re not, selfish as it is.* (5BM)

The relationship between her affected negatively self esteem and the discomfort felt by others knowing about her problem was evident in the Greek woman's account that follows.

*I: Was there another reason for telling the people you have?*

*R: Em I suppose the ones that I work with, because I needed to have time off, you know when I had the treatment. But, I suppose I'm real open about anything and everything anyway, so you know I just say far too much. (laughter) People I don't know that much, I wouldn't.*

*I: Why?*

*R: I don't know. Because I feel embarrassed. I feel again, stupid and that's why in a way now, I wish nobody knew, other than you know my family, because I can still feel I don't know a freak (gets very emotional).* (8GF)

Similarly, in the extract below, the respondent put the blame on God at a moment where he was emotionally hurt.

*I: (laughter)] Em, now I would like you to tell me about your thoughts and feeling of your fertility problem at the moment. How do you feel and what are you thinking at the moment?*

*R: How I feel at the moment? Em I feel very down at the moment because it hasn't worked and we've had two attempts at it. I feel numb. I feel as though somebody's against me, and in like the work I do, looking after old people and that lot, I feel as though maybe God is cheating me because I'm helping them at the later end of their lives and I wish he'd give me like a break and say "right, this guy has done all this hard work, looking after these old people, we'll give him what he wants" you know, and that's how I feel at the moment (laughter) that he's cheating me. Em, but, I don't know I'm just so down because it hasn't worked it's a matter of building myself back up to the stage where I want to go for it again, and that it. It's a bit difficult at the moment. (Mm)* (2BM)

In the Greek context, where there were few voices accepting involuntary childlessness, it was found that they came from participants with less strong and absolute views

towards parenthood. For instance, the Greek woman's account that follows was one of these cases. When she was asked how would she feel if she could not have children in her life she replied:

*R: Certainly, it would be difficult for me, but not that it would be, meaning I believe that I started my life with Strato so that to be with Strato. If we can have children it would be the best, but not that it would be the a and the z let's say in our relationship, not that our relationship will end or that we must necessarily have a child in order to be together.* (8GF)

When the interviewer asked her how she did feel towards couples who chose not to have children in their lives when there was no organic problem, she answered:

*R: It's their choice. I don't have a problem with that, it's their choice.*

*I: You don't feel anything*

*R: Not anything special. I believe that they'll miss them at some point, like I'll miss them if I don't have them, but it's their choice. It's different having, to want [a child] and to have a child, to want a child and not being able to have it and it's different if it's your choice not to have [one]. It's a matter of choice.* (8GF)

## 7.6 Overview

The organic dimensions of subfertility and its threatening aspect to one's identity were two major themes that came out of the analysis. These two themes were apparent for both the British and the Greek interviewees. They were part of the conventional repertoire. Their existence was based on the predominant pronatalistic and biomedical discourses. Resisting voices were used in order to help interviewees cope with the threat imposed on them. The 'personal issue' theme was one such voice coming from the emancipating repertoire. Its aim was to protect subfertile respondents' identity from external threats. By pushing the analysis even further, an interesting relationship was revealed between blame attribution, pronatalistic ideas and threatened identities.

# Chapter 8

# Biomedical discourses

## 8.1 Introductory notes

As was already mentioned in the previous chapter, the biomedical discourses were used a lot by both British and Greek subfertile interviewees. Four themes were revealed by the discourse analysis regarding fertility treatments. Fertility treatments were constructed as a: a) chance to parenthood, b) sacrifice, c) choice and d) learning experience. A presentation of the content and the function of the discourses concerning the reproductive technologies is given in this chapter.

## 8.2 Fertility treatments as a chance

The construction of fertility treatments as a chance to achieve parenthood was a powerful theme that was found mainly in the Greek context. It was part of the conventional repertoire. The medical treatments were subfertile couples' hope to having their own child.

*I: Have you thought what will you do if this treatment does not work?*

*R1: The the thoughts of the outcome of the IVF is is worrying in a way that that would be it, there would be no more there would be no more, like hope it would be like losing somebody. All I can put it down to. Losing somebody close to you that you've had it there all the time and now, he's gone, that's it, you know. Such a weird I don't know*

*until I get to that stage, basically it wouldn't be I'm not looking forward to it, I know that.* (2BM)

*R2: Em how Tracy feels about it? I don't think (smiling) she likes doing it, for one minute em but I think she thinks that, basically she thinks that's the only chance of getting pregnant.* (8BM)

The construction of fertility treatments as the only solution to infertility was often found in the Greek context.

*I: What do you believe others think about the IVF you've been undertaken, meaning what does your husband, your parents, your siblings think about it?*

*R1: Ham, they think of it as something good, (they believe) that I will make it because I don't think there is another solution.*

*I: Yes there is hope*

*R1: Yes there is definitely hope.* (5GF)

*I: What do you think others think about it, your friends, parents, those that know?*

*R2: I reckon that they are thinking of it as the right solution, since we have already told them that there is no other way, it's the simple logic, suggesting that this is the only road, what else would they think?* (9GM)

Greek interviewees were more positive than the British when talking about the fertility treatments. The Greek participant below stated that she was not affected by the negative things she heard about IVF. As characteristically said IVF for her was like being thrown a life board. The specific participant had tried IVF once and she was soon to start her second attempt. When she was asked if there was anything to worry her about IVF she replied:

*R: No. We've heard different things, but all of them are positive, there isn't anything intensively negative which will make me think and say that I won't follow this method, because I don't know, for some reason, no.*

*I: Yes*

*R: For me, it's something like being thrown a life board. This is the way I see it.*

*I: Yes, and isn't anything there to make you feel worried?*

*R: No, no, none of the things I've heard has bothered me so far.* (8GF)

In the Greek man's account that follows the hope brought by the reproductive technologies was mentioned. In particular, when he was asked if he had thought what he would do in case the treatment he and his wife intended to follow did not succeed, among other things he replied:

*R: Look the chances given to us till now are low anyway. Thus, we are thinking, I believe that Christa does too, to go for the ICSI and that's O.K. We are not afraid or*

*concerned about it. Yes, we are given another glimpse of hope, which I believe is something positive. I mean, we were saying that if that didn't work, what were we going to do, but since there is the micro fertilization let's say it gives us more hope and I believe that this is the most positive (thing). So we think about it and we don't have stress, like when you know you're heading towards the boundaries, so you become more stressed with the outcome (of the treatment). Thus, we are more relaxed now. (laughter)* (8GM)

### 8.2.1 Overview

Reproductive technologies were seen as a chance for couples facing fertility problems to achieve parenthood. Subfertile interviewees, especially the Greeks were very hopeful that they will have at some point their child with the help of the various medical treatments. As was characteristically said about the treatments by a Greek respondent "is like being thrown a life board".

## 8.3 Fertility treatments as a sacrifice

The sacrifice theme in this context had to do with all the negative aspects of the treatments. A lot of sacrifices needed to be done for getting a baby at the end, if of course the treatment was successful. This theme is similar to the sacrifice theme presented in the parenthood context (Section 6.5). Both were part of the conventional repertoire, according to which parenthood was worthy of all the sacrifices.

Worries about the health of the mother and the prospective baby were major ones.

*I: I would like to ask you about IVF. What are your worries and concerns in relation to this treatment?*

*R: Yes, another thing is that lately I worry about my personal health. I mean I am worried about my baby's health, too – when it comes. I want my baby to be strong above all, you know, I don't want to have a baby just for having a baby. Of course, when you have to go through such procedures, you are worried in case it's not going to be healthy. Because there are cases where the baby born was not healthy and since the chances of IVF and the natural pregnancy are the same, you know, there are cases of IVF babies that were born problematic.*

*I: Just like in normal pregnancies.*

*R: Just like in normal pregnancies. There you do it easily, but here things are very tough. That's the difference. There you (xxx), here you have it after many efforts, a lot of struggle and stress. There is a great difference; therefore you demand to have something good (laughter). Now, this has no significance, either you have it by trying hard, or by the natural way. Unfortunately, the chances are the same. Unfortunately, they are the same.* (9GF)

According to the claims made by the participant above, subfertile couples have to make many sacrifices for having a baby and thus they deserve to have a healthy baby more than do 'normal' parents. In the following extract, the side effects of the drugs

and the emotional difficulties involved with the IVF treatment for the female patient are described very vividly by a British man in the account presented below.

*I: What do you think other people think about you having an IVF treatment?*

*R: A lot of people think we're brave going through it. But I don't think a lot of people understand what you're going through until you've actually been through it yourself. They just see it as though you know, it's taking drugs, and just popping the egg and sperm together, sticking it in and hoping for the best. They don't see, like the emotional side, actually getting over different hurdles of actually going to see the IVF unit to arrange the treatment, arrange the drugs, to go through the drugs and if something goes wrong the stress it can cause the couple to, you know, be set back maybe a couple of days or whatever, they don't see all that side of it, they just think it's like, how can I say it, going to hospital for a I don't know like a minor thing like Xray or something, they just see it that way, they don't see how important it is to the people that are having it, plus the stress and whatever you go through and going through it.*

*[...]*

*I: What do you think that your wife thinks about the IVF treatment?*

*R: At the beginning it was an absolute miracle (laughter) but as time's gone on and we've gone through the treatment, it's it's em how can I say it? It's having an effect on her because of the emotional rides and that, it seems to be bringing her down quite often. Em she feels that she needs, needs to do it to achieve our goal. Em basically it's the emotional rides she doesn't like you know, I mean, we want to know instantly*

*(laughter) what goes on, you know what I mean, like instead of having to wait you know, for like, to find out if the sniffer's worked, the injections have worked. The worst part for Julie during the treatment is the actual sniffer, because it brings her down so low and as well the outcome of it, and if it doesn't work it's it's I mean the feeling we got when Kay got for the actual, when we got told that she was pregnant but unfortunately it went ectopic, then few days she was so high, so happy with herself, you know it finally worked, she felt pregnant and everything and she thought that was the best thing of the treatment but, sadly you know it didn't work which mainly there's the emotional side of it and the actual treatment which is so upsetting. I mean for me it is because I see my wife change from a nice person to being so low, aggravated, em sad, it's it's horrible to see her being like that (laughter) but you know that in a couple of weeks she's going to be boosted up because she goes on the actual injections which can see a change in her instantly you know and she understands that that part is like the no go area part, I daren't ask her for anything or you know, I try and keep the house tidy, not not em get on her nerves, I think I'd have a knife in my back if I did. (laughter)* (2BM)

The procedures involved in fertility treatments are often seen as dehumanizing. Such accounts were mostly offered by British participants. A British male participant expressed his concern regarding the production of a sample. His wife had similar concerns. The latter are given in the second extract below.

*R1: [...] Em I suppose there is a slight fear from a man's point of view as well that (laughter) concerns me about I may give a sample that may not have any sperm in it, a little bit of that concern, because there was one sample I did give, just after I'd been ill, which was it wasn't actually a proper sample, it was, I made a mistake when I took it*

*I: Right*

*R1: a little bit, a little edgy over that side of it, yes, a little bit edgy. (laughter) So em a little concerned over that but it didn't seem to matter last time, so I'm getting used to it. (laughter)* (6BM)

*R2: Em concerns and fears about this fertility treatment? Em I think it's a very undignified type of treatment, I think that's one of the concerns rather than a fear I think that's got to do with the clinical the clinical side of it, and my concern is that the the, I mean one of my concerns was when when the man has to produce sperm, you know they make him go into this little toilet, well why can't they have a proper bedroom, you know where the woman can go with them, you know, and I'm thinking OK I know it's got to do with resources but that, that was, when I actually had the treatment, out of all the treatment I remembered Bill being sent off to go into the toilet, to get his sperm thinking it's ten minutes why isn't he back?*

*[...]*

*I was saying to myself, cor this is ludicrous, they put all, they make, you know yeah, the concerns for me but I didn't feel they had any concern about the partner so much you know about his process, so I feel really concerned, and that does concern me, and*

*(xxxxxx) about it and said how's he going to get along and we've tried to look at ways which would make it easier, but my concern was for the male partner more than the woman's, cause the woman's looked after. But the clinicalness of it, that concerns me em which we talked about anyway. So that's it. Aha.* (6BF)

This dehumanizing aspect of the treatments was also described by a Greek woman, who did not follow a treatment at that time.

*I: When you were having treatment what were in general your worries and fears? Was there anything to make you worried or scared?*

*R: Yes, yes and it still keeps worrying me. No matter what the therapy was, I've always thought about the medication, what happens. No matter what was happening I've always believed that there will be consequences on my health. I've always had it in my mind. [...] I mean I felt as if I was abusing my organism. I know I tormented it, I could feel it, I could see it too, but yet I did make this choice, even though I knew that I was maltreating my self. The same thing goes for my husband too.* (7GF)

In the extract that follows a very descriptive account is given on how a positive attitude towards the treatments diminished across attempts.

*I: Now about the treatment you had one of them, you are going to try again, are there any concerns, any fears you have regarding this?*

*R: I think the second time is worse. When I filled, when we filled the form in we were probably quite, not optimistic, it's the unknown, you watch a video and you talk through the treatment, and so, and we'd waited so long, I mean that's what I couldn't put on the form, I think we didn't find it stressful because it was like, hallelujah, you know four years later or whatever down the line, at last we were beginning, so we were probably as high as kites at that point when we filled the forms in so that is why you'll have got I would think from mine and probably from Joan's quite positive, because we didn't really find it stressful, we were so glad to be there so, and everybody kept saying "It's a very stressful time" we were thinking "No, give me those injections". I think now the second time there's more trepidation because you know all the palaver with the injections and it was very painful, egg retrieval, so part of me's thinking "ohhh" I'm not looking forward to that, and also I think er, particularly probably Joan must now be more doubtful, it's our final time so there's a bit more pressure on. I always at the back of my mind had this well if it's going to work it's probably the second time because on a lot of the statistics it seems to be second time, but when we've gone back as well they've said that the drugs level and everything were, I responded well so they're not going to change it, so it's not as if they're going to be able to "Well we got it a little bit wrong" and it'll be right the second time, so I think it's a little bit more pressurized. I'm not looking forward to it this time at all, whereas the first time it was like "yes".* (15BF)

Although the Greek participants were more positive towards the treatments than the British interviewees, they didn't have the same attitude towards the medical personnel. Such mistrust was not found in any of the accounts given by the British interviewees.

*I: Now, I want to ask you, what are your concerns and fears regarding the IVF you're going to have? [second attempt]*

*R: Our worries and fears concern the doctors' job. It' s a very delicate subject and we can't comprehend their work. And due to the fact that there are lots of rumors, we are afraid of being exploited, you know, because the other [the doctor] sees it clearly as a financial source, he sees it as an object, he does not see you so much as a patient - we have already learn this from the past - he considers you, solely as a client. These are the fears I have, I mean, to check if they really will do their job right, because our previous doctor didn't do his job properly and that's why we failed.*

*I: Is there anything else in relation to the treatment that scares you?*

*R: Well, the method of treatment and the rest don't make me scared, because is has been tested; it has succeeded for some people. I'm not afraid of it.* (9GM)

In the account that follows there are two interesting points. The first one has to do with the view that women suffer the most with the treatments. The other one has to do with participant's claims in relation to his trust to doctors. Although he said that he trusted them, he had also been concerned with opposing thoughts. It has to be pointed out that any mistrust mentioned had to do with the ethos of the doctors and not with their professional competence.

*I: Now I would like you to tell me about the IVF treatment. What are your worries and concerns regarding this treatment?*

*R: Still, deep down I ask myself why should my wife put up with this hardship, because it is my wife who suffers the most [with the procedure], as far as I'm concerned, I'm O.K. I've overcome it [my bit]; it's nothing of course compared with what Christa goes through. Apart from this, it's O.K., I have no other problem.*

*[...]*

*I: Is there anything else to make you scared or worried?*

*R: Besides that, I trust them [the doctors], no, I don't think they will do something, I don't know, to put another sperm (laughter), I don't know. I don't think and I don't even want to think (laughter) that this might happen. I mean I trust them (the doctors).*

(8GM)

Similarly in the extract below, blame was attributed to doctors' practising standards.

*I: Have you thought what you will do if the IVF you are going to have does not succeed?*

*R: I've thought about it. If this doesn't work, we will try one and two and three and five and ten more times, as long as it's necessary. However, the doctors, who practice IVF, should think is (that they have) to do their work and to do it as best possible. There shouldn't be exploitation or indifference because I believe that they take advantage of these situations. I mean, if I may speak free, according to my personal=*

*I: =Of course*

*R: experience, there are some friends, other couples who had an IVF and suffered a lot. The cost was enormous. It is said to a couple "it's very easy to have a baby nowadays with the IVF". You are not told though where to go, what are you going to do there, how much you must have in your pocket and how much you have to go through or if the IVF works the first time. I believe that they make you have it once and twice and three and four times, just for getting hold of the money each attempt of IVF costs.*

*[...]*

*to take it even further, it is said, "go there, to this institution and the rest. But when? In the morning, when you are at work? Even in this field, the State is lacking. I am referring to the fact that doctors in hospitals examine only in the morning. Since you are working, how are you supposed to go to the hospital? Your wife is working, how is she supposed to go to the hospital? Don't they think of this? In other words, are the doctors 'doctors deluxe' that examine only in the morning? (That).* (3GM)

An exception was the account offered by this Greek man below, where trust to doctors was claimed, without any direct or indirect references to the doctors' ethos. The specific interviewee and his wife had one unsuccessful IVF attempt and they were going to go for the ICSI.

*I: Are there any worries or fears about this treatment, meaning something that you think about with stress?*

*R: Regarding the drugs they'll give us?*

*I: Generally, for the drugs and the procedure itself, regarding anything that has to do with the treatment.*

*R: [...] I'm afraid of nothing, no. The doctors are very good and I have trust in them. Generally, I trust all Greek scientists, not just doctors. However, the rest of the Greek population should realize that. Anyway (laughter). If I don't cover you to a question, please tell me so.* (10GM)

The account below was given by a Greek man whose fertility problem was unexplained. At the time of the interview his wife was under ovulation induction and they also had to have sexual contact at specific times in order to increase their chances to conception. A gender discourse appeared here, suggesting that from a man's perspective is harder to follow such a method than it is for a woman.

