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The experience of involuntary childless Turkish migrants in the Netherlands : parenthood motives, psycho-social consequences, responses and help-seeking behavior

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1 General Introduction

1.1 Introduction

The desire to have a child is for most people essential. Therefore, when people are having difficulties with realizing this desire, it is likely to place a heavy burden on them. Their future prospects change. Additionally, if they want to solve their fertility problems, they might have to seek medical assistance to get pregnant. Even if they do seek help this does not necessarily mean that they will have a child. They may need to come to terms with the possibility of remaining childless, which can be compared to a process of mourning (Kirkman, 2003; Lechner, Van Dalen, & Bolman, 2007). In addition to the personal grief that people experience, their social environment may also impact on how they experience problems with having a child. Others might for instance expect them to become parents, resulting in pressure. On the other hand other people might also be a source of support for childless couples.

This thesis explores the experience of involuntary childlessness for Turkish people living in the Netherlands. What are their motivations for parenthood and what is the influence of their cultural background on their motivations? How do they experience their fertility problems? What are the psychological and social consequences of their involuntary childlessness and how do they respond? Do they seek help? And what kind of help do they choose? Does having a different cultural background from the majority population influence these experiences and responses? In this chapter we provide a short overview of the developments in research regarding involuntary childlessness. This is followed by a discussion of the possible role of culture, the role of migration and the specific situation of Turkish migrants in the Netherlands. Next the aims and outline of this thesis is presented.

1.2 Research about involuntary childlessness

In the medical literature, infertility is usually defined as not becoming pregnant within a year of trying to conceive a child through regular intercourse. The world wide prevalence of current infertility, following this definition, is estimated at about 9%. Nevertheless, the prevalence rates vary modestly between countries (Boivin, Bunting, Collins, & Nygren, 2007). Both male and female factors can cause infertility, but infertility may also be the result of the combination of two specific partners. These three clusters of causes each account for approximately 30% of the infertility problems. The remaining 10% are unexplained (NVOG, 2004).

Within the scientific literature, the emphasis has long been exclusively on medical aspects of involuntary childlessness. However, more recently the experiences of involuntarily childless couples have gained increasing attention within social science research. The first studies of the psychological and social consequences of involuntary childlessness were conducted primarily in Western Europe, the USA and other Western societies (Brkovich & Fisher, 1998; Greil, 1997). These studies were followed in the 1990's by studies about the experiences of involuntary childlessness in non-Western societies, including Africa, Asia, and the Middle East (e.g., Inhorn & Van Balen, 2002; Van Balen, Gerrits, & Inhorn, 2000; Vayena, Rowe, & Griffin, 2001).

Studies conducted in Western and non-Western societies indicate that in all societies, involuntary childlessness is a sensitive topic and a source of personal concern and social stress. However, people (particularly women) living in non-Western societies appear to experience more severe social consequences of involuntary childlessness, like serious social stigmatization and exclusion, marital or social violence, forced divorce, and increased occurrence of co-wives, than people in Western societies (Daar & Merali, 2001; Van Balen & Inhorn, 2002). Possibly as a result of these social consequences, non-Western involuntarily childless couples appear to report more psychological consequences, like emotional distress, than do infertile Western couples (Dyer, Abrahams, Mokoena, Lombard, & van der Spuy, 2005). Nevertheless, in non-Western societies the proportion of infertile people receiving biomedical treatment is lower than that in Western societies (Boivin et al., 2007).

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The observed differences in social consequences and emotional distress are frequently related to cultural differences in the values attached to having children and to being a mother or father in a certain culture (Dyer, 2007). These values are reflected in the parenthood motives people have. These motives might range from individual motives, like the joy a child provides, or a biological urge to have a child, to social motives, like those related to social power, to the continuation of the family line, social pressure and economic reasons (Van Balen & Inhorn, 2002). In general, non-Western societies have a stronger pronatalist culture (i.e., having children is the undisputed social norm) than have Western societies. Therefore, social parenthood motives are more common in non-Western societies (Van Balen & Inhorn, 2002). Also, cultural beliefs about procreation and the causes of involuntary childlessness are thought to explain the observed differences between Western and non-Western couples. Within some non-Western societies, tradition- and religion based beliefs about procreation and involuntary childlessness (like monogenetic procreation beliefs) exist that differ from the Western biomedical model (Delaney, 1991; Nahar, 2007). People might for instance believe that their childlessness is caused by envy, spirits or a deity (also called personalistic causes), by naturalistic causes like the influence of cold and heat, or that solely the woman or, less often, the man is held responsible for the fertility problems (Daar & Merali, 2001; Guz, Ozkan, Sarisoy, Yanik, & Yanik, 2003; Ombelet & Campo, 2007). These beliefs about different attributions of responsibility for infertility may influence the way infertility is experienced and may also influence the attribution of blame for infertility and of feelings of guilt. Furthermore, explanatory models about procreation and infertility can influence the help-seeking behavior of involuntarily childless couples. People who believe their infertility is caused by a personalistic cause would for instance rather seek help from traditional or spiritual healers than go to infertility services (Gerrits, 1997; Guntupalli, 2004; Nahar, 2007).