*I: What do you think your wife thinks about the method you are undertaking?*

*R: I think that normally it must, she might think that she's annoyed less because the goal is specific and she desires it very much. O.K.? She might say "hmm, I don't mind, I'll do it" just for [the accomplishment of the goal], but O.K., it's much more different for a woman than for a man, what I'm saying is, I believe that for a man is even harder. That's my opinion, as a man. A woman might tell you that for a woman this kind of contact that this kind of contact is harder for her than for a man.* (4GM)

### 8.3.1 Overview

The sacrifice theme was a major one for both cultures. However, the British were found to be more concerned with the practical and emotional aspects of the treatments than were the Greeks. Quite interestingly, some of the Greek interviewees were concerned about any possible exploitation from the doctors practising reproductive medicine. This theme was similar to the sacrifice theme presented in Section 6.5. It was part of the conventional repertoire that accepts the 'sacred' quality of parenthood.

## 8.4 The 'choice' theme

In the context of fertility treatments the 'choice' theme was a dominant one. Since the reproductive technologies offered many options to parenthood and not a definite successful outcome, subfertile couples had to make a number of choices about the type, the number of attempts and other related aspects.

*I: Have you thought what you will do if your next treatment won't work?*

*R1: Yes, of course. After discussion, that is, because these things are done with discussion, so after that, (we've decided that) we are likely to try again, unless there is another method and we tried that one. But I don't think (that there is), I think that it ends here. Micro fertilization is the newest method that exists, at least that's what we've been told. We'll try it again and again and if it's needed (we'll try it) again.*

(10GM)

*I: Have you thought what will you do if this treatment, laparoscopy, won't succeed, that is to say, if it won't have a positive outcome?*

*R2: Yes. After this, the only suggestion by the doctors will be the IVF. To tell you the truth, we'll think about that. We haven't decided about it yet. Probably, we are going to reach till the end. Now, I don't know how many attempts we are going to have.* (2GM)

The above were typical responses coming from the Greek interviewees. Adoption was also mentioned as the second best option in both cultural contexts. Such accounts were found in the British context, however they were not the only ones. Fostering and the option of a childfree life were equally found.

*I: What do you think other people think about your treatment, the IVF treatment?*

*R1: Em I think some people might think I'm chasing a dream, I don't know if I am, I've been I've been trying this for, trying to get pregnant for fourteen years now, I don't know if I am chasing a dream or not. I'm actually at a crossroads in my life, I don't know whether to go down the road for another IVF treatment or go down another road towards adoption. I mean, some people might also say that I am a bit old to be doing this.* (2BF)

*I: Have your thought about what you will do if the next treatment you have doesn't work?*

*R2: Em, I would either adopt or stay childless for the rest of my life.*

*I: You thought about it?*

*R2: Yes.*

*I: Em have you thought what you would do if this treatment does not work?*

*R2: Yeah, erm, we thought we'd give it em two or three years on this, and then if not go for adoption if if we'll be acceptable for it. Erm, I mean Rachel's five years older than me so we, we always thought was if we leave it too long, because we would like a family, then then obviously we'd have have to start start the adoption process which can be fair fairly lengthy as well, so we think we we'd rather go down that path than like like, if the treatment didn't work and then say that's it we won't have a family, we'd like to adopt one then, if we could. (9BM)*

An interesting account referring to adoption is presented below. This interviewee favoured adoption than donor treatments on the basis that an adopted child will have an equivalent relationship with both adoptive parents.

*I: Have you thought what you will do if this treatment does not work?*

*R: Are you referring only to this attempt we are going to have? Because there will be others after the second one.*

*I: You've thought about=*

*R: =We hope that we will succeed. Especially my husband. Personally, I think of the possibility of an adoption. Even though I can have a child, I don't want to have one*

*with the use of someone else's sperm, I would like to adopt one, so as to be equivalent to both of us. I don't want him saying "<u>your</u> child", I want him to say "<u>our</u> child". In that case, it will indeed be our child. My husband never talks about adoption, he doesn't want it. He doesn't even think of it. He doesn't want to (think about it). I think that even if we never manage to have a baby, he will never accept to adopt one. That's what I think. But I would like to. I would like to have a child in my life, even if it's not absolutely mine.* (9GF)

Accounts like the one below were not found in the Greeks participants' talk.

*I: Have you thought of what you will do if the treatment does not work?*

*R: Yes. We've always jested we'd get a dog. (laughter) Yeah, well if it doesn't work this time it will be the end, physically and emotionally I don't want to go through it again, I don't (in a deterministic way) for me.* (5BF)

Choices were getting more complex when they concerned the involvement of donors.

*I: Have you thought what you would do if the second attempt you have doesn't work?*

*R1: There's a possibility of erm, I think at the moment we've been told the second attempt is about 8% chance of working, which is quite low really isn't it? And there is a possibility of Sophie using donor eggs, and they say maybe be about 40% chance. But it's something we've talked about last week and we've almost made our minds up*

*not to use donor eggs because we want our child. But it is possibly something that we could possibly think about again if the second attempt doesn't work. The feelings, the initial feelings are that we don't want a child enough for it not to be ours, do you know what I mean, genetically.*

*I: Have you thought maybe to have another attempt or?*

*R1: On 8% at nearly £4,000 a go it's erm, you get into diminutive returns really don't you. So, there is a line that has to be drawn somewhere isn't there? And to have two attempts I think is a fair chance of letting fate take it's course. But to just say "Oh let's just keep going and find the money a way really" from my point of view, it's not a waste but it would get to become wasteful.* (15BM)

*I: Erm, you've answered the other question about what you think of doing in the future, I mean, but you said about the treatment, there are some options but*

*R2: Yeah, there's other options, erm, I wouldn't like, I wouldn't want to foster, I wouldn't like us to adopt really, and I think if Susan would, wanted to go through it with donor sperm I probably would go along with it now. Erm, and just try and get on with it really, or, but I am a little bit afraid that at the back of my mind I'd know it would only be, it'd be more Susan's child than actually ours, I suppose, I suppose that's at the back of my mind as well, to be honest.* (13BM)

The account below was the only one coming from a Greek participant, which was open to the possibility of having a child with donated genetic material. However, the

interaction between her and the interviewer shows her hesitation in even naming this option.

*I: Have you thought what you will do if your next attempt won't work?*

*R: I've thought about it. Yes, I've thought about it, I've thought that I would like a lot to adopt a child. Now, Sratos is a bit negative about this, I don't know, I believe that he hasn't even thought about it, or he does but not profoundly, or basically he doesn't want to think about it (laughter). I'm the one who has thought about adoption.*

*I:Hmm*

*R: or some other, now I don't know how likely this is, we'll see about that later, we'll discuss this with the doctor as well. One of the methods you referred to in the questionnaire*

*I: ICSI?*

*R: Well ICSI is basic, let's say.*

*I: This means you are going to have this, if (your current treatment) does not work.*

*R: Finally yes, we'll probably [end in there*

*I: you'll go there]*

*R: we'll end in there*

*I: you then said you've thought about adoption and then it was (in the questionnaire the treatment) with eggs=*

*R: =bravo=*

*I: =from another woman*

*R: =from donors, yes.*

*I: =or yes, let's say from a donor.*

*R: =yes*

*I: That is to say, that you have thought about this or something like this.*

*R: I have thought about it, of course with many presuppositions, to know where it comes from, what it is, in other words this needs a tremendous search, so these things are not that simple.*

*I: Yes, but you have considered it as a solution.*

*R: Yes, but I won't have a problem with any such solution.* (8GF)

The importance of this theme is well described in the account below.

*I: Right. Now have you thought what will you do if this treatment, if you can't have the I.C.S.I. in the end?*

*R: If I can't, have I thought what I'll do? Em, yes I think about it all the time because I need to decide what I'm going to do. We need to decide. But I also think, you see I also, I actually do believe really it's, a lot of it is really my decision. I think it's in my power you see to like end it, it sounds a bit awful doesn't it, in your power, but I could sort of tonight, or tomorrow, I could just say "Right, that's it we'll not do any of it any more" and I can have a very peaceful life, but that's a big, you feel as though it's like ahh, it's my decision you know, and that's a big decision to take on, not on your own*

*behalf but on the other person's behalf and in effect on your whole family's behalf. You know, if it was, I think in a way it would be easier if I had a medical condition which made it difficult for me to have children, I would say "Oh well you know, it's terrible that this has happened to me but you know I have to live with it". I think it's the choice element. So there you go. [...] I know, I'm very impatient though. I feel like it's been going on for that long, I feel you know, I just feel that I wish there could be some sort of decisions made, I feel impatient for the decisions, just for a bit of peace.* (13BF)

In the latter extract, a gender discourse appeared concerning the female power in decision taking regarding reproductive issues. This is also apparent in the account that follows.

*I: Hmm What about your partner, your husband, what does he think?*

*R: He hasn't told me what he thinks about the future, he's waiting for me to make a decision, on what we do and where we go next before he tells me anything. (2BF)*

### 8.4.1 Overview

The 'choice' theme was strongly embedded in the biomedical discourses. All subfertile interviewees faced a number of dilemmas concerning the fertility treatments and other ways of having a child. For the Greek participants fertility treatments and adoption were the paths to parenthood that were commonly considered. For the

British interviewees the medical treatments, adoption, fostering and a childfree life were included in their choices.

## 8.5 Fertility treatments as a learning experience

A common account produced by the British interviewees, when asked if they could think of anything positive about the treatment apart from having a child, had to do with the help offered to medical researchers and consequently to future subfertile couples by trial and error across the unsuccessful attempts. Such an account was not found in the Greek context.

*I: Can you foresee any positive aspects of the treatment apart from having a child?*

*R1: Erm, positive aspects? [...] Em, I think it would be good for like research as well so like the more they do it the more people who are then in our position em, it it would help.* (9BM)

*I: Can you foresee any positive aspects of the treatment, of the IVF treatment apart from having a child?*

*R2: Yes (with certainty), I I think even if it doesn't work for me there's an element of foreword research for the people who are actually carrying out the treatment because they learn by, not mistakes but the failings should I say, and if you know somebody's failed in the past to help the consultants and the surgeons to get to this stage now, and if we have to fail and many others have to fail to find out the reasons why in the next*

*few years then I think it's positive because obviously there's there's a problem somewhere for such a high failure rate and at the end of the day it's going to be positive for research and perhaps future people. I think that's the positive side to it. It helps a lot of people that perhaps need a little bit of help, and anyway if you can get twenty babies out of a hundred that you wouldn't have anyway that's a positive note as well isn't it? Or that's how I look at it, you know I think that's positive, the positive side. You couldn't get a better team though, they're great. (OK)* (5BF)

For the Greek subfertile couples, this experience was a learning experience for them personally. It was mostly conceived as a negative experience that made them stronger and more mature.

*R1: The only positive thing that simultaneously is negative, too, - now that I have started and in a way I get the experience of it - is that you enter a long procedure and this procedure is negative in a way. You go there without knowing, you know, as they say, like a fish out of the water. They treat you there like sheep and nothing more. You experience a really disappointing situation.* (3GM)

*R2: Basically I believe that the more problems one has to face, the more he understands in depth the person he is with (his partner), and most of all, himself and afterwards he attributes more value to other things in life, like health.* (1GM)

Also, there were some accounts, found in both cultural contexts, referring to the medical knowledge gained by patients themselves from their involvement in the medical treatments.

*I: There's nothing to concern you?*

*R1: Not that I've heard of at the moment. I mean in a way em it's more exciting than anything really, thinking that you know, we're involved in something special really, em, like this now, and things like that which is different to what other couples go through. It's it's a learning experience really. But I'm not frightened of anything at all.* (9BM)

*R2: [...] and that my wife has also become an expert in medical issues (laughter).* (7GM)

For others this experience was a chance to test their relationship with their partners and find out how strong this was. The participant below gives a vivid description.

*I: Is there anything positive that you can think of regarding the treatment apart from having a child?*

*R: Look, the only positive about the whole matter, is that I see my wife let's say that see makes some sacrifices on the matter, meaning she goes through some things. This show let's say that she loves me very much because she knows I want a child, and she*

*is doing some things that somebody else might not have done them. May be not all women do this. Maybe another woman would say "no, I am not going through all this because you want a child so much". Now, I also believe that this [situation] gets us closer and show how united we are and how much we love each other.* (8GM)

Finally, there were some resisting voices coming from both the British and the Greek contexts that did not view the whole experience as a useful or a learning one.

*I: Can you think of anything positive regarding the treatment apart from having a child?*

*R1: No, not really, not now. (coughed twice) Can't think of anything positive. No, sorry. (laughter)* (2BF)

*R2: No, I can't.*

*I: O.K.*

*R2: Has it happened and I haven't realized it? I don't know, something positive. The situation is a little distressing. I do not think that I've earned something from it. An experience. If this is something positive, yes, [I've earned] an experience.* (10GF)

### 8.5.1 Overview

Being involved with the reproductive technologies was seen as beneficial from both the British and the Greek interviewees. However, there were differences in the content of the sub-themes used between the two cultures. This theme was part of the conventional repertoire. The resisting voices were not absent, although they were not many.

## 8.6 Overview of the biomedical discourses

The discourses on reproductive technologies were powerful, since all the interviewees were treatment-oriented. Four were the themes revealed by the employment of discourse analysis. In particular, the fertility treatments were seen as a: a) chance to parenthood, b) sacrifice, c) choice and d) learning experience. Similarities and differences between the British and the Greek cultures were stated and of course the limited, but powerful, resisting voices that were derived from the emancipating repertoire were presented, too.

# Chapter 9

# Discussion

This chapter consists of two parts. In Part I a discussion of the results concerning each one of the three main areas of study is presented. In Part II methodological considerations are presented. Emphasis is given to the evaluation of the research findings and their theoretical and clinical implications. Suggestions for future research are also made throughout this chapter.

## Part I

### 9.1 Main conclusions of the study

A discussion in relation to parenthood takes place, followed by a discussion about subfertility and finally about fertility treatments. As was hypothesized, the Greek participants were overall more positive towards parenthood and the reproductive technologies than were the British. However, the British were found to be affected more by subfertility, because they took it more personally than did the Greeks. No gender differences were found in relation to any of the three areas of study. The role of culture is emphasized and the need for more cross-cultural research becomes evident.

### 9.1.1 In relation to parenthood

Both quantitative and qualitative results suggest that Greeks value more the importance of having children than do the British participants. According to the quantitative analysis, this difference is attributable to the items that reflect the fact that parenthood is a natural expectation for the individual and a marriage. No differences were found between the British and the Greek participants in relation to the items that reflect the fact that parenthood acts as a confirmation of the individual's sexual identity. The latter came out of the performance of an analysis of variance. It is interesting that results coming out of the factor analysis performed for the Meaning of Parenthood Scale (see Section 5.2.1) showed that for the Greeks the items that perceive parenthood to be linked with the sexual identity of the individual did not seem to be of particular importance for the formation of a factor, while for the British a 'sexual identity' factor was formed. It seems that although the British participants distinguished items referring to sexual identity, overall these were not that important when compared with the rest of the items.

The discourse analysis's results seem to agree with the findings of the quantitative analysis. Greek participants made fewer references to the 'sacrifice' theme, indicating possibly that Greeks had a stronger desire for having a child than did the British. It seems that this desire overshadowed the demanding nature of parenthood. Also, for the majority of the Greek participants, parenthood was not a matter of choice, it was the 'ultimate', with which nothing else could be compared. The pronatalistic discourses seem to monopolize the ideological sphere in the Greek culture.

However, this was not the case for the British culture. Both conventional and emancipating discourses were apparent. The discourses and their inter-relationships revealed by this study for the British sample are similar to discourses found in Weaver and Ussher's (1997) discourse analytic study with British white mothers. There are of course differences in the themes, since Weaver and Ussher's study focused on the changes in women's lives with the acquisition of a child. In both studies, the negative and the positive elements of parenthood co-existed meaningfully. The power of the pronatalistic ideas was significantly greater than the power of the emancipating ideas. However, Weaver and Ussher's study was limited to women's views.

Jones and Brayfield's (1997) results, suggesting that cultural elements were responsible for the differences found among western European countries, while the demographic ones were less important, are in agreement with the findings of this study, since most of the demographic variables were not related with attitudes to parenthood. It is also worth pointing out that religious beliefs were not found to be correlated with attitudes to parenthood for the Greek participants, while there was a very low correlation ($r$=-.17) for the British participants. Specifically, the participants that describe themselves as more religious place a higher value on the importance of parenthood. The qualitative results of the study did not find religious beliefs to be important in relation to the meaning attributed to parenthood for either the British or the Greek participants.

Moreover, quantitative results found no gender differences, indicating that parenthood is equally important for both genders, thus contradicting previous work suggesting that parenthood is more important to women than it is to men. The gender discourses found in relation to parenthood are also in accordance with the qualitative research on parenthood (Ferri & Smith, 1995; Weaver & Ussher, 1997; Barclay & Lupton, 1999; Daniel & Taylor, 1999). Specifically, the analysis suggested an equal responsibility between the two genders. It was common agreement that the practical aspects of parenthood are placed on women and not on men. The discourse analysis's results also suggest that, at least at an emotional level, children improve the relationship between husband and wife, while at a practical level they put a strain on the relationship. This might be an explanation for the conflicting findings found in previous quantitative studies regarding the effect of children on the marital relationship.

Although gender differences were not found in relation to attitudes to parenthood, sex role characteristics seem to play an important role on pronatalistic attitudes. There were indications that people with stronger feminine characteristics attribute more importance to parenthood than those with less strong feminine qualities. This is worthy of further exploration.

Overall results deriving from both the quantitative and the qualitative parts of this study indicate that cultural elements are important for determining attitudes to parenthood. Although there are differences captured between the British and the

Greek subfertile participants, the positive discourses overshadowed the negative ones, indicating the overall importance of parenthood in both cultures. Finally, it has to be mentioned that the quantitative part of this study having to do with parenthood could have been investigated more thoroughly by including more variables (e.g., motivation). However, since this study was mainly about the experience of subfertility and fertility treatments, a more extensive exploration of other factors was not considered essential.

### 9.1.2 In relation to subfertility

No psychometric instrument was used in relation to attitudes to subfertility. There was no valid instrument found by the researcher in the existing literature in relation to attitudes to subfertility. This area was indirectly investigated within the quantitative perspective by comparing the subfertile participants with the fertile ones in relation to attitudes to parenthood. Results suggest that British subfertile participants attribute more importance to parenthood than do the British fertile participants. This is consistent with the hypothesis that subfertile couples would value parenthood more than fertile couples, since the former have more problems in achieving it.

Findings are different though for the Greek participants, where no significant differences were found between fertile and subfertile participants in relation to attitudes to parenthood. This finding suggests that there is a homogeneous reality in the Greek culture in relation to the conventional pronatalistic attitudes. The latter is so

powerful that individuals' perceptions of fertility are not influenced by their own fertility status.

The qualitative part of the study was very informative in relation to the way subfertile couples experienced their fertility problem. Results showed that the interviewees' fertility problem was strongly linked with the biomedical perspective. This of course was of no surprise since all participants forming the interview sample were treatment-oriented. The threat theme was also evident in both cultural contexts. The British and the Greek interviewees reported being very much affected, negatively of course, by their fertility problems. As could be expected, the person having the responsibility for the specific problem was mostly affected. There were gender discourses indicating that men were or would be more affected than women if they were the ones responsible for the couple's inability to have children. It was also suggested that blame was usually placed on women regarding infertility. These gender discourses are consistent with the results from previous qualitative studies (Raval et al., 1987; Miranda et al., 1995; Kazantzidou & Levine, 1996; Molock, 2000; Papreen et al., 2000). Quite interestingly, the Greek subfertile men did not use the responsibility sub-theme, having to do with the psychological burden put on the one responsible for the couple's fertility problem.

What is more interesting though was the struggle between the pronatalistic ideas that threatened interviewees' identity and the resisting voices fighting for the normality of infertility (e.g., by constructing fertility as a matter of luck). More resisting voices

came from the British interviewees. Such a struggle could be an indication of the bigger effect of subfertility on their self-esteem. The latter speculation is also supported by the finding that for the British interviewees parenthood was a personal choice, that was characterized by dynamism and control. The latter could justify a great vulnerability, when this choice cannot be fulfilled. These speculations were mentioned in Kazantzidou and Levine's (1996) study, too.

Specifically, in the latter study it was suggested that the Greek fertile participants were not affected by infertility in the degree British respondents were, because for the Greeks infertility was mainly perceived as a family matter, as a shared problem and not so much as a personal problem, as it seemed to be the case for the British. The latter study suggested that infertility was linked more with the social and personal identity of the British than of the Greek participants. That study was conducted only with presumably fertile people, investigating their attitudes to a hypothetical infertility.

In accordance to the above claims, Edelmann and his colleagues (1994) suggested that within the western world, social and personal identity needs appeared to be more important motives for childbearing. The latter is in accordance with the construction of participants' fertility problem as a personal one. This theme was mostly used by the British participants in order to protect themselves from all possible kinds of intrusion coming from the 'fertile world'.

In agreement with the above is Yüksel and Kentenick's (1988) study, which investigated attitudes to parenthood and infertility between Turkish and German subfertile women. It was found that the Turkish women showed less ambivalence and usually experienced enhanced self-worth and self-confidence through childbearing, while the German women were more oriented towards their partner and career and faced more conflicting feelings regarding parenthood.

It seems that as initially speculated, the protagonistic elements of choice and individualism in western countries create a bigger ambivalence towards parenthood and greater pressure on subfertile individuals. For the British subfertile couples it is a more dynamic process to pursue parenthood, it is more of a decision than it is for the Greek people. Thus, the emergence of fertility problems has a more personal and powerful effect on them. Specifically, subfertility affects their personal identity. For the Greeks, again as it was initially speculated, their pursuit of parenthood is linked with powerful societal norms and thus subfertility affects their role identities as parents. Furthermore, in relation to the Greek subfertile interviewees, it was found that the more absolute one is in accepting the specific societal norms, the more threatening the experience of subfertility is for him/her. Greek participants, who have more enriched ideas regarding parenthood and involuntary childlessness, are not that threatened by subfertility and do not feel the need to accuse others for their behaviour (e.g., their fertile friends or couples who do not want to parent children).

In both cultures subfertile individuals' lives are greatly affected. One cannot tell which reality is better, as well being differences were not found. The goal is the same, but the realities are quite different in terms of ideological problems. More power and freedom is given to the British by society and thus, their fight is greater. For the British subfertile individuals an internal struggle takes place between their already made choice for a child centered life and the society's freedom to live differently. Subfertility is a threat to their freedom. For the Greek subfertile individuals the attack is imposed by society itself. It hits them hard too though. For the Greeks there is no other way for living meaningfully apart from having a child.

In the long run things might be more positive for the subfertile couple in Britain because society will not be that hard on them if they decide to live a childfree life. They can find peace and meaning in an alternative form of living or in parenting and thus have a greater chance of achieving happiness than the Greek subfertile couples. Future research could investigate the above speculations by studying long-term involuntarily childless couples. Finally, the formulation of a scale that would identify and evaluate subfertile individuals' perceptions regarding their fertility problem would be very useful both to researchers and practitioners engaged in helping subfertile persons.

### 9.1.3 In relation to fertility treatments

This area of research was investigated using both quantitative and qualitative methods of this study. The quantitative results suggest that the British fertile participants had the most negative attitudes towards fertility treatments, with the exception of donor treatments. The attitudes towards the latter were similarly negative for the British and the Greek groups, regardless of fertility status. Results also suggest that, overall, participants were mainly concerned with the effect of reproductive technologies on couples' sexual life, fetal physical health, man's self esteem and with interference with the natural process.

The above findings are partially consistent with Shiloh et al.'s (1991b) results, suggesting that subfertile participants have more positive attitudes towards the treatments than do the fertile participants. As was found, this was true only for the British and not for the Greeks. The latter emphasizes the role of culture on attitudes to reproductive technologies. In addition to the high value attributed to parenthood by the Greek people, regardless of their fertility status, it seems that fertility status is not related to Greek people's attitudes to the fertility treatments. There is a homogeneity in the Greek culture regarding attitudes to fertility and the medical treatments for subfertility.

In contrast with Shiloh et al.'s (1991b) findings, which suggested that fertile women were more concerned with the health of the fetus than were the subfertile women, no differences were found between the fertile and the subfertile participants in this study

in relation to fetal health. The only significant difference found between the two fertility groups was in relation to moral dilemmas. The fertile group was more concerned with the moral aspects of the treatments than was the subfertile group. Also, the results of the discourse analysis indicated that subfertile participants were very much concerned with the health of a prospective child (see Section 8.3, p.227).

Interestingly, the item having to do with medical sophistication of the treatments from Shiloh et al.'s (1991b) scale did not fit well with the other items of the scale, as the reliability item analysis showed. This item actually damages the psychometric robustness of the instrument. A possible explanation might be that this specific item lacks a clear evaluative direction, unlike the other items. For example, loss of self-esteem is clearly undesirable. But it is unclear whether 'medical sophistication' is desirable or undesirable. This judgement may vary more between individuals or even between cultures than is the case for the other items.

Although according to the quantitative findings there were no significant differences found between the British and the Greek subfertile participants regarding attitudes to treatments, the results revealed by discourse analysis suggested that the Greek interviewees were more positive towards the treatments than were the British interviewees. Specifically, the construction of fertility treatments as a chance to achieve parenthood was a powerful theme that was found mainly in the Greek context. Also, in relation to the sacrifice theme, the British were more concerned with the practical and emotional aspects of the treatments than were the Greeks. The weakness

of the quantitative part of the study to unravel significant differences between the British and the Greek subfertile sample could be presumably due to the low statistical power of the three and four-way interactions that would show any such differences.

Furthermore, quite interesting was the finding from the discourse analysis suggesting that, although the Greek interviewees were very positive towards the treatments, they did not have the same positive evaluation of the medical personnel. Specifically, some Greek interviewees showed a great mistrust in relation to the ethos of the doctors. Such voices did not come out of any of the British interviewees. This might be due to the lack of governmental control on doctors and medical centers practicing reproductive medicine in Greece.

Finally, although reproductive technologies included many options and choices for both British and Greek patients, it seems that the choices of the British were overall more expanded than were the choices of the Greeks. Specifically, fostering, donor treatments, even a childfree life were acceptable options for the British, while this was not the case for the Greeks. Since the Greek culture is governed mainly by the traditionalist repertoire, it is not surprising that the paths to parenthood are more limited and conservative than they are in the British culture, which is more liberal and democratic in relation to reproductive issues.

Although the results largely verified the hypothesis of the study in relation to differences between the British and the Greek participants' attitudes to fertility

treatments, the reason for the specific differences was not the one initially offered. Specifically, it was suggested that Greeks have more positive attitudes to reproductive technologies than the British. It was speculated that the greater importance attributed to children in the Greek culture would make the Greek participants more fond of ways of helping couples with subfertility problems to achieve biological parenthood (e.g., medical interventions) than the British. However, such a justification cannot be accepted as true, since no correlations were found between attitudes to parenthood and attitudes to fertility treatments either for the whole sample or for the subgroups.

Additionally, in relation to the fertility treatments, both Greek fertile and subfertile participants were very positive. The Greek subfertile couples especially seemed to put all their hopes in these treatments and did not permit themselves to doubt the strength of the reproductive technologies. Any negativism was often attributed to the medics who were perceived as unethical. The latter could be due to the unrealistically high expectations that are cultivated in the subfertile couples by the doctors.

In agreement with results suggested from previous studies, the perceptions of subfertile women, who have already had some kind of treatment, were more positive than those of the fertile women. However, this was true though only for the British sample. According to Shiloh's study with American participants there were differences with respect to female-centered treatments between fertile women and infertile women. However, overall subfertile participants were more positive than were the fertile controls towards a variety of fertility treatments.

Similar trends to those above were shown in Grand's work (1997) with American participants. Arguably, a positive attitude seems to act as a coping mechanism for the subfertile individuals. Based on the above results it can be speculated that the difference in attitudes between fertile and subfertile individuals applies to modern western European cultures and not to more traditional eastern European societies like Greece. So in the States and Britain the subfertile individuals are more positive to the fertility treatments than the fertile ones, while this is not the case in Greece. Greek people, regardless of fertility status, are very positive towards the treatments.

Furthermore, gender was not found to have an effect on attitudes to fertility treatments. The speculation that women would be more positive towards the treatments than men was not verified. Similarly to attitudes to parenthood, attitudes to medical treatments were found to relate with the participants' sex roles. It seems that the more masculine have the more positive attitudes towards the treatments. This can be explained by the dynamic and action-oriented characteristics of the masculine sex-typed individual. Other variables that have been found to relate to participants' attitudes to fertility treatments and are worthy of further investigation are education and Life in General. Also, the type of treatment that participants are undergoing at the time of the investigation seems to be an important variable, that would be wise to control for in future studies. Also, it is worth noting that social support was not correlated with attitudes to fertility treatments.

Fertile participants' accounts would have further enlightened the investigation of this area. Future research could look more into the above suggested cultural differences. Also, it would be interesting to study the discourses used by subfertile couples who stop pursuing treatment after some attempts in order to understand the subfertility experience from a different perspective.

# Part II

## 9.2 Methodological considerations and further recommendations for future research

This study managed to give an interesting picture regarding the research issues by using two different methodological perspectives. The quantitative results are in agreement with the results of the discourse analysis, showing that both methodologies can be used in a complementary way, giving insight to each other. Also, one method can be used as a validation tool for the other. Unfortunately, the qualitative part of this study did not include fertile participants. It would be very interesting to see this in a future study. However, if the researcher was to repeat this study, she would prefer to use a less structured interview, as this would allow the different ideologies to be unravelled in a less conventional context, as is most appropriate for the qualitative paradigm.

In this study both quantitative and qualitative research methods were used in the interests of completeness. The latter logic is in agreement with many researchers (e.g., Kirk & Miller, 1986; Oiler Boyed, 1993; Silverman, 1993; Morse, 1994). Although triangulation was not specifically employed to assess the validity of the results of this study, it could be argued that this took place at a secondary level. The lack of contrasting results produced by the quantitative and the qualitative analyses strengthens the validation of both methods (Bloor, 1997; Murphy et al., 1998). Furthermore, in the case of the dissimilar results found between the two methods in

relation to British and Greek subfertile participants' perceptions of the fertility treatments, the qualitative findings pinpoint the necessity of further and more focused quantitative investigation of the specific variables.

In relation to the generalizability of the results of this study, it has to be acknowledged that the subfertile participants were all treatment-oriented. The idea of a longitudinal study with a normal population with no suspected subfertility problems at their initial involvement in the study could be suggested for solving the above bias, but the resources needed for such a study mean that it is unlikely to be undertaken.

Also, it should be noted that more Greeks than British were not undergoing treatment at the time of the data collection. Furthermore, more Greeks had tried other treatments previously than had the British (see Appendix 21), e.g., treatments with drugs and hormones and IUI. None of the British subfertile sample had tried any of the above treatments, but had progressed immediately to more technologically advanced medical treatments. This is the case for the whole subfertile sample, as well as for the sample of the subfertile interviewees (see Appendix 4b). The above different medical background of the two national subfertile groups could be responsible for the differing attitudes of these groups in relation to the medical treatments.

The Greeks were ethnically a homogeneous group, as were the British (because recruitment was restricted to white English individuals). Hence, both the quantitative and qualitative results can be generalized only to white English and Greek individuals

living in their country of origin. In the case of couples facing subfertility problems, results can be generalized only to treatment oriented ones.

Another important aspect having to do with the participants is that they were volunteers. Thus, results cannot be generalized to all subfertile patients. It was clearly stated in the recruitment letter (Appendices 12a and 12c) sent to the subfertile couples, that their participation was voluntary and had nothing to do with their treatment. Especially, in the letter approaching the British subfertile sample (Appendix 12a), it was repeatedly stated that, although their participation would be very much appreciated, they did not have to take part in this study. On ethical grounds the possibility of taking part in the study due to feelings of obligation to the medical center or out of fear for any negative consequences regarding their treatment was one of the main considerations of the researcher. It has also to be mentioned that the British subfertile couples were discouraged from taking part in this study if they had been approached to take part in any similar studies. The latter might be the reason for the low reply rate for the British subfertile sample (23.7%).

The letter to the Greeks was phrased less formally with respect to the relevant ethical issues, as the 'legalistic' style of the British letter would seem strange to Greek individuals. The low reply rate of the Greek subfertile couples recruited from the public sector (21.5%) can be explained by the fact that most of them were recruited via mail.

The high response rate for the Greek couples that were approached at the private medical practice (72.7%) is worth noting. This could be explained by the fact that most of the patients of the specific practice were undergoing investigations or were receiving a drug treatment. This was quite different from the medical history of the British subfertile couples and the Greek subfertile couples that were approached in the public sector. The majority of the latter two groups were either undergoing an assisted conception technique and/or had undergone one in the past. Consequently, Greek subfertile couples from the private sector were arguably less tired and more pleased with the medical sector, than the other two groups.

Another explanation for the high response rate for the Greek subfertile couples, that were approached at the private medical practice, and the most possible one, is that all of them were approached directly. They were given the questionnaires and the information letter at the time of their visit to the practice by the researcher, who explained with great discretion the purpose of the study to the patients. Some of them filled in the questionnaires at the time of their visit to the practice but, most of them took them with them at home and brought the completed questionnaires with them in their next visit to the doctor.

In relation to the measures chosen for inclusion in the quantitative study, these were all widely used, self-administered psychological tests. However, there were no norms available for the Greek sample for any of the psychological instruments considered for use in this research. Hence, this was not a criterion for the selection of instruments.

Rather, the ones chosen were those used by studies in this area of interest. Furthermore, since we were not interested in abnormal/deviant behaviour and control groups were used in both cultural groups, the fact that there were no norms for the Greek sample, does not seem to pose any threat to the validity of the findings of this study for comparisons within the two national subgroups.

However, the typical ways in which people answer the questions may be rather different between the two cultural groups. The possibility of the existence of systematic response biases due to cultural or language differences cannot be ignored for all instruments used. Because of this the validity of the cross-cultural comparisons has to be regarded with caution. However, on a more positive note, the qualitative findings of the study, to whom the above 'psychometric' problems do not apply, provide to a large extent validation for the cross-cultural quantitative results.

Finally, the mean scores obtained for the specific populations of this study could be used as indicators for future studies, that will investigate a similar population cohort. Specifically, this study provides important information against which future research in Greece can be compared.

### 9.2.1 Ethics

Participants' protection from any possible harm or discomfort as a result of their involvement in the study was of formost importance. One of the main considerations was to disrupt participants' lives as little as possible, making sure that no harm would

be caused. For example, the researcher did not challenge the interviewees' responses during the interview, even though doing so would reveal more of their experience. Interviewees were already in a vulnerable position and keeping the balances required sensitive handling of the interview process. It was also hoped that participants would feel glad to have contributed to a worthwhile study. This was obviously the case for the majority of the interview sample, who at the end of the interview openly expressed their pleasure at having participated.

It is believed that the researcher's personal values and special training played a catalytic role in facilitating participants to express themselves openly and honestly, but without undue distress.

**9.3 Quality issues in the qualitative research.**

As was stated in the Method Section (Section 4.1, p.74), the researcher adopts the view that qualitative research should be evaluated by criteria coming from the qualitative paradigm (Morgan, 1983; Lincoln & Guba, 1985; Marshall, 1985; Sandelowski, 1986; Guba & Lincoln, 1989; Henwood & Pidgeon, 1993). However, qualitative researchers who agree with the latter view have not agreed upon a set of criteria for assessing qualitative research (Sandelowski, 1986; Murphy et al., 1998). It has been suggested that the choice of criteria is a matter of judgement (Murphy et al., 1998). Of course, the criteria for evaluation should aim to ensure the soundness of the evaluation and not be a justification for the validity of the study. Also, ethical issues should be central to the researchers.

For example, respondent validation or member checking is a widely proposed criterion for assessing the validity of research findings (e.g., Sandelowski, 1986; Beck, 1993; Morse, 1994). However, it is not appropriate in many cases (Murphy et al., 1998) and this particular piece of qualitative work was felt to be one of those cases. In addition to concerns about the strength of the latter assessment criteria (Silverman, 1985; Emerson & Pollner, 1988; Hammersley, 1990, 1992; Henwood & Pidgeon, 1993; Bloor, 1983, 1997), respondent validation was not adopted for ethical reasons.