The difference in the proportion of people receiving biomedical treatment is probably also determined by wide disparities in the availability of infertility services, in the accessibility (because of treatment costs), and the availability of specific treatments across societies (Boivin et al., 2007; Nachtigall, 2006; Van Balen & Gerrits, 2001).

1.3 Involuntarily childless non-Western couples living in Western cultures

The situation of involuntarily childless, non-Western couples living in Western cultures is special. When people migrate to a different country they bring their own culture with them and in the new country they are confronted with a new culture (including different customs, different beliefs, different norms and values). For involuntarily childless non-Western couples (hereafter called migrants) this means that they are confronted with a culture that potentially holds different cultural values of having children and different procreation beliefs. Through the confrontation with a new culture in a new country a process of socio-cultural and psychological change occurs, a process that has been called 'acculturation' (Berry, Kim, Power, Young, & Bujaki, 1989). It could be hypothesized that when involuntarily childless non-Western migrants are more adapted to the Western culture, they might experience fewer social consequences and less emotional distress than less adapted couples. Furthermore, the availability and accessibility of care differs from their country of origin. It is likely that when non-Western couples live in a country where infertility services are more available and better accessible than in their country of origin, they would more often use these services than couples in the country of origin do.

The limited research about involuntarily childless non-Western migrants suggests that they report more social and psychological consequences than do infertile Western couples (Kentenich & Yuksel, 1997; Schmid, Kirchengast, Vytiska Binstorfer, & Huber, 2004a, 2004b). Little is known about how the psycho-social consequences of involuntary childlessness differs between non-Western migrants and couples from the country of origin. Neither is much known about the impact of acculturation processes on this experience. Acculturation processes and the degree of adaptation to the culture of the country of residence, however, do seem to influence couples' ability to access biomedical care and biomedical information: people who are not able to speak the language of the host country (a sign of little adaptation) have more difficulties with accessing fertility services and related relevant information than those who do know the dominant language, for example (e.g., Culley, Hudson, Rapport, Katbamna, & Johnson, 2006; Inhorn, 2006). No information is available regarding the number of

non-Western migrants visiting Dutch infertility services as Dutch infertility services do not routinely collect data about the ethnic background of patients (Evenblij, Mackenbach, & van der Veen, 2004).

1.4 Turkish migrants in the Netherlands and their antecedents

This thesis explores the psychological and social aspects of infertility amongst one of the largest non-Western migrant groups in the Netherlands: Turkish migrants. At present, the Netherlands officially has more than 372.000 first and second generation Turkish migrants (2.3% of the total population of 16.4 million people) (Statistics Netherlands, 2007).

In the 1960s, the first Turkish men were invited by Dutch companies to come to the Netherlands because of a shortage in the labor market, in particular in the lower segment. Most Turkish laborers were recruited in Central Anatolia, a region in Turkey. Half of them came from villages, five percent came from large cities, the others from smaller cities. The influx of Turkish people to the Netherlands increased rapidly. When labor recruitment was brought to an end in 1974, the influx of new Turkish people into the Netherlands continued due to family reunification, marriage, asylum request, and informal channels (Kaya, 2006). Over recent years the immigration of Turkish people to the Netherlands has been mainly the consequence of the high number of Turkish migrants (first and second generation) finding their partner in the country of origin (Hooghiemstra, 2003; SCP/WODC/CBS, 2005). In the last few years, however, the number of Turkish people coming to the Netherlands on marriage has decreased (Van Huis, 2008), as has the number of Turkish people immigrating to the Netherlands as a whole (Statistics Netherlands, 2008).

Turkish people in the Netherlands have a relatively low level of education in comparison with Dutch people, and women have lower educational levels than men. Nevertheless, the second generation is catching up when compared to Dutch people. Also the difference between men and women is becoming less pronounced (Kaya, 2006; SCP/WODC/CBS, 2005). Furthermore, about a third of all Turkish migrants reports that they do not know or only have limited knowledge of Dutch (Dagevos, Euwals,

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Gijsbert, & Roodenburg, 2006). The identification with the own ethnic group is high: almost half of the Turkish migrants identify themselves predominantly as Turkish, while only 12 % feel themselves predominantly Dutch. Two thirds have more contact with other Turkish migrants than with the indigenous Dutch population (SCP/WODC/CBS, 2005). Most Turkish migrants still maintain a strong bond with Turkey and with family in Turkey (Böcker, 2000).