Specifically, interviewees were not given a full copy of the interview transcript and they were not invited to modify or delete anything written there. It was thought that receiving a copy of one's own speech and asking them to reflect on it could be very distressing particularly if they discovered any discontinuities or contradictions at the time of the interview.

So the rejection of using member checks as a test of validity was not due to the problems previous researchers have referred to (e.g., Emerson, 1981; Bloor, 1983), but mostly due to the ethical considerations in relation to the interviewees' well being, especially for the specific topic that was so personal, sensitive and powerful. It is worth pointing out that none of the interviewees asked for a draft of their interviews. Only a few showed an interest in finding out about the results of the study.

### 9.3.1 Coherence

A main criterion for ensuring the validity of the findings of a qualitative study is coherence (Potter & Wetherell, 1987). This was adopted as a guide to the researcher during the analysis and as a validation tool after the analysis was completed. The analysis was thought to be valid only when it accounted for all the analytic claims and managed to give explanations even to the most exceptional or 'neutral' claims.

Furthermore, the interaction between the participants and the researcher was analyzed, not solely the participants' speech. Looking into participants' accounts outside of the context set by the researcher, would threaten greatly the validity of the findings. Thus, reflexivity is a catalytic term in the evaluation of any piece of research, but especially qualitative studies.

### 9.3.2 Reflexivity

A presentation of many crucial issues upon which the researcher had reflected throughout this work is given here. Of course, it is not possible to present a full picture. It is hoped that enough information is being given to help readers better comprehend this work and evaluate its findings.

First of all, the selection of the specific methodologies is in accordance with the researcher's interests and values. For example, since the researcher was interested in understanding the experiences of subfertile couples in order to select information for

enhancing their well being, qualitative methodologies that focus on social realities other than 'understanding' were excluded.

Another example in relation to the effect of the researcher's values in the formulation of the data collected has to do with the use of the term subfertility in both the questionnaires and the interview questions. This term was chosen because it was thought to be the most appropriate term of the situation, both empowering for the interviewees and helpful in establishing a base for a more dynamic and equal interaction between the researcher and the researched. Subfertility is a neutral and representative term of the situation. Referring to participants' fertility situation as a problem would have a negative effect to start with and would restrict participants by bringing forward their disempowered self.

Also, in order to enhance interviewees' trust and hence allow them to reveal as many aspects of their experience as possible, basic counselling skills were used. Paraphrasing, active listening, attention to both verbal and non verbal behaviour and probing were used in order to encourage interviewees to talk and help them to give a more complete picture of their subfertility experience. In combination with respecting, being genuine and empathic with the interviewees, the researcher tried to help them present a representative and sincere picture of their experience.

In the rare instances of reluctance and resistance from the interviewees, the researcher was not discouraged. Her understanding of normal defences and of the vulnerable

position of the interviewees rendered even the rare remarks of mistrust or hostility justifiable. The researcher's genuine attitude, real interest and respect for the interviewees' thoughts and feelings seem to have been recognised by all interviewees, who shared freely and gladly their experiences in relation to subfertility. The researcher also made it obvious to participants that she was appreciative of their willingness to share their experience and time with her. All the interviewees were polite and appreciative of the researcher's efforts to investigate this issue and to help future couples facing the same problem as theirs.

### 9.3.3 Personal reflexivity

Self-development and counselling were two of the general frameworks used by the researcher for achieving an awareness of high standards with respect to her standing to the investigated topic. Reflecting on the counselling sessions and keeping notes of personal feelings and thoughts showed that this process was a rich one in terms of emotional reactions to the interviewees' experiences, e.g., sadness and sympathy for what they go through at an emotional, cognitive or practical level, admiration for their courage, and, at other times, anger for their determination to become parents and to go through anything, joy for being united with their partners and for pursuing this goal together, and, at other times, irritation for disvaluing and ignoring other important things in life and for being miserable due to their involuntary childlessness. The researcher's views did not change upon parenthood and subfertility. She did and still does value children highly and evaluates subfertility as a great problem in a person's life. Although, the researcher does believe that there are other meaningful ways of

living other than parenting children, she has been sure that subfertile couples need much help from subfertility counsellors in coping with this complex experience.

The researcher believes that a genuine interest in the unique experience of each one of the interviewees helped her not to block the interviewees' responses in any way. The researcher also thinks that she managed to be with the interviewees, but also to maintain a healthy and functional distance, ensuring that no bias of hers would block her interactions with the interviewees.

Another important issue had to do with participants' perceptions of the researcher and the presentation of the letters with which the participants were approached about the research. My status as a student – researcher offered the reassurance that I was interested in researching the specific area and not that, for example, their mental health was being investigated for use by the personnel of the clinic. Also, the researcher believes that this interest in exploring their experience implied to the interviewees that there was no kind of information that would be inappropriate.

Furthermore, since couples had a dependent position in the medical context, in order to facilitate them freely expressing their true feelings and thoughts, it had to be made clear to them that I was an independent researcher, interested solely in their personal experience. Although the medical clinics were essential collaborators in providing access to these patients, there was not any direct or indirect dependency between them and the researcher. As was mentioned in the acknowledgements, this work was

funded partially by the University of Hull and this gave the researcher the freedom to do her work without any third-party influences.

The researcher kept an open mind throughout the research process, questioning and reflecting. For example, she began to question, whether the assumptions of the powerful medical context were beneficial or not to the subfertile couples. Questions like the following puzzled the researcher: "Is it in the subfertile couples' interest to go through anything for achieving having a child at the end?", "How can a couple know when to stop pursuing treatments or how often to pursue them?". The researcher also questioned the necessity of children in one's lives, or why is it so difficult to accept childlessness.

In relation to the researcher's appearance when meeting with the subfertile couples, it was gender-neutral in an effort to encourage both partners to reveal their true feelings and thoughts regardless of any gender related artifacts. I wanted my appearance to make both partners feel comfortable. In particular, I wanted to ensure that female interviewees (possibly with a threatened identity) would not see me as a threat or would not direct their attention to me as a woman. The latter was the same for male interviewees. Also, participants assumed, due to my age and being student, that I was not a parent. I was not in the outgroup, nor in the ingroup. This more neutral position did not pose a threat to them.

### 9.3.4 Overview

The complexity of ensuring and evaluating qualitative results is evident from the above discussion. All necessary steps for ensuring respect for participants' essence were addressed by the researcher throughout the research process. The researcher's personal standing towards the topic, her personal values and graduate research and counselling training helped in this process.

## 9.4 Theoretical and practical implications of the findings.

An appropriate criterion when considering any kind of research work is to adopt that of examining the 'illumination' provided by the research, rather than just asking about the validity of the results (Murphy et al., 1998). This criterion is referred to as 'relevance' by Hammersley (1990), having to do with the implications of the findings. The major theoretical findings that can have practical implications and these clinical implications are presented in this section. Thus, the theoretical implications that have to do with the strengths and limitations of this study, that are reported in Part I of this chapter for guiding future research, are not repeated here.

### 9.4.1 Theoretical implications.

British and Greek participants' attitudes to parenthood, subfertility and fertility treatments were more related to national culture than to demographic factors, verifying the importance of culture in relation to these issues. Of great interest is the finding suggesting that there is a homogeneous reality in the Greek culture in relation to the conventional pronatalistic attitudes and the perceptions of the fertility treatments.

These attitudes are so powerful that they are not affected by the participants' fertility status. This is not the case in the British culture, which showed differences between fertile and subfertile participants, with the latter being more positive to the fertility treatments. This finding is consistent with the existing literature.

Interestingly, Greek subfertile participants were found to be critical of the ethos of the doctors (Section 8.3, pp. 233-235) and reported being uninformed about procedures, options and other treatment-related aspects (Section 8.5, p.246), which was not an issue raised by the British sample.

Another important theoretical implication of this study has to do with the verification of the findings of the prior study of the researcher (Kazantzidou & Levine, 1996), suggesting that parenthood was a personal choice for the British, while it was a family matter for the Greek individuals. Thus, for the British subfertile individuals, the effect of subfertility is more dynamic and personal, while for the Greek ones the effect has more to do with their parental role identity.

For the Greeks the problem lies with the monodimensionality of the Greek social norms, which encompass no other way of living apart from child focused. Thus, it was found that those Greek subfertile participants who had more enriched ideas regarding parenthood and involuntarily childlessness, were not as threatened by subfertily as were those who were more absolute-minded.

Another major finding has to do with the lack of gender differences intra-culturally and cross-culturally regarding attitudes to parenthood and attitudes to fertility treatments. Also, the finding that religious beliefs do not seem to play an important role in attitudes to fertility treatments is worthy of further exploration.

### 9.4.2 Practical implications for the Greek cultural context

In the Greek culture the necessity of receiving basic information about the treatments is obvious. Not being well prepared, many times because of having unrealistic expectations, results in the subfertile individual, in the end, feeling a great loss of control and attributing all the blame to doctors. The well-being of patients is jeopardized and the doctors earn a bad reputation that is, many times, undeserved. The adoption of positive outlook, combined with realism about the approach to subfertility would be more beneficial.

Thus, it seems that the following would be beneficial for the Greek people: a) more information giving in relation to the emotional and the practical aspects of the treatments, b) acknowledging the legitimacy of other forms of living, apart from the family one, that are dignified and meaningful. Accepting and respecting different forms of living, not family centered, in combination with the dominant pronatalistic views would help Greek subfertile individuals feel less threatened from subfertility and the 'fertile club'. This would give them the chance to have a more realistic perception of the reproductive technologies and to be more in control of their lives. Also, they will have a more 'philanthropic' attitude to life, that respects other persons

not solely according to their parental status. Counselling could also help subfertile couples reconsider their values and the criteria for judging their life. It could also help them cope more dynamically within this powerful conventional cultural context and choose the most appropriate route for becoming parents. For many couples in Greece adoption might be viewed positively if it is promoted more by society.

Also, it is critical for professionals to be educated and persuaded about the importance of meeting the psychological needs of the subfertile couple and the dangers involved when these are not met adequately. Even when specialized psychologists in this area are supported by doctors, this should not be done just for the typical reasons of projecting the image of a more complete service. The existing reality for the Greek subfertile couple is a great threat to one's identity and self-worth as a human being. Also, it can have long term implications such as unresolved losses from many quick unsuccessful attempts. The rejection by the 'fertile world' and the stresses imposed on the subfertile individual renders the latter vulnerable to depression and other mental health problems. The interventions need to be seen with a positive, but realistic view that will support the couple in their pursuit of parenthood.

The Greek couple facing subfertility needs psychological help. The social problems that could emerge are great, if for example in their desperation, or due to pressure from doctors, they go for a donor treatment without working their thoughts and feelings. Building relationships on a superficially stable base can be very dangerous. It has to be noted that in Greece there is no law that obliges the subfertile couple,

before starting receiving a donor treatment, to meet with a trained counsellor, as is the case in Britain. In such circumstances, the values of building a family may be sacrificed just for the sake of fitting in a society that lives no space for alternative ways of living.

Medical professionals, by giving more information to their patients, will help them understand the difficulties involved and that in spite of these difficulties, they are determined to do their best to help the couple in their pursuit of parenthood. Such an attitude would be helpful to the couple, who would really appreciate the medics' efforts and determination. But above all, society in its pursuit of creating life must not forget that even childless human beings are worthy of the respect and happiness that is given freely to parents by the strict and narrow Greek normative system. Also, public awareness and education is crucial for all Greeks in relation to subfertility and involuntarily childlessness.

### 9.4.3 Practical implications for the British

The British culture accepts the importance of the family way of living, as well as alternative forms of living. Thus, this society might not be entirely understanding of the subfertile couples' obstinacy and persistence in pursuing parenthood at any cost. In relation to the attitudes of the British subfertile participants, these, as it was found, are full of struggles and conflicting ideas. British subfertile individuals are part of the liberal British culture, but they are also conscious citizens that have chosen to live their lives in the family context. So, the difficulties involved put the subfertile

individual in a difficult situation where his/her personal preference to living is not the 'ultimate' according to the societal norms, but s/he decides to pursue it via reproductive technologies, irrespective of the financial, emotional, health costs involved.

The tolerance of the British society is not as great as the Greek's in relation to the pursuit of parenthood. The British subfertile group seem to adopt a positive attitude to fertility treatments as a coping mechanism, while their fertile counterparts have a less positive attitude to the treatments. Thus, it seems reasonable to speculate that it would be helpful for the subfertile couples to acknowledge the importance of their wish to become parents and to support them in their pursuit of parenthood. Professionals in the medical arena and counsellors could ease their struggle by acknowledging and respecting them for their efforts in pursuing such a meaningful goal. Friends and relatives could also help the subfertile couple by adopting a more supportive role.

## 9.5 Conclusion

This thesis has highlighted the complexity and painfulness of subfertility in a couple's life in both cultural settings. The importance of well-trained psychologists, who will help couples cope better with the treatments and/or explore other non medical solutions to subfertility cannot be stressed too much. The need for further research in this area is also apparent. This should address the gaps in knowledge in relation to the role of culture and thus, benefit in the training of other professionals (counsellors, medics) in dealing more adequately with the real needs of the subfertile couple within

specific cultural settings. British professionals should be more culturally sensitive when treating patients from different cultural systems. Also, Greek professionals and especially counsellors should be aware that most of the literature informing them about the psychological experience of subfertile individuals has derived mainly from studies of western European populations and thus need to be treated with scepticism.

Future research could study different cultural contexts within distinct European ethnic groups, so as to verify the conclusions and speculations of the current study and then expand our knowledge by studying non-European industrialized societies and non-traditional families. The identification of the discourses used by different family styles potentially could help expand our knowledge about the predominant ideologies and find more positive, liberal and maybe meaningful constructions of living in a family. This could give more freedom to subfertile persons in dealing with their problems and a more respected place for them to live in society. What is more, the relationship between self-esteem and blame attribution in the fertility/subfertility context would be very interesting to investigate more thoroughly. Finally, it is worth mentioning that the importance of alternative, though meaningful, life styles is being undervalued by the predominant social ideology of both cultures. One wonders about the value attributed by societies to people who do not parent children, but who nurture our souls, minds and hearts (e.g., writers, counsellors, priests, etc.).

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# Appendices

## Appendix 1: Reasons for wanting to have a child

| Abbreviated name | Item |
|---|---|
| | I want a child because... |
| Deep need | ...I feel a deep need for a child |
| Family line | ...I want to carry on the family line |
| Give love | ...of the love and affection I could give a child |
| Receive love | ...of the love and affection I could receive from a child |
| Enjoyment | ...of the enjoyment and fun a child could give |
| Cement relationship | ...a child would cement my relationship with my partner |
| Religion | ...my religious beliefs/philosophy of life lead me to want a child |
| Family pressures | ...the pressures and expectations from my family lead me to want a child |
| Pressures from friends | ...the pressures and expectations from my friends and acquaintances lead me to want a child |
| Most friends have children | ...because most of my friends have children |
| Make us a family | ...it will make us a family |
| Woman's role | ...it is part of a woman's role |

| | |
|---|---|
| Guide a new person | ...I want to guide and help a new person |
| Provide a good home | ...I can give a child a good home |
| Could bring up a child well | ...bringing up a child is something I could do really well |
| Own experience | ...my own experience of being a child |
| Enhance masculinity /femininity | ...having a child will enhance my masculinity /femininity. I want a child because not having a child will diminish my masculinity/femininity |
| Love and support in old age | ...I want love and support in old age |
| Help at home/work | ...a child could give me help at home or with work |
| Very important to partner | ...it is very important to my partner |
| Most worthwhile thing | ...bringing up a child is one of the most worthwhile thing a person can do |
| Shape next generation | ...I feel I should take part in shaping the next generation |
| Material benefits | ...of the material benefits a child could bring |
| Part of both of us | ...it will be something that is a part of both of us |

## APPENDIX 2: The 15 perceptual dimensions of Shiloh et al.'s (1991) scale

1. Social norms: is considered socially acceptable/is considered socially unacceptable.
2. Pain: causes pain and physical discomfort/does not cause pain and physical discomfort.
3. Bonding to child: may cause difficulties in bonding to the baby and in parenting/can facilitate bonding to the baby and parenting.
4. Couple's relationship: is detrimental to the couple's emotional relationship/causes tightening and strengthening of the couple's emotional relationship.
5. Hope for success: elicits hope for success and optimism/does not elicit hope. elicits expectation of failure.
6. Physical threat: involves risk of physical damage or unhealthv side effects to the patient/does not involve any physical threat to the patient.
7. Fetal health: elicits concerns about fetal physical health/secures fetal physical health.
8. Humiliation: causes humiliation/does not humiliate.
9. Medical sophistication: uses most sophisticated medical technology/simple and unsophisticated medicine.
10. Sexual life: detrimental to normal sexual life/contributes to improvement of sexual life.
11. Social exposure: much social exposure, cannot be hidden from others/enables total privacy and secrecy.
12. Moral dilemma: elicits philosophic, moral, or religious concerns/does not elicit any philosophic, moral, or religious concerns.
13. Artificiality: artificial and unnatural/does not interfere with the natural process.
14. Self-esteem (F): hurts woman's self-esteem/does not hurt woman's self-esteem.
15. Self-esteem (M): hurts man's self-esteem/does not hurt man's selfesteem.

# Appendix 3

## Procedural guide for discourse analysis by Billig (1997)

1. Read background material about discursive psychology and about the topic you want to study;
2. Read some more
3. Decide on the type of data you wish to study;
4. Collect data. If the data are printed materials, proceed to 9;
5. If you are collecting speech data, then collect your tape-recordings;
6. Listen to tape-recordings;
7. Transcribe the recordings;
8. Check the transcriptions against the tapes;
9. Read the transcription/data;
10. Keep reading them; start looking for interesting features and developing "intuitive hunches";
11. Start indexing for themes and discursive features;
12. Read, read and read, especially to check out "intuitive hunches" against the data; always try to look for counter-examples;
13. Start writing preliminary analyses, testing your "hunches" against the details of the data; always be critical;
14. Keep drafting and re-drafting analyses, comparing different extracts, looking in detail at extracts and being aware of counter-examples;
15. Keep writing, reading, thinking and analyzing until you produce a version with which you are not totally dissatisfied;
16. Be prepared to return to Stage 1.

# Appendix 4: Descriptive statistics for the sub-groups

**Table I: Descriptive statistics for the British participants and the sub-groups.**

| Demographic characteristics | British | | | | | | All |
|---|---|---|---|---|---|---|---|
| | Fertile | | | Subfertile | | | |
| | Men | Women | Total | Men | Women | Total | |
| **Age** | | | | | | | |
| Mean | 33.68 | 31.76 | 32.72 | 35.88 | 32.32 | 34.10 | 33.41 |
| Standard deviation | 5.73 | 5.82 | 5.82 | 7.03 | 4.40 | 6.10 | 5.99 |
| Median | 34 | 32 | 32.50 | 35 | 32 | 33.50 | 33 |
| Min | 23 | 21 | 21 | 25 | 22 | 22 | 21 |
| Max | 45 | 44 | 45 | 58 | 44 | 58 | 58 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |
| **Come from a town** | 39 | 42 | 81 | 34 | 36 | 70 | 151 |
| **Come from a village** | 10 | 6 | 16 | 16 | 13 | 29 | 45 |
| **Education** | | | | | | | |
| Elementary | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| High school | 11 | 7 | 18 | 9 | 3 | 12 | 30 |
| A, O levels, GCSE | 12 | 17 | 29 | 15 | 27 | 42 | 71 |
| Higher Diplomas, Higher National Certificates | 9 | 11 | 20 | 18 | 8 | 26 | 46 |
| University | 17 | 15 | 32 | 7 | 12 | 19 | 51 |
| **Employed** | 45 | 40 | 85 | 47 | 42 | 89 | 174 |
| **Unemployed** | 5 | 10 | 15 | 3 | 8 | 11 | 26 |
| **Member of a religious group** | 11 | 15 | 26 | 4 | 6 | 10 | 36 |
| **Not in a religious group** | 39 | 35 | 74 | 46 | 44 | 90 | 164 |

| **Degree of religiousness** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mean | 5.44 | 4.86 | 5.15 | 5.35 | 5.02 | 5.18 | 5.17 |
| Standard deviation | 1.86 | 1.97 | 1.93 | 1.65 | 1.57 | 1.61 | 1.77 |
| Median | 6 | 5 | 6 | 5 | 5 | 5 | 5 |
| Min | 1 | 1 | 1 | 1 | | 1 | 1 |
| Max | 6 | 6 | 7 | 7 | | 7 | 7 |
| N | 50 | 49 | 99 | 49 | 50 | 99 | 198 |
| **Years with partner** | | | | | | | |
| Mean | 9.9 | 9.93 | 9.915 | 8.78 | 8.78 | 8.78 | 9.347 |
| Standard deviation | 5.73 | 5.71 | 5.69 | 4.69 | 4.67 | 4.65 | 5.21 |
| Median | 9 | 9 | 9 | 8 | 8 | 8 | 8 |
| Min. | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Max. | 23 | 23 | 23 | 20 | 20 | 20 | 23 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |
| **Without any children** | 14 | 14 | 28 | 37 | 37 | 74 | 102 |
| **With children** | 36 | 36 | 72 | 13 | 13 | 26 | 98 |
| **Total number of children (own, adopted, stepchildren)** | | | | | | | |
| Mean | 1.28 | 1.28 | 1.28 | .46 | .46 | .46 | .87 |
| Standard deviation | 1.21 | 1.21 | 1.21 | .91 | .91 | .91 | 1.14 |
| Median | 1 | 1 | 1 | 0 | 0 | 0 | 0 |
| Min | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Max | 6 | 6 | 6 | 4 | 4 | 4 | 6 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |
| **Living without any children** | 16 | 16 | 32 | 43 | 43 | 86 | 118 |
| **Living with children** | 34 | 34 | 68 | 7 | 7 | 14 | 82 |
| **No of natural children** | | | | | | | |
| Mean | 1.22 | 1.14 | 1.18 | .38 | .10 | .24 | .71 |
| Standard deviation | 1.04 | 1.03 | 1.03 | .88 | .36 | .68 | .99 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Median | 1 | 1 | 1 | 0 | 0 | 0 | 0 |
| Min. | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Max. | 4 | 4 | 4 | 4 | 2 | 4 | 4 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |
| **Siblings** | | | | | | | |
| Mean | 1.84 | 2.10 | 1.97 | 2.67 | 2 | 2.33 | 2.15 |
| Standard deviation | 1.79 | 1.45 | 1.62 | 1.93 | 1.34 | 1.68 | 1.66 |
| Median | 1.50 | 2 | 2 | 2 | 2 | 2 | 2 |
| Min. | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Max. | 9 | 8 | 9 | 9 | 6 | 9 | 9 |
| N | 50 | 50 | 100 | 49 | 50 | 50 | 199 |

**Table II: Descriptive statistics for the Greek participants and the sub-groups.**

| **Demographic characteristics** | **Greek** | | | | | | **All** |
|---|---|---|---|---|---|---|---|
| | **Fertile** | | | **Subfertile** | | | |
| | **Men** | **Women** | **Total** | **Men** | **Women** | **Total** | |
| **Age** | | | | | | | |
| Mean | 33.94 | 30.02 | 31.98 | 35.22 | 31.65 | 33.45 | 32.71 |
| Standard deviation | 6.80 | 5.31 | 6.38 | 4.67 | 4.03 | 4.70 | 5.64 |
| Median | 33 | 29.5 | 31 | 34 | 31 | 33 | 32 |
| Min | 24 | 22 | 22 | 23 | 22 | 22 | 22 |
| Max | 51 | 40 | 51 | 44 | 42 | 44 | 51 |
| N | 50 | 50 | 100 | 50 | 49 | 99 | 199 |
| **Come from a town** | 40 | 43 | 83 | 34 | 32 | 66 | 149 |
| **Come from a village** | 8 | 7 | 15 | 16 | 18 | 34 | 49 |
| **Education** | | | | | | | |
| Elementary | 2 | 0 | 2 | 1 | 3 | 4 | 6 |
| Technical School | 8 | 2 | 10 | 15 | 7 | 22 | 32 |
| High School, | 12 | 20 | 32 | 18 | 21 | 39 | 71 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Higher Certificates, Diplomas Technological Educational Institutes (TEI) | 5 | 7 | 12 | 5 | 5 | 10 | 22 |
| University | 23 | 20 | 43 | 11 | 14 | 25 | 68 |
| **Employed** | 47 | 37 | 84 | (50) | 39 | 89 | 173 |
| **Unemployed** | 3 | 13 | 16 | (-) | 11 | 11 | 27 |
| **Member of a religious group** | (50) | (50) | (100) | (50) | (50) | (100) | (200) |
| **Not in a religious group** | (0) | (0) | (0) | (0) | (0) | (0) | (0) |
| **Degree of religiousness** | | | | | | | |
| Mean | 4.34 | 4 | 4.17 | 3.78 | 3.49 | 3.63 | 3.90 |
| Standard deviation | 1.74 | 1.49 | 1.61 | 1.71 | 1.47 | 1.59 | 1.62 |
| Median | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Min | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Max | 7 | 7 | 7 | 7 | 6 | 7 | 7 |
| N | 47 | 49 | 96 | 49 | 49 | 98 | 194 |
| **Years with partner** | | | | | | | |
| Mean | 8.1 | 8.1 | 8.1 | 8.53 | 8.53 | 8.53 | 8.31 |
| Standard deviation | 5.40 | 5.40 | 5.37 | 4.09 | 4.09 | 4.07 | 4.76 |
| Median | 7 | 7 | 7 | 9 | 9 | 9 | 7.76 |
| Min. | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Max. | 23 | 23 | 23 | 19 | 19 | 19 | 23 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |
| **Without any children** | 27 | 27 | 54 | 41 | 41 | 82 | 136 |
| **With children** | 17 | 17 | 34 | 8 | 8 | 16 | 50 |
| **Total number of children (own, adopted, stepchildren)** | | | | | | | |
| Mean | .61 | .61 | .61 | .18 | .18 | .18 | .39 |
| Standard deviation | .84 | .84 | .84 | .44 | .44 | .44 | .69 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Median | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Min | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Max | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| N | 44 | 44 | 88 | 49 | 49 | 98 | 186 |
| **Living without any children** | 28 | 28 | 56 | 42 | 42 | 84 | 140 |
| **Living with children** | 22 | 22 | 44 | 8 | 8 | 16 | 60 |
| **No of natural children** | | | | | | | |
| Mean | .57 | .57 | .57 | .16 | .16 | .16 | .35 |
| Standard deviation | .82 | .82 | .81 | .37 | .37 | .37 | .65 |
| Median | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Min. | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Max. | 2 | 2 | 2 | 2 | 1 | 1 | 2 |
| N | 44 | 44 | 88 | 49 | 49 | 98 | 186 |
| **Siblings** | | | | | | | |
| Mean | 1.24 | 1.30 | 1.27 | 1.46 | 1.52 | 1.49 | 1.38 |
| Standard deviation | .59 | .76 | .68 | .91 | 1.01 | .96 | .84 |
| Median | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Min | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Max | 4 | 3 | 4 | 4 | 6 | 6 | 6 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |

# Appendix 4a: Descriptive statistics for the subfertile sample of the qualitative part of the study

| Descriptive statistics for the subfertile participants and the sub-groups. | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Demographic characteristics** | **Subfertile** | | | | | | **All** |
| | **British** | | | **Greek** | | | |
| | **Men** | **Women** | **Total** | **Men** | **Women** | **Total** | |
| **Age** | | | | | | | |
| Mean | 38 | 34.60 | 36.30 | 35 | 32.50 | 33.75 | 35.02 |
| Standard deviation | 6.72 | 3.92 | 5.63 | 3.89 | 2.99 | 3.61 | 4.84 |
| Median | 38.50 | 35 | 35.50 | 34.50 | 31.50 | 33.50 | 34.50 |
| Min | 25 | 27 | 25 | 30 | 30 | 30 | 25 |
| Max | 47 | 42 | 47 | 42 | 38 | 42 | 47 |
| N | 10 | 10 | 20 | 10 | 10 | 20 | 40 |
| **Come from a town** | 8 | 8 | 16 | 9 | 4 | 13 | 29 |
| **Come from a village** | 2 | 2 | 4 | 1 | 6 | 7 | 11 |
| **Education** | | | | | | | |
| Elementary | 0 | 0 | 0 | 0 | 2 | 2 | 2 |
| High school | 2 | 1 | 3 | 2 | 0 | 2 | 5 |
| A, O levels, GCSE | 5 | 4 | 9 | 5 | 1 | 6 | 15 |
| Higher Diplomas, Higher National Certificates | 2 | 2 | 4 | 0 | 4 | 4 | 8 |
| University | 1 | 3 | 4 | 3 | 3 | 6 | 10 |
| **Employed** | 10 | 9 | 19 | 10 | 9 | 19 | 38 |
| **Unemployed** | 0 | 1 | 1 | 0 | 1 | 1 | 2 |
| **Member of a religious group** | 1 | 1 | 2 | 10 | 10 | 20 | 22 |
| **Not in a religious group** | 9 | 9 | 18 | 0 | 0 | 0 | 18 |

| **Degree of religiousness** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mean | 4.78 | 4.30 | 4.53 | 4.40 | 3.50 | 3.95 | 4.23 |
| Standard deviation | 1.86 | 1.77 | 1.77 | 1.90 | 1.43 | 1.70 | 7.74 |
| Median | 5 | 5 | 5 | 3.50 | 4 | 4 | 4 |
| Min | 1 | 1 | 1 | 2 | 1 | 1 | 1 |
| Max | 7 | 6 | 7 | 7 | 6 | 7 | 7 |
| N | 9 | 10 | 19 | 10 | 10 | 20 | 39 |
| **Years with partner** | | | | | | | |
| Mean | 9.10 | 9.15 | 9.12 | 11.40 | 11.40 | 11.40 | 10.26 |
| Standard deviation | 6 | 5.97 | 5.83 | 5.42 | 5.42 | 5.28 | 5.61 |
| Median | 7.75 | 7.75 | 7.75 | 12 | 12 | 12 | 11 |
| Min. | 1 | 1 | 1 | 3 | 3 | 3 | 1 |
| Max. | 20 | 20 | 20 | 19 | 19 | 19 | 20 |
| N | 10 | 10 | 20 | 10 | 10 | 20 | 40 |
| **Without any children** | 5 | 5 | 10 | 9 | 9 | 18 | 28 |
| **With children** | 5 | 5 | 10 | 1 | 1 | 2 | 12 |
| **Total number of children (own, adopted, stepchildren)** | | | | | | | |
| Mean | 1 | 1 | 1 | 0.10 | 0.10 | 0.10 | 0.55 |
| Standard deviation | 1.33 | 1.33 | 1.30 | 0.32 | 0.32 | 0.31 | 1.04 |
| Median | 0.50 | 0.50 | 0.50 | 0 | 0 | 0 | 0 |
| Min | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Max | 4 | 4 | 4 | 1 | 1 | 1 | 4 |
| N | 10 | 10 | 20 | 10 | 10 | 20 | 40 |
| **Living without any children** | 6 | 6 | 12 | 9 | 9 | 18 | 30 |
| **Living with children** | 4 | 4 | 8 | 1 | 1 | 2 | 10 |
| **No of natural children** | | | | | | | |
| Mean | 0.80 | 0.20 | 0.50 | 0.10 | 0.10 | 0.10 | 0.30 |
| Standard deviation | 1.40 | 0.42 | 1.05 | 0.32 | 0.32 | 0.31 | 0.79 |
| Median | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Min. | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Max. | 4 | 1 | 4 | 1 | 1 | 1 | 4 |
| N | 10 | 10 | 20 | 10 | 10 | 20 | 40 |
| **Siblings** | | | | | | | |
| Mean | 2.40 | 1.90 | 2.15 | 1.30 | 1.40 | 1.35 | 1.75 |
| Standard deviation | 1.26 | 0.88 | 1.09 | 0.95 | 0.84 | 0.87 | 1.06 |
| Median | 2 | 2 | 2 | 1 | 1 | 1 | 1 |
| Min. | 1 | 1 | 1 | 1 | 0 | 0 | 0 |
| Max. | 4 | 3 | 4 | 4 | 3 | 4 | 4 |
| N | 10 | 10 | 20 | 10 | 10 | 20 | 40 |

# Appendix 4b: Descriptive statistics for the treatment-related characteristics of the subfertile sample of the qualitative part of the study

| Treatment-Related Characteristics | British subfertile | | | Greek subfertile | | | All sub-fertile |
|---|---|---|---|---|---|---|---|
| | Men | Women | Total | Men | Women | Total | |
| **Cause of problem** | | | | | | | |
| Female | 2 | 2 | 4 | 3 | 3 | 6 | 10 |
| Male | 6 | 6 | 12 | 1 | 1 | 2 | 14 |
| Both male and female | 1 | 1 | 2 | 5 | 5 | 10 | 12 |
| Unknown cause | 1 | 1 | 2 | 1 | 1 | 2 | 4 |
| Missing | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **How long ago did you find out about this problem?** | | | | | | | |
| Mean years | 5.05 | 3.75 | 4.40 | 3.50 | 3.50 | 3.50 | 3.95 |
| Standard deviation | 4.83 | 3.79 | 4.27 | 4.62 | 4.62 | 4.50 | 4.35 |
| Median | 3.25 | 3 | 3 | 2 | 2 | 2 | 2 |
| Min | 0.50 | 0.50 | 0.50 | 1 | 1 | 1 | 0.50 |
| Max | 14 | 13 | 14 | 16 | 16 | 16 | 16 |
| N | 10 | 10 | 20 | 10 | 10 | 20 | 40 |
| **Time trying to conceive** | | | | | | | |
| Mean years | 5.95 | 5.95 | 5.95 | 6.40 | 6.40 | 6.40 | 6.17 |
| Standard deviation | 4.74 | 4.74 | 4.61 | 4.48 | 4.48 | 4.36 | 4.43 |
| Median | 4.50 | 4.50 | 4.50 | 5 | 5 | 5 | 4.50 |
| Min | 1 | 1 | 1 | 2 | 2 | 2 | 1 |
| Max | 15 | 15 | 15 | 16 | 16 | 16 | 16 |
| N | 10 | 10 | 20 | 10 | 10 | 20 | 40 |
| **When did you first consult a GP about your fertility problem?** | | | | | | | |
| Mean years | 4.95 | 5.10 | 5.02 | 4.70 | 5 | 4.85 | 4.94 |
| Standard deviation | 4.35 | 4.27 | 4.20 | 5.03 | 5.01 | 4.89 | 4.50 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Median | 3.50 | 4 | 4 | 3 | 3 | 3 | 3 |
| Min | 0.50 | 0.50 | 0.50 | 1 | 1 | 1 | 0.50 |
| Max | 13 | 13 | 13 | 16 | 16 | 16 | 16 |
| N | 10 | 10 | 20 | 10 | 10 | 20 | 40 |
| **Type of current treatment** | | | | | | | |
| **Under no treatment** | 1 | 1 | 2 | 6 | 4 | 10 | 12 |
| Drugs / hormones | 0 | 0 | 0 | 0 | 2 | 2 | 2 |
| IUI | 0 | 0 | 0 | 1 | 1 | 2 | 2 |
| IVF with husband's semen | 5 | 5 | 10 | 3 | 3 | 6 | 16 |
| ICSI | 3 | 3 | 6 | 0 | 0 | 0 | 6 |
| DI | 1 | 1 | 2 | 0 | 0 | 0 | 2 |
| Microsurgery | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Have tried no other treatment previously** | 6 | 7 | 13 | 2 | 3 | 5 | 18 |
| **Have tried other treatment previously if different from current one** | 4 | 3 | 7 | 8 | 7 | 15 | 22 |
| Drugs / hormones | 0 | 0 | 0 | 3 | 1 | 4 | 4 |
| IUI | 1 | 1 | 2 | 3 | 3 | 6 | 8 |
| IVF with husband's semen | 1 | 1 | 2 | 2 | 2 | 4 | 6 |
| ICSI | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DI | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Microsurgery | 2 | 1 | 3 | 0 | 1 | 1 | 4 |
| **How long ago did you first begin receiving treatment?** | | | | | | | |
| Mean years | 2.37 | 2.52 | 2.44 | 2.70 | 2.73 | 2.72 | 2.58 |
| Standard deviation | 3.26 | 3.42 | 3.24 | 3.64 | 3.71 | 3.58 | 3.38 |
| Median | 1.50 | 2 | 2 | 1.50 | 1.25 | 1.50 | 2 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Min | 0.08 | 0.08 | 0.08 | 0 | 0 | 0 | 0 |
| Max | 11 | 11 | 11 | 12 | 12 | 12 | 12 |
| N | 10 | 9 | 19 | 10 | 10 | 20 | 39 |

## Appendix 5: Sociodemographic characteristics' questionnaire

In this section, we would like to gather some general background information concerning the people who participated in this study.