The majority of Turkish migrants belong to the Sunni branch of Islam. Sunni Islam does not allow infertility treatments involving a donor gametes or surrogacy. Also adoption is prohibited by Islam (Inhorn, 2006), although allowed by state laws in Turkey. The degree to which Turkish migrants are aware of these fatwas and adhere to them might vary (see also Isikoglu et al., 2006). A minority of Turkish migrants belongs to the Alevi branch of Islam, some belong to other denominations, or are not religious (Kaya, 2006). The Alevi branch of Islam is a humanist philosophy with no official regulations regarding infertility treatment and gametes donation (Yildirim, 2002).

1.5 The present research project

1.5.1 Aims

This thesis was conducted to learn more about the experience of involuntary childlessness amongst infertile Turkish migrants in the Netherlands. The theoretical importance of such a project lies in advancing knowledge of 1) the motivations people have to desire a child, 2) psycho-social consequences of and responses to involuntary childlessness, 3) help seeking behavior, 4) the role of culture and 5) the role of migration and of being a migrant on parenthood motivations, psycho-social consequences of and responses to involuntary childlessness and on help seeking. In addition to advancing theoretical insights in this area, this project was designed to have a practical purpose. On the basis of theoretical knowledge of Turkish migrant couples, this project aims to enable health care providers to better accommodate their Turkish migrant patients, taking their needs, background and experiences into account (Richters, 2000; Shadid, 1993).

1.5.2 Outline of this thesis

In this thesis one literature study and four empirical studies are presented in five chapters. These chapters can be read individually.

In *Chapter 2* a literature study about non-biomedical procreation beliefs in the Middle East (including Turkey) and their connection with the biomedical model is reported. In this chapter the existence of non-biomedical procreation beliefs among a number of Middle Eastern migrants and the possible influence of these beliefs on how Middle Eastern migrants may experience infertility and may perceive biomedical examinations and treatments are discussed.

Chapter 3 describes a questionnaire study about the parenthood motives of infertile Turkish migrants in the Netherlands as compared to those of infertile Dutch men and women. This comparison highlights the cultural differences and similarities between the Dutch and Turkish migrant cultures in the value attached to having children. Infertile couples often have more manifest reasons to desire a child, while their motives do not differ from the general population (Van Balen & Trimbos-Kemper, 1995). By studying their motives more knowledge is gained about the parenthood motives of the Turkish migrant community in general. At the same time knowledge about parenthood motives leads to a better understanding of differences in psychosocial consequences of involuntary childlessness (e.g., experience, social pressure, emotional distress, and help-seeking behavior) (Van Balen, 2001). Additionally, the potential relationship between the parenthood motives of Turkish migrants and the degree of adaptation to the Dutch culture is examined, in order to give insight into the possible influence of acculturation processes on the meaning of involuntary childlessness.

Chapter 4 describes a qualitative study about the experiences of involuntarily childless Turkish migrants in the Netherlands. This in-depth interview study offers the possibility to explore a whole range of psychosocial aspects as raised by the respondents, to observe possible differences among Turkish migrants, and to relate the experiences to cultural background and migration related factors.

Chapter 5 reports on a questionnaire study in which cultural differences in the effects of infertility on emotional distress are investigated. This study compares reported emotional distress among infertile people in three samples: Turkish migrants in the Netherlands, Turkish people living in Western Turkey and Dutch people. Separate

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analyses were conducted for men and women. Comparing Turkish migrants with both Dutch and Turkish men and women may not only reveal cultural differences, but may also reveal the influence of living in the Netherlands on the experience of involuntary childlessness for Turkish migrants.

The *6th Chapter* reports on the help-seeking behavior of involuntarily childless Turkish migrants. Based on a questionnaire study the help-seeking behavior and willingness towards treatments involving gamete donation and surrogacy are presented. Using data from an in-depth interview study, the decision-making processes regarding biomedical help are described according to a typology developed by Verdurmen (1997): the 'follow the doctor', 'step by step', 'taking control' and 'setting limits' types. This study gives an indication of the accessibility of the Dutch biomedical system to Turkish migrants, the role of culture in help seeking behavior and in attitudes towards treatments (like the religious stance towards treatments involving donor gametes or surrogacy) and the use of Turkish infertility services.

A final chapter (*Chapter 7*) presents a general conclusion and discussion of the presented studies.