1. Are you: **MALE / FEMALE**

2. Age: .....

3. Would you describe yourself as a person who grew up in an urban or in a rural environment? **URBAN / RURAL**

4. Do you have any children? **YES / NO**

If yes, how many are: a. your own natural children? .....

b. your stepchildren? .....

c. adopted? .....

5. How long have you been together with your partner? .....

6. About your education.

Please, list any formal educational qualifications you have earned: .....

.....

7. Do you happen to be a member of a religious organisation or group? **YES / NO**

If yes, please specify. .....

8. Do you consider yourself to be a person that is

very religious 1 2 3 4 5 6 7 not at all religious

9. How many brothers and sisters do you have? .....

10. Are you working? **YES / NO**

If yes, what is your job? .....

11. What is the nature of your fertility problem?

a. female cause b. male cause c. both male and female cause d. unknown cause

12. How long ago did you find out about this problem? .....

13. How long have you been trying to conceive? .....

14. When did you first consult a GP about your fertility problem? .....

15. What type of treatment are you currently having?

.....

16. Have you tried any other treatments previously? **YES / NO**

If yes, please specify .....

17. How long ago did you first begin receiving treatment for your fertility problem?

.....

18. Have you ever consulted a doctor or your GP about any suspected fertility problems? **YES / NO**

19. Have you ever had any investigations concerning any suspected fertility problems? **YES / NO**

If yes, what was the result of your investigation? .....

## Appendix 6: Quality of Life Questionnaire

Here are some words and phrases which we would like you to use to describe how you feel about your present life. For example, if you think your present life is very " boring ", put a tick in the space right next to the word " boring ". If you think it is very " interesting ", put a space right next to the word " interesting ". If you think it is somewhere in between, put a tick in one of the in-between spaces, where ever you think it belongs. Put a tick in one space on every line.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Boring** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Interesting** |
| **Enjoyable** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Miserable** |
| **Easy** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Hard** |
| **Useless** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Worthwhile** |
| **Friendly** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Lonely** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Full** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Empty** |
| **Discou-raging** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Hopeful** |
| **Tied down** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Free** |
| **Disap-pointing** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Rewarding** |
| **Brings out the best in me** | ___ | ___ | ___ | ___ | ___ | ___ | ___ | **Doesn't give me a chance** |

# Appendix 7: Fertility treatments' scale

## Ovulation induction

In this section, we would like to know your point of view about **ovulation induction.**

This treatment is used in cases **where the female partner is sub-fertile.** It refers to the use of various drugs taken daily to increase the number of eggs produced in the ovaries. Please put a tick in the space that best represents your point of view regarding ovulation induction in accordance with the following statements. Put a tick in one space on every line.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. is considered socially acceptable | ___ | ___ | ___ | ___ | ___ | ___ | ___ | is considered socially unacceptable |
| 2. causes pain and physical discomfort discomfort | ___ | ___ | ___ | ___ | ___ | ___ | ___ | does not cause pain and physical |
| 3. may cause difficulties in bonding to the baby and in parenting | ___ | ___ | ___ | ___ | ___ | ___ | ___ | can facilitate bonding to the baby and parenting |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 4. is detrimental to the couple's emotional relationship | ___ | ___ | ___ | ___ | ___ | ___ | ___ | causes tightening and strengthening of the couple's emotional relationship |
| 5. elicits hope for success and optimism | ___ | ___ | ___ | ___ | ___ | ___ | ___ | elicits expectation of failure |
| 6. involves risk of physical damage or unhealthy side effects to the patient | ___ | ___ | ___ | ___ | ___ | ___ | ___ | does not involve any physical threat to the patient |
| 7. elicits concerns about fetal physical health | ___ | ___ | ___ | ___ | ___ | ___ | ___ | secures fetal physical health |
| 8. causes humiliation | ___ | ___ | ___ | ___ | ___ | ___ | ___ | does not humiliate |
| 9. uses most sophisticated medical technology | ___ | ___ | ___ | ___ | ___ | ___ | ___ | uses simple and unsophisticated medicine |

| | | |
|---|---|---|
| 10. detrimental to normal sexual life | ___ ___ ___ ___ ___ ___ ___ | contributes to improvement of sexual life |
| 11. much social exposure, cannot be hidden from others | ___ ___ ___ ___ ___ ___ ___ | enables total privacy and secrecy |
| 12. elicits philosophic, moral, or religious concerns | ___ ___ ___ ___ ___ ___ ___ | does not elicit any philosophic, moral, or religious concerns |
| 13. artificial and unnatural | ___ ___ ___ ___ ___ ___ ___ | does not interfere with the natural process |
| 14. hurts a woman's self-esteem | ___ ___ ___ ___ ___ ___ ___ | does not hurt a woman's self-esteem |
| 15. hurt a man's self-esteem | ___ ___ ___ ___ ___ ___ ___ | does not hurt a man's self-esteem |

## Drug treatment for males

**Drug treatment for males** refers to drugs taken in order to enhance sperm production and performance. This medical treatment is used in cases where **the male partner is sub-fertile**. Please put a tick in the space that best represents your point of view regarding drug treatment for males in accordance with the following statements. Put a tick in one space on every line.

*Followed by the scale*

## IVF with husband's semen

In this section, we would like to know your point of view about **in-vitro fertilization with husband's semen**. I.V.F. entails bringing the male sperm and the female egg together outside the body, so that fertilisation occurs. The tiny fertilised egg (now called an embryo) is transferred back 48 hours later directly into the womb to develop normally. This treatment was developed for cases where **the female partner is sub-fertile.** Please put a tick in the space that best represents your point of view regarding IVF with husband's semen in accordance with the following statements. Put a tick in one space on every line.

*Followed by the scale*

## Intracytoplasmic sperm injection

**Intracytoplasmic sperm injection** is carried out when the sperm count or motility is very poor. This treatment follows much the same procedure as IVF, but a single sperm is injected into the egg. This has been picked up by a very fine needle from the semen sample produced by the husband. Intracytoplasmic sperm injection is used **when the male partner is sub-fertile**. Please put a tick in the space that best represents your point of view regarding intracytoplasmic sperm injection in accordance with the following statements. Put a tick in one space on every line.

*Followed by the scale*

## Artificial insemination with donor eggs

In this section, we would like to know your opinion about **in-vitro fertilization with eggs donated by another woman**. This treatment follows much the same procedure as IVF, but using donor eggs. This treatment is used **in cases of female sub-fertility**. Please put a tick in the space that best represents your point of view regarding artificial insemination with donor eggs in accordance with the following statements. Put a tick in one space on every line.

*Followed by the scale*

## Artificial insemination with donor semen

In this section, we would like to know your opinion about **artificial insemination with donor semen**. In this treatment, sperm is donated by another man and then it is placed directly into the vagina, cervix, or uterus. This treatment is used **when the male partner is sub-fertile**. Please put a tick in the space that best represents your point of view regarding artificial insemination with donor semen in accordance with the following statements. Put a tick in one space on every line.

*Followed by the scale*

## Appendix 8: Meaning Of Parenthood Scale (MPS)

Please put a tick in the space that best represents your point of you regarding the following statements. Put a tick in one space on every line.

1. Having children makes a marriage into a family.

strongly agree ___ ___ ___ ___ ___ strongly disagree

2. It is only natural that a woman should want children.

strongly agree ___ ___ ___ ___ ___ strongly disagree

3 The disappointment of not having children is greater for a woman than it is for a man

strongly agree ___ ___ ___ ___ ___ strongly disagree

4. It is only natural that a man should want children.

strongly agree ___ ___ ___ ___ ___ strongly disagree

5. Having children makes a stronger bond between husband and wife.

strongly agree ___ ___ ___ ___ ___ strongly disagree

6. It is more difficult for a man to accept being subfertile than it is for a woman.

strongly agree ___ ___ ___ ___ ___ strongly disagree

7. Having children is the most important function of marriage.

strongly agree ___ ___ ___ ___ ___ strongly disagree

8. Becoming a mother makes a woman truly female.

strongly agree ___ ___ ___ ___ ___ strongly disagree

9. A man can never be sure about his masculinity until he is a father.

strongly agree ___ ___ ___ ___ ___ strongly disagree

## Appendix 9: Social Support Questionnaire

In this section, we would like to find out about the people who provide you with help or support regarding your fertility problem and your fertility treatment. Each question has two parts. In the first part please, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person's initials and their relationship to you (see example). To protect anonymity you may wish to list only the person's first or last initial. Do not list more than one person next to each of the numbers beneath the question.

In the second part please, circle how satisfied you are with the overall support you have in relation to this question. If you have no support for a question, check the words ' No one, ' but still rate your level of satisfaction. Do not list more than nine persons per question.

Please answer all the questions as best as you can. All your responses will be treated as confidential.

**Example: Who do you know whom you can trust with very personal thoughts that worry you?**

| | | | |
|---|---|---|---|
| No one | 1) T.N. (colleague) | 4) T.N. (student) | 7) |
| | 2) L.M. (superior) | 5) | 8) |
| | 3) R.S. (colleague) | 6) | 9) |

**How satisfied?**

| | | |
|---|---|---|
| 1-very satisfied | 3-a little satisfied | 5-fairly dissatisfied |
| 2-fairly satisfied | 4-a little dissatisfied | 6-very dissatisfied |

---

**1a. Whom can you really count on to distract you from your worries when you feel under stress?**

| | | | |
|---|---|---|---|
| No one | 1) | 4) | 7) |
| | 2) | 5) | 8) |
| | 3) | 6) | 9) |

**1b. How satisfied are you with the support you receive in the above situation?**

very satisfied 1 2 3 4 5 6 very dissatisfied

**2a. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?**

| | | | |
|---|---|---|---|
| No one | 1) | 4) | 7) |
| | 2) | 5) | 8) |
| | 3) | 6) | 9) |

**2b. How satisfied?**

very satisfied 1 2 3 4 5 6 very dissatisfied

**3a. Who accepts you totally, including both your worst and your best points?**

| | | | |
|---|---|---|---|
| No one | 1) | 4) | 7) |
| | 2) | 5) | 8) |
| | 3) | 6) | 9) |

**3b. How satisfied?**

very satisfied 1 2 3 4 5 6 very dissatisfied

**4a. Whom can you really count on to care about you, regardless of what is happening to you?**

| | | | |
|---|---|---|---|
| No one | 1) | 4) | 7) |
| | 2) | 5) | 8) |
| | 3) | 6) | 9) |

**4b. How satisfied?**

very satisfied 1 2 3 4 5 6 very dissatisfied

**5a. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?**

| | | | |
|---|---|---|---|
| No one | 1) | 4) | 7) |
| | 2) | 5) | 8) |
| | 3) | 6) | 9) |

**5b. How satisfied?**

very satisfied 1 2 3 4 5 6 very dissatisfied

**6a. Whom can you count on to console you when you are very upset?**

| | | | |
|---|---|---|---|
| No one | 1) | 4) | 7) |
| | 2) | 5) | 8) |
| | 3) | 6) | 9) |

**6b. How satisfied?**

very satisfied 1 2 3 4 5 6 very dissatisfied

# Appendix 10: Reliability results of all* the scales: Cronbach alphas

*** except the QOL (see Section 4.4, p.78)**

| Instruments | British | Greek | Both |
|---|---|---|---|
| Bem Sex Role Inventory | .79 | .81 | .81 |
| General Health Questionnaire | .88 | .84 | .86 |
| Meaning of Parenthood Scale | .81 | .68 | .80 |
| Shiloh et al.'s scale across the six fertility treatments (15 items) | .80 - .88 | .80 - .89 | .80 - .89 |
| Social Support Questionnaire (for subfertile only) | .77 | .75 | .76 |

## Appendix 11a: Interview's questions and prompts

At the beginning of the interview, I would like to talk about your feelings towards parenthood.

1) What does having a child mean to you personally?

Prompt: How would you feel if you could not have children in your life and why?

2) In what ways do you think that having a child will change your relationship with others?

Prompts: How would you feel towards others if you could not have children and why?

What about your relationship with your partner / family / relatives / friends?

3) What do you feel about couples who choose not to have children?

**********

1) Now I would like you to tell me about your feelings and thoughts regarding your fertility problem at the moment.

Prompt: Have you had any positive / negative thoughts or feelings?

2) Who have you told about this problem?

Prompts: Why did you tell them?

Why did you not tell others?

3) What did these people think about your situation?

Prompts: What about your partner / family / relatives / friends?

**********

In this part, I would like to talk about the fertility treatment you are going to have.

1) What are your concerns / fears at the moment about your treatment?

2) What do you think other people think about your treatment?

Prompt: What about your partner / family / relatives / friends?

3) Have you thought what you would do if this treatment does not work?

4) Can you foresee any positive aspects of the treatment apart from having a child?

## Appendix 11b: Pilot interview's questions

1) What does a child mean to you personally?

2) What does having a child mean to your partner?

3) In what ways do you expect your life to change by having a child?

4) In what ways do you think being a parent will change your relationship with others?

5) In what ways do you think you as a child and your siblings,if you have any, have changed your parents' life?

6) What is your parents' opinion about you having children?

7) There are people that want to have a child-free life. Can you think of any reasons for such a decision?

**********

1) Now I would like you to tell me about your reactions when you first found out about the problem of fertility (feelings).

2) What are your feelings and thoughts about it at the moment?

3) In what ways has this problem of fertility affected your life?

4) Who have you told about this problem and why?

5) Were you satisfied with their reactions? If not, how would you like them to have reacted?

6) Is there anybody else you would like to talk to, but you did not for some reason? How would you expect them to react?

7) Can you think of any other persons that have been affected by this problem of yours? In what ways?

8) What significant others think about this fertility problem (friends, relatives)?

**********

1) What infertility treatments were available to you?

2) Why did you choose this treatment?

3) What are your concerns / fears at the moment about this treatment?

4) What are your partner's concerns and worries regarding this treatment?

5) What do other people close to you think about you having this treatment?

6) Have you thought of alternative plans in case this treatment does not work?

7) If you decided not to have children, what do you think others would think of you?

8) Do you think that your relationship with some people could be affected by such a decision? In what ways?

# Appendix 12a: Recruitment of British subfertile sample

## Research Project Information letter

Dear Sir / Madam,

I am writing to you to inform you about a research project which is shortly to begin in the IVF Unit. All couples who might be receiving treatment are welcomed to participate in this study which will explore men and women's needs in relation to parenthood and fertility treatments. The study will compare men and women with and without fertility problems. The aim of the research is to better understand the impact of sub-fertility on individuals' lives so that their needs can be more effectively met. All individuals and couples are welcome to take part in this study whether or not they decide to proceed with treatment.

If you sign the enclosed permission form you will be sent a package of questionnaires for you to complete at home. The questionnaires take roughly 20 to 25 minutes to complete. If on receiving the questionnaires you decide you do not wish to participate in the study, then we will ask you to return them to the IVF Unit uncompleted in the enclosed envelope. The questionnaires can be completed anonymously.

Your participation is voluntary and has nothing to do with your treatment. Also if you have been approached to take part in any similar studies taking place either in the Gavin Brown Clinic or the IVF Unit we recommend that you do not participate in this one. If you think you might like to take part in this study, please fill in the permission form provided and return it to the IVF Unit in the enclosed envelop. Finally, I would like to mention again that you do not have to take part in this study, but your participation would be much appreciated. Upon receiving your permission form you will be sent the study questionnaires by the research worker, Sophia Kazantzidou.

Yours sincerely,

Steve Maguiness

Medical Director

Hull IVF Unit

# Appendix 12b: Permission form to be sent questionnaires for the British subfertile sample

## Permission form

We, _____, have read the Research Project Information Letter. We understand that if we agree to be sent questionnaires we are under no obligation to complete them.

We give our permission to be sent the questionnaires.

_____ ( woman's signature )

_____ ( woman's printed name)

_____ (man's signature)

_____ ( man's printed name)

## Appendix 12c: Information letter about the study

### Information Letter (Parenthood and Sub-fertility Treatment Research Project).

Dear Mr. and Mrs.

Thank you for giving your permission to be sent questionnaires. Two sets of questionnaires are included in this package, one for you and one for your partner. Since one of the aims of the study is to compare men with women, it is very important that both of you complete them. You are asked to answer each item as quickly as possible. You don't need to know anything about the subject of the questionnaires. I am interested in your beliefs, expectations and guesses on each question.

Questionnaires can be completed anonymously. These should be returned to me in the envelopes provided. If on receiving the questionnaires you decide you do not wish to participate in the study, please return them to the IVF Unit uncompleted in the enclosed envelope. Although your participation is voluntary, it would be much appreciated.

In addition to the questionnaire information, I will be undertaking more in - depth interviews with some couples. These interviews will take place in couples'

homes and will last between 30 to 45 minutes for each partner. Interviews will be taped. For confidentiality reasons, names will not be recorded on the tapes which will be wiped within 24 hours. The purpose of the interviews is to explore in more depth some of the issues covered in the questionnaires. If you think you and your partner might be prepared to take part in these interviews, please complete and return the enclosed permission form.

Whatever your decision, may I take the opportunity to thank you for your attention and interest in this study.

Yours sincerely,

Sophia Kazantzidou.

# Appendix 12d: Permission form to be contacted by phone for the subfertile sample

## Permission form

We, _____, have read the information letter. We understand that if we agree to be contacted we are under no obligation to be interviewed and that we can withdraw from the study whenever we want.

We give our permission to be contacted by telephone in order to find out more about the interview and maybe to arrange an appointment. We can be contacted at the following number _____.

_____ ( woman's signature)

_____ ( man's signature)

## Appendix 13: Reminder letter for returning the questionnaires

11/11/1997

Dear Mr. and Mrs.

I am writing to you about the questionnaires that I sent to you about 6 weeks ago. These were in relation to my research about parenthood and fertility treatments. A number of these questionnaire packets have not been returned to me and so I am not able to progress with the research.

However, if you have already completed and returned the questionnaires to the IVF Unit please ignore this letter.

If you have forgotten about them, then may I remind you to fill them in and return them to the Unit as soon as possible.

If you have decided not to take part in this research project, it would be very helpful to me if you could state your reasons for not participating. Please, tear off the slip below, explaining why you do not wish to participate in the study. This can be returned to the IVF Unit with your uncompleted questionnaires in the prepaid envelope previously provided with the questionnaires.

Thank you for your attention once more.

Yours sincerely,

Sophia Kazantzidou

## Appendix 14: Response rates for the British subfertile sample

221 couples were sent an information letter.

106 couples agreed to be sent the sets of questionnaires.

10 couples were excluded from the study because they did not meet the criteria.

5 couples did not complete fully the sets of questionnaires, thus they were excluded also from the study.

50 couples completed correctly the sets of questionnaires

23.7% reply rate

# Appendix 15: Consent form about the interviews for the British and the Greek subfertile samples

## Consent Form

We, _____, have read the information letters and the study has been discussed with us by Sophia Kazantzidou. We understand that participation in the interview is voluntary, that it does not affect our treatment and that we can withdraw from the study any time if we decide to do so.

_____ (woman's signature)

_____ (man's signature)

# Appendix 16: Transcription notation

| Symbols | Meaning |
|---|---|
| [ ] | Speech overlap |
| = | Contiguous utterances |
| [word] | Words or phrases added by the author to make the transcribed text more easily readable |
| (word) | Uncertain hearing<br>or<br>Description of participant's behaviour |
| word | Emphasis |
| […] | Text omitted deliberately |

# Appendix 17: Recruitment of the Greek subfertile sample

## Invitation of Participation to a Study regarding Fatherhood / Motherhood.

Dear Sir / Madam,

I am writing to you to inform you about a research project which has begun in the IVF Unit of St. Sofia's Hospital. All couples who might be facing a fertility problem are welcomed to participate in this study which will explore men and women's needs in relation to parenthood and fertility treatments. The aim of the research is to better understand the impact of sub-fertility on individuals' lives so that their needs can be more effectively met. All individuals and couples are welcome to take part in this study whether or not they are under a treatment.

Two sets of questionnaires are included in this package, one for you and one for your partner. Since one of the aims of the study is to compare men with women, it is very important that both of you complete them. These should be returned to me in the envelopes provided. The information you will send us are strictly confidential and thus we don't ask for your names. The questionnaires take roughly 20 to 25 minutes to complete. Your participation is voluntary. If you do not wish to participate in the study, please return the questionnaires uncompleted in the enclosed envelope.

In addition to the questionnaire information, I will be undertaking more in - depth interviews with some couples. These interviews will take place in couples'

homes and will last between 30 to 45 minutes for each partner. Interviews will be taped. For confidentiality reasons, names will not be recorded on the tapes which will be wiped within 24 hours. The purpose of the interviews is to explore in more depth some of the issues covered in the questionnaires. If you think you and your partner might be prepared to take part in these interviews, please complete and return the enclosed permission form.

Whatever your decision, may I take the opportunity to thank you for your attention and interest in this study.

Yours sincerely,

Sophia Kazantzidou

## Appendix 18: Response rates from the Greek subfertile sample

**Recruitment from public sector**

67 couples that were sent the information letters and the sets of questionnaires.

2 couples were excluded because they did not meet the criteria.

6 couples did not complete fully the questionnaires

14 sets of questionnaires were completed properly by both partners

21.5% reply rate

**Recruitment from private sector**

55 information letters and sets of questionnaires were given out.

1 couple was excluded from the study because it did not meet the criteria

1 couple did not complete fully the sets of questionnaires

2 denied to take part

39 questionnaires were completed correctly by both partners

72.7% response rate

---

53 were completed correctly from both settings

47.1% reply rate.

# Appendix 19a: Recruitment of British fertile sample

## PARTICIPANTS WANTED

I am a Ph.D. student in psychology and I am interested in cross-cultural and gender differences in how people think about parenthood and sub-fertility. I am looking for couples to participate in a study exploring men and women's attitudes about parenthood and fertility treatments.

Couples must be British and be in a stable relationship (2 years +). The female's age should be from 25 to 40 years old. The study would involve you and your partner completing some short questionnaires (20-25 Minutes). You are asked to answer each item as quickly as possible. You don't need to know anything about the subject of the questionnaires. I am interested in your beliefs, expectations and guesses on each question. Questionnaires can be completed anonymously.

If you want to take part in this study, you can send one of the attached slips below requesting a package of questionnaires for you and your partner to complete at home. I would be grateful to all individuals who can find the time to participate in this study, which I think they will find very interesting.

Sophia Kazantzidou

If you want to participate in this study you can fill in the slip provided below and return it to me via internal mail.

---

Please tick one of the statements below:

___ I would like to be sent questionnaires for the study. I understand that I am under no obligation to complete the questionnaires if I decide I do not wish to participate in the research.

_____ (your name)

_____ (your address)

_____

___ I would like more information about the study before being sent questionnaires. Please contact me.

(Name) _____ on (tel) _____ .

---

**Return to: Sophia Kazantzidou / Department of Psychology**

# Appendix 19b: Recruitment of the Greek fertile sample

## Information Letter

## (Attitudes on Fatherhood / Motherhood)

Dear Sir and Madam,

You are kindly requested to participate in this study which explores men and women's attitudes in relation to fertility and fertility treatments. The aim of this research is to better understand couples' needs regarding parenthood and their opinions on fertility treatments.

Two sets of questionnaires are included in this package, one for you and one for your partner. Since one of the aims of the study is to compare men with women, it is very important that both of you complete them. You will need roughly 15 minutes to complete the questionnaires which I believe you will find very interesting. The information you will send us are strictly confidential and thus we don't ask for your names.

Please, complete the questionnaires and return them in the envelope provided. If you decide that you do not wish to take part in this study, please return the questionnaires uncompleted. Whatever your decision, may I take the opportunity to thank you for your attention and interest in this study.

Yours sincerely,

Sophia Kazantzidou

# Appendix 20: Response rates for the British and Greek subfertile sample

## British Fertile Couples

127 information letters and sets of questionnaires were given out.

5 couples did not complete fully the questionnaires

51 sets of questionnaires were completed correctly by both partners.

40.2% reply rate

## Greek fertile couples

95 information letters and sets of questionnaires were given out.

11 couples did not complete fully the questionnaires.

50 couples completed correctly and fully the questionnaires.

52.6% reply rate

# Appendix 21: Descriptive statistics for the treatment-related characteristics of the subfertile sample

| Treatment-Related Characteristics | British subfertile | | | Greek subfertile | | | All sub-fertile |
|---|---|---|---|---|---|---|---|
| | Men | Women | Total | Men | Women | Total | |
| **Cause of problem** | | | | | | | |
| Female | 17 | 17 | 34 | 5 | 5 | 10 | 44 |
| Male | 14 | 14 | 28 | 27 | 27 | 54 | 82 |
| Both male and female | 6 | 6 | 12 | 12 | 12 | 24 | 36 |
| Unknown cause | 13 | 13 | 26 | 5 | 5 | 10 | 36 |
| Missing | 0 | 0 | 0 | 1 | 1 | 2 | 2 |
| **How long ago did you find out about this problem?** | | | | | | | |
| Mean years | 3.33 | 3.37 | 3.35 | 3.51 | 3.47 | 3.49 | 3.42 |
| Standard deviation | 3.17 | 3.16 | 3.15 | 3.27 | 3.29 | 3.26 | 3.20 |
| Median | 2.50 | 2.50 | 2.50 | 2 | 2 | 2 | 2.50 |
| Min | .166 | .166 | .166 | .125 | .125 | .125 | .125 |
| Max | 14 | 13 | 14 | 16 | 16 | 16 | 16 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |
| **Time trying to conceive** | | | | | | | |
| Mean years | 4.51 | 5.05 | 4.78 | 4.28 | 4.29 | 4.28 | 4.53 |
| Standard deviation | 3.38 | 3.81 | 3.59 | 3.57 | 3.57 | 3.55 | 3.57 |
| Median | 4 | 4 | 4 | 3 | 3 | 3 | 4 |
| Min | 0 | 1 | 0 | .166 | .166 | .166 | 0 |
| Max | 19 | 19 | 19 | 16 | 16 | 16 | 19 |
| N | 50 | 50 | 100 | 49 | 49 | 98 | 198 |

| **When did you first consult a GP about your fertility problem?** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mean years | 2.92 | 3.47 | 3.20 | 3.69 | 3.70 | 3.69 | 3.45 |
| Standard deviation | 2.70 | 2.89 | 2.80 | 3.43 | 3.46 | 3.43 | 3.13 |
| Median | 2 | 2.50 | 2.50 | 3 | 2.50 | 3 | 2.50 |
| Min | 0 | 0 | 0 | .125 | 0 | 0 | 0 |
| Max | 13 | 13 | 13 | 16 | 16 | 16 | 16 |
| N | 47 | 49 | 96 | 49 | 49 | 98 | 194 |
| **Type of current treatment** | | | | | | | |
| **Under no treatment** | 18 | 18 | 36 | 22 | 36 | 58 | 94 |
| Drugs / hormones | 0 | 0 | 0 | 20 | 6 | 26 | 26 |
| IUI | 0 | 0 | 0 | 2 | 2 | 4 | 4 |
| IVF with husband's semen | 24 | 24 | 48 | 6 | 6 | 12 | 60 |
| ICSI | 5 | 5 | 10 | 0 | 0 | 0 | 10 |
| DI | 3 | 3 | 6 | 0 | 0 | 0 | 6 |
| Microsurgery | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Have tried no other treatment previously** | 39 | 26 | 65 | 24 | 31 | 55 | 120 |
| **Have tried other treatment previously if different from current one** | 11 | 24 | 35 | 26 | 19 | 45 | 80 |
| Drugs / hormones | 1 | 15 | 16 | 7 | 4 | 11 | 27 |
| IUI | 5 | 5 | 10 | 6 | 10 | 16 | 26 |
| IVF with husband's semen | 3 | 3 | 6 | 4 | 4 | 8 | 14 |
| ICSI | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DI | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Microsurgery | 2 | 1 | 3 | 9 | 1 | 10 | 13 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **How long ago did you first begin receiving treatment?** | | | | | | | |
| Mean years | 1.05 | 1.76 | 1.42 | 2.49 | 1.66 | 2.07 | 1.76 |
| Standard deviation | 1.91 | 2.19 | 2.08 | 2.64 | 2.65 | 2.66 | 2.42 |
| Median | .29 | 1 | .50 | 2 | .02 | 1 | .75 |
| Min | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Max | 11 | 11 | 11 | 12 | 12 | 12 | 12 |
| N | 44 | 47 | 91 | 49 | 50 | 99 | 190 |

## Appendix 22: Subfertility history of the fertile sample

| | British fertile | | | Greek fertile | | | All fertile |
|---|---|---|---|---|---|---|---|
| | Men | Women | Total | Men | Women | Total | |
| Have consulted a doctor or a GP about any suspected fertility problem | 3 | 3 | 6 | 9 | 7 | 16 | 22 |
| Have not consulted a doctor or a GP about any suspected fertility problem | 47 | 47 | 94 | 41 | 43 | 84 | 178 |
| Have had investigations concerning any suspected fertility problem | 3 | 2 | 5 | 10 | 6 | 16 | 21 |
| Diagnosis of subfertility | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Did not have ever any investigations concerning fertility problems | 47 | 48 | 95 | 39 | 43 | 82 | 177 |
| Missing | 0 | 0 | 0 | 1 | 0 | 2 | 2 |

# Appendix 23a

**Table I: BEM Masculinity and Femininity scores for the British, the Greeks and the sub-groups.**

| | British | | | | | | All |
|---|---|---|---|---|---|---|---|
| | Fertile | | | Subfertile | | | |
| | Men | Women | Total | Men | Women | Total | |
| **BEM MASCULINE** | | | | | | | |
| Mean | 4.93 | 4.52 | 4.72 | 4.86 | 4.44 | 4.65 | 4.69 |
| Standard deviation | .69 | .91 | .83 | .78 | .88 | .85 | .84 |
| Median | 5 | 4.40 | 4.65 | 5.00 | 4.40 | 4.60 | 4.60 |
| Min | 3.30 | 3.00 | 3.00 | 3.20 | 2.40 | 2.40 | 2.40 |
| Max | 6.30 | 6.60 | 6.60 | 6.40 | 6.44 | 6.44 | 6.60 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |
| **BEM FEMININE** | | | | | | | |
| Mean | 4.95 | 5.64 | 5.30 | 5.22 | 5.81 | 5.51 | 5.41 |
| Standard deviation | .78 | .66 | .80 | .98 | .55 | .84 | .83 |
| Median | 5.15 | 5.70 | 5.40 | 5.50 | 5.90 | 5.60 | 5.50 |
| Min | 3.10 | 3.90 | 3.10 | 2.00 | 4.10 | 2.00 | 2.00 |
| Max | 6.50 | 6.90 | 6.90 | 6.70 | 6.90 | 6.90 | 6.90 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |

| | Greek | | | | | | |
|---|---|---|---|---|---|---|---|
| | Fertile | | | Subfertile | | | |
| | Men | Women | Total | Men | Women | Total | All |
| **BEM MASCULINE** | | | | | | | |
| Mean | 5.05 | 4.61 | 4.83 | 5.15 | 4.79 | 4.97 | 4.90 |
| Standard deviation | .81 | .83 | .84 | .78 | .90 | .86 | .85 |
| Median | 5.20 | 4.60 | 4.80 | 5.30 | 4.70 | 5.00 | 4.90 |
| Min | 3.20 | 2.60 | 2.60 | 3.10 | 2.90 | 2.90 | 2.60 |
| Max | 6.70 | 7.00 | 7.00 | 6.60 | 6.70 | 6.70 | 7.00 |
| N | 48 | 47 | 95 | 47 | 47 | 94 | 189 |
| **BEM FEMININE** | | | | | | | |
| Mean | 5.69 | 5.98 | 5.83 | 5.68 | 6.05 | 5.87 | 5.85 |
| Standard deviation | .78 | .61 | .71 | .82 | .57 | .73 | .72 |
| Median | 5.70 | 6.00 | 5.90 | 5.80 | 6.10 | 5.90 | 5.90 |
| Min | 3.20 | 4.50 | 3.20 | 3.30 | 4.80 | 3.30 | 3.20 |
| Max | 6.90 | 7.00 | 7.00 | 7.00 | 6.90 | 7.00 | 7.00 |
| N | 48 | 47 | 95 | 46 | 47 | 93 | 188 |

## Appendix 23b

**Table I: BEM sex role classifications for the British, the Greeks and the sub-groups.**

| | British | | | | | | |
|---|---|---|---|---|---|---|---|
| | Fertile | | | Subfertile | | | All |
| BEM | Men | Women | Total | Men | Women | Total | |
| Androgynous | 7 | 11 | 18 | 12 | 11 | 23 | 41 |
| Masculine | 22 | 7 | 29 | 16 | 7 | 23 | 52 |
| Feminine | 2 | 15 | 17 | 6 | 20 | 26 | 43 |
| Undifferentiated | 19 | 17 | 36 | 16 | 12 | 28 | 64 |
| Missing | | | | | | | 0 |
| | | | | | | | |
| | Greek | | | | | | |
| | Fertile | | | Subfertile | | | |
| | Men | Women | Total | Men | Women | Total | |
| BEM | | | | | | | |
| Androgynous | 23 | 15 | 38 | 18 | 18 | 36 | 74 |
| Masculine | 8 | 3 | 11 | 13 | 5 | 18 | 29 |
| Feminine | 5 | 20 | 25 | 8 | 19 | 27 | 52 |
| Undifferentiated | 12 | 9 | 21 | 7 | 5 | 12 | 33 |
| Missing | 2 | 3 | 5 | 4 | 3 | 7 | 12 |

# Appendix 24: Descriptive statistics for the well being variables across the sub-groups

**Table I: QOL scores[1] for the British and the sub-groups.**

| | British | | | | | | All |
|---|---|---|---|---|---|---|---|
| | Fertile | | | Subfertile | | | |
| | Men | Women | Total | Men | Women | Total | |
| **Life in general** | | | | | | | |
| Mean | 2.76 | 2.45 | 2.60 | 2.63 | 2.93 | 2.78 | 2.69 |
| Standard dev. | .96 | .95 | .96 | 1.09 | 1.22 | 1.16 | 1.07 |
| Median | 2.62 | 2.25 | 2.37 | 2.50 | 2.81 | 2.62 | 2.50 |
| Min | 1 | .83 | .83 | 1 | 1 | 1 | .83 |
| Max | 5.75 | 5.12 | 5.75 | 7 | 5.62 | 7 | 7 |
| N | 50 | 49 | 99 | 50 | 50 | 100 | 199 |
| | | | | | | | |
| **Easy - hard** | | | | | | | |
| Mean | 4.24 | 3.96 | 4.10 | 3.66 | 4.08 | 3.87 | 3.98 |
| Standard dev. | 1.73 | 1.62 | 1.68 | 1.67 | 1.69 | 1.69 | 1.68 |
| Median | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Min | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Max | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| N | 50 | 49 | 99 | 50 | 50 | 100 | 199 |
| | | | | | | | |
| **Free - tied down** | | | | | | | |
| Mean | 3.88 | 3.80 | 3.84 | 3.54 | 3.20 | 3.37 | 3.60 |
| Standard dev. | 1.53 | 1.35 | 1.44 | 1.31 | 1.40 | 1.36 | 1.42 |
| Median | 4 | 4 | 4 | 4 | 3 | 4 | 4 |
| Min | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Max | 7 | 7 | 7 | 7 | 6 | 7 | 7 |
| N | 50 | 49 | 99 | 50 | 50 | 100 | 199 |

[1] Scores ranged from 1 to 7 (1 = good quality of life, 7 = low quality of life)

**Table II: QOL scores for the Greeks and the sub-groups.**

| | GREEK | | | | | | |
|---|---|---|---|---|---|---|---|
| | Fertile | | | Subfertile | | | All |
| | Men | Women | Total | Men | Women | Total | |
| **Life in general** | | | | | | | |
| Mean | 2.38 | 2.43 | 2.41 | 2.55 | 2.80 | 2.68 | 2.54 |
| Standard deviation | 1.21 | 1.22 | 1.21 | 1.27 | 1.23 | 1.25 | 1.23 |
| Median | 2.12 | 2.12 | 2.12 | 2.50 | 2.75 | 2.56 | 2.37 |
| Min | 1 | .94 | .94 | 1 | 1 | 1 | .94 |
| Max | 5.87 | 5.62 | 5.87 | 6.25 | 6.25 | 6.25 | 6.25 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |
| | | | | | | | |
| **Easy - hard** | | | | | | | |
| Mean | 4.72 | 4.62 | 4.67 | 4.06 | 4.12 | 4.09 | 4.38 |
| Standard deviations | 1.78 | 1.95 | 1.86 | 1.95 | 1.89 | 1.91 | 1.90 |
| Median | 5 | 4.50 | 5 | 4 | 4 | 4 | 4 |
| Min | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Max | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |
| | | | | | | | |
| **Free - tied down** | | | | | | | |
| Mean | 4.50 | 4.24 | 4.37 | 3.90 | 3.72 | 3.81 | 4.09 |
| Standard deviation | 2.03 | 1.78 | 1.91 | 1.98 | 2.02 | 1.99 | 1.96 |
| Median | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Min | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Max | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| N | 50 | 50 | 100 | 50 | 50 | 100 | 200 |

**Table III: Total GHQ scores for the British, the Greeks and the sub-groups.**

| | British | | | | | | |
|---|---|---|---|---|---|---|---|
| | Fertile | | | Subfertile | | | All |
| | Men | Women | Total | Men | Women | Total | |
| Mean | 10.90 | 11.61 | 11.25 | 10.62 | 13.42 | 12.02 | 11.64 |
| Standard dev. | 5.30 | 5.48 | 5.37 | 4.77 | 6.77 | 5.99 | 5.69 |
| Median | 9 | 11 | 10 | 10 | 12 | 11 | 11 |
| Min | 2 | 4 | 2 | 1 | 2 | 1 | 1 |
| Max | 26 | 29 | 29 | 25 | 31 | 31 | 31 |
| N | 50 | 49 | 99 | 50 | 50 | 100 | 199 |

| | Greek | | | | | | |
|---|---|---|---|---|---|---|---|
| | Fertile | | | Subfertile | | | |
| | Men | Women | Total | Men | Women | Total | All |
| Mean | 10.06 | 12.10 | 11.08 | 9.33 | 11.50 | 10.42 | 10.75 |
| Standard dev. | 5.35 | 6.58 | 6.06 | 4.23 | 5.47 | 4.99 | 5.55 |
| Median | 9 | 10 | 9 | 8 | 11 | 10 | 10 |
| Min | 1 | 3 | 1 | 4 | 4 | 4 | 1 |
| Max | 25 | 29 | 29 | 26 | 31.99 | 31.99 | 31.99 |
| N | 50 | 50 | 100 | 49 | 50 | 99 | 199 |

# Appendix 25: Correlation coefficients for the well being variables across sub-groups

**Table I: Correlation coefficients for the well being variables for the British participants**

| N=198 | GHQ | Life in general | Easy - hard | Free - tied down |
|---|---|---|---|---|
| **GHQ** | 1.00 | .58* | .40* | .26* |
| **Life in general** | .58* | 1.00 | .39* | .29* |
| **Easy - hard** | .40* | .39* | 1.00 | .33* |
| **Free - tied down** | .26* | .29* | .33* | 1.00 |

*** significant correlations at p<.05**

**Table II: Correlation coefficients for the well being variables for the Greek participants**

| N=199 | GHQ | Life in general | Easy - hard | Free - tied down |
|---|---|---|---|---|
| **GHQ** | 1.00 | .68* | .35* | .26* |
| **Life in general** | .68* | 1.00 | .32* | .31* |
| **Easy - hard** | .35* | .32* | 1.00 | .38* |
| **Free - tied down** | .26* | .31* | .38* | 1.00 |

*** significant correlations at p<.05**

**Table III: Correlation coefficients for the well being variables for the fertile participants**

| N=198 | GHQ | Life in general | Easy - hard | Free - tied down |
|---|---|---|---|---|
| GHQ | 1.00 | .62* | .34* | .15* |
| Life in general | .62* | 1.00 | .29* | .24* |
| Easy - hard | .34* | .29* | 1.00 | .41* |
| Free - tied down | .15* | .24* | .41* | 1.00 |

* significant correlations at p<.05

**Table IV: Correlation coefficients for the well being variables for the subfertile participants**

| N=199 | GHQ | Life in general | Easy - hard | Free - tied down |
|---|---|---|---|---|
| GHQ | 1.00 | .65* | .39* | .34* |
| Life in general | .65* | 1.00 | .41* | .37* |
| Easy - hard | .39* | .41* | 1.00 | .31* |
| Free - tied down | .34* | .37* | .31* | 1.00 |

* significant correlations at p<.05

**Table V: Correlation coefficients for the well being variables for the male participants**

| N=199 | GHQ | Life in general | Easy - hard | Free - tied down |
|---|---|---|---|---|
| GHQ | 1.00 | .62* | .35* | .24* |
| Life in general | .62* | 1.00 | .32* | .29* |
| Easy - hard | .35* | .32* | 1.00 | .32* |
| Free - tied down | .24* | .29* | .32* | 1.00 |

* significant correlations at p<.05

**Table VI: Correlation coefficients for the well being variables for the female participants**

| N=198 | GHQ | Life in general | Easy - hard | Free - tied down |
|---|---|---|---|---|
| GHQ | 1.00 | .66* | .38* | .27* |
| Life in general | .66* | 1.00 | .36* | .30* |
| Easy - hard | .38* | .36* | 1.00 | .41* |
| Free - tied down | .27* | .30* | .41* | 1.00 |

* significant correlations at p<.05

# Appendix 26

**Table I: Means and standard deviations* of appraisal of social support in relation to nationality and gender**

*** in parenthesis**

| | **British** | **Greek** | **Total** |
|---|---|---|---|
| **Males** | 1.92<br>(1.15) | 1.99<br>(1.31) | 1.96<br>(1.23) |
| **Females** | 1.53<br>(.65) | 1.81<br>(1.00) | 1.67<br>(.85) |
| **Total** | 1.73<br>(.95) | 1.90<br>(1.16) | 1.81<br>(1.06) |

# Appendix 27: Correlation coefficients for sociodemographic, well being and social support variables with attitudes to parenthood and to fertility treatments

**Table I: Correlation coefficients for attitudes to parenthood and attitudes to fertility treatments (14 dimensions) for the whole sample and the sub-groups**

| All groups | British | Greek | Fertile | Sub-fertile | Men | Women |
|---|---|---|---|---|---|---|
| -.06 | -.11 | .12 | -.11 | .03 | -.01 | -.10 |

*significant correlations at p<.05

**Table II: Correlation coefficients for attitudes to parenthood and the demographic variables for the whole sample and the sub-groups**

| Demographic variables | All groups | British | Greek | Fertile | Sub-fertile | Men | Women |
|---|---|---|---|---|---|---|---|
| Age | .05 | .15* | .06 | -.01 | .08 | .08 | .01 |
| Number of Natural children | .00 | .09 | .19* | .01 | .14 | -.03 | .03 |
| Living with children | .02 | .04 | .23* | .00 | .18* | -.04 | .07 |
| Years with partner | -.06 | -.05 | .10 | -.09 | -.01 | -.03 | -.08 |
| Education | -.11* | -.05 | -.04 | -.07 | -.17* | -.18* | -.03 |
| Degree of Religiousness | -.26* | -.17* | -.05 | -.27* | -.24* | -.23* | -.29* |
| Number of siblings | -.10* | .06 | -.02 | -.11 | -.11 | -.11 | -.10 |

*significant correlations at p<.05

**Table III: Correlation coefficients for attitudes to parenthood and the well being variables for the whole sample and the sub-groups**

| Groups | GHQ (total) | Life in general | Easy - hard | Free - tied down |
|---|---|---|---|---|
| **All Groups** | -.03 | -.03 | .07 | .12* |
| **British** | -.04 | -.01 | -.06 | .06 |
| **Greek** | .06 | .02 | .10 | .06 |
| **Fertile** | .02 | -.09 | .15* | .17* |
| **Sub-fertile** | -.09 | .02 | .01 | .10 |
| **Men** | .01 | -.06 | .10 | .12 |
| **Women** | -.07 | -.01 | .04 | .12 |

*significant correlations at p<.05

**Table IV: Correlation coefficients for attitudes to parenthood and the social support variables for the subfertile participants and the sub-groups**

| Social support variables | British subfertile | | | Greek subfertile | | | All subfertile |
|---|---|---|---|---|---|---|---|
| | Men | Women | All | Men | Women | All | |
| **Number of supportive people** | .08 | -.13 | -.08 | -.35* | -.45* | -.39* | -.26* |
| **Satisfaction with social support** | -.07 | .09 | .02 | .22 | .02 | .13 | .09 |

*significant correlations at p<.05

**Table V: Correlation coefficients for total attitudes to fertility treatments across the 14 dimensions and the demographic variables for the whole sample and the sub-groups**

| Demographic variables | All groups | British | Greek | Fertile | Subfertile | Men | Women |
|---|---|---|---|---|---|---|---|
| Age | -.03 | -.05 | -.03 | .06 | -.08 | .01 | -.08 |
| Number of natural children | .10 | .23* | -.16* | .18* | -.15* | .16* | .05 |
| Living with children | -.01 | .15* | -.23* | .01 | -.17* | .01 | -.02 |
| Years with partner | .09 | .10 | .04 | .08 | .11 | .11 | .08 |
| Education | -.14* | -.25* | -.09 | -.16* | -.11 | -.19* | -.10 |
| Degree of Religiousness | -.04 | -.07 | -.12 | -.06 | -.04 | .03 | -.11 |
| Number of siblings | .03 | -.05 | .06 | .11 | -.03 | .06 | -.01 |

*significant correlations at p<.05

**Table VI: Correlation coefficients for attitudes to fertility treatments and the well being variables for the whole sample and the sub-groups.**

| Groups | GHQ | Life in general | Easy - hard | Free - tied down |
|---|---|---|---|---|
| **All Groups** | .21* | .27* | .15* | .15* |
| **British** | .11 | .21* | .23* | .22* |
| **Greek** | .28* | .30* | .12 | .13 |
| **Fertile** | .15* | .18* | .02 | .05 |
| **Sub-fertile** | .28* | .37* | .26* | .20* |
| **Men** | .28* | .40* | .20* | .15* |
| **Women** | .16* | .15* | .11 | .14* |

***significant correlations at p<.05**

**Table VII: Correlation coefficients for attitudes to fertility treatments and the social support variables for the subfertile participants and the sub-groups**

| Social support variables | British subfertile | | | Greek subfertile | | | All subfertile |
|---|---|---|---|---|---|---|---|
| | Men | Women | All | Men | Women | All | |
| **Number of supportive people** | .11 | .21 | .14 | -.14 | -.08 | -.09 | .02 |
| **Satisfaction with social support** | .19 | -.02 | .11 | .27 | .24 | .24* | .19* |

***significant correlations at p<.05**

# Appendix 28

**Table I: Effects, means and standard deviations* for employment, religion affiliation and living with(out) children on MPS and attitudes to treatments (14 dimensions)**

***in parenthesis**

| | **MPS** | **Attitudes to treatments** |
|---|---|---|
| **Employment** | $F(1,396)=.014$, $p=.906$ | $F(1,379)=.87$, $p=.35$ |
| Employed | 3.33 (.79) | 3.44 (1.01) |
| Non employed | 3.34 (.85) | 3.30 (1.04) |
| **Religion affiliation** | $F(1,197)=2.76$, $p=.098$ | $F(1,192)=2.95$, $p=.087$ |
| Member of a religious group | 3.12 (.71) | 3.80 (1.00) |
| Non member | 2.88 (.81) | 3.49 (.91) |
| **Living with children** | $F(1,396)=1.55$, $p=.213$ | $F(1,379)=.02$, $p=.878$ |
| With | 3.41 (.85) | 3.43 (1.05) |
| Without | 3.30 (.84) | 3.42 (1.00) |

# Appendix 29: Factor loadings for the Meaning of Parenthood Scale (MPS)

| Table I: Unrotated factor loadings for the British and the Greek participants. | | | | |
|---|---|---|---|---|
| | British | | Greek | |
| | Factor 1 | Factor 2 | Factor 1 | Factor 2 |
| MPS1 | .71 | -.14 | .66 | -.28 |
| MPS2 | .77 | -.00 | .61 | .59 |
| MPS3 | .44 | .61 | .20 | -.31 |
| MPS4 | .70 | .25 | .46 | .73 |
| MPS5 | .68 | .34 | .71 | .06 |
| MPS6 | .31 | .69 | .22 | -.49 |
| MPS7 | .68 | -.27 | .73 | -.20 |
| MPS8 | .80 | .13 | .69 | -.11 |
| MPS9 | .56 | .20 | .52 | -.31 |

| Table II: Unrotated factor loadings for the fertile and the subfertile participants. | | | | | |
|---|---|---|---|---|---|
| | Fertile | | | Subfertile | |
| | Factor 1 | Factor 2 | Factor 3 | Factor 1 | Factor 2 |
| MPS1 | -.63 | -.06 | -.35 | .53 | .27 |
| MPS2 | -.84 | -.07 | -.05 | .72 | -.48 |
| MPS3 | -.29 | -.79 | .23 | .33 | .56 |
| MPS4 | -.77 | .15 | -.14 | .69 | -.58 |
| MPS5 | -.77 | .37 | -.03 | .74 | .01 |
| MPS6 | -.37 | -.49 | -.56 | .33 | .44 |
| MPS7 | -.81 | .19 | .05 | .76 | -.05 |
| MPS8 | -.79 | .03 | .29 | .77 | .13 |
| MPS9 | -.41 | -.16 | .64 | .55 | .37 |

**Table III: Unrotated factor loadings for men and women.**

| | Men | | | Women | |
|---|---|---|---|---|---|
| | Factor 1 | Factor 2 | Factor 3 | Factor 1 | Factor 2 |
| **MPS1** | .55 | .24 | -.52 | .57 | .32 |
| **MPS2** | .74 | .04 | .48 | .83 | -.28 |
| **MPS3** | .21 | -.82 | .06 | .39 | .49 |
| **MPS4** | .74 | .21 | .50 | .73 | -.46 |
| **MPS5** | .73 | .29 | -.12 | .79 | -.12 |
| **MPS6** | .35 | -.08 | -.47 | .34 | .57 |
| **MPS7** | .80 | .08 | -.13 | .78 | -.17 |
| **MPS8** | .80 | -.21 | -.06 | .77 | .03 |
| **MPS9** | .51 | -.45 | -.10 | .45 | .44 |

# Appendix 30: Reliability results for Shiloh et al.'s (1991) scale across each one of the fertility treatments

**Table I: Cronbach alphas for the 14-item scale and in parenthesis the alphas for the 15-item scale**

| | British | Greek | Both |
|---|---|---|---|
| **Ovulation induction** | .83 (.80) | .81 (.80) | .83 (.81) |
| **Drug treatment for males** | .86 (.84) | .84 (.82) | .85 (.84) |
| **IVF** | .89 (.88) | .87 (.87) | .88 (.87) |
| **ICSI** | .87 (.86) | .88 (.87) | .88 (.87) |
| **Egg donor** | .88 (.87) | .91 (.90) | .90 (.89) |
| **Sperm donor** | .89 (.88) | .90 (.89) | .90 (89) |

**Appendix 31a: Effect sizes* for main effects and interactions for nationality, fertility status, gender, the six fertility treatments and the 14 dimensions**

**their calculation was based on the following equation: $n^2p=(dfh \times F) / (dfh \times F + dfe)$ – (Cohen, 1977)*

| | |
|---|---|
| **Nationality** | 0.014 |
| **Fertility** | 0.012 |
| **Treatments** | 0.404 |
| **Dimensions** | 0.200 |
| **Nationality x Fertility** | 0.024 |
| **Nationality x Treatment** | 0.051 |
| **Nationality x Dimensions** | 0.042 |
| **Fertility x Dimensions** | 0.010 |
| **Treatments x Dimensions** | 0.105 |
| **Nationality x Fertility x Dimensions** | 0.0069 |
| **Fertility x Treatments x Dimensions** | 0.0049 |
| **Nationality x Treatments x Dimensions** | 0.00082 |
| **Nationality x Fertility x Treatments x Dimensions** | 0.0045 |

## Appendix 31b: Effect sizes* for the main effects and interactions for nationality, fertility status, gender, the six treatments and the 9th dimension

**their calculation was based on the following equation: $n^2p=(dfh \times F) / (dfh \times F + dfe)$ – (Cohen, 1977)*

| | |
|---|---|
| **Nationality** | 0.057 |
| **Fertility** | 0.0151 |
| **Treatments** | 0.147 |
| **Nationality x Fertility** | 0.0377 |
| **Nationality x Treatment** | 0.0084 |
| **Nationality x Fertility x Treatments** | 0.0091 |

# Appendix 32: Coding categories for parenthood, fertility problem and fertility treatments

**Categories in relation to parenthood:**

1) Mandatory
2) marriage/family
3) time
4) adult identity
5) lifestyle
6) intimate relationships
7) love
8) choice

**Categories in relation to fertility problem:**

1) status
2) recurrent thought
3) self
4) psychological inadequacy
5) coping
6) others' expectations
7) others and fertility problem
8) social racism
9) religious beliefs

**Categories in relation to fertility treatment:**

**1)** worries

**2)** others and treatment

**3)** positive aspects

**4)** options/dilemmas in case of failure