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4 The experience of involuntarily childless Turkish migrants in the Netherlands: a qualitative study*

The consequences of involuntary childlessness are influenced by culture in several ways. This study explores the experiences and responses of infertile Turkish migrants in the Netherlands. Twenty in-depth interviews were conducted with childless Turkish migrants in the Netherlands (11 couples and 9 women). Interviews were transcribed verbatim and were analyzed using interpretative phenomenological analysis (IPA). The respondents' experiences were clustered around six superordinate themes: effects on self; effects on the relationship with the partner; effects on the relationship with others; disclosure; coping; and the future. Most transcripts reveal that involuntary childlessness has a profound negative influence on multiple aspects of the lives of the respondents. The strong pronatalist ideology, misconceptions about infertility and treatment, and migration related aspects like language difficulties, appear to play a role in the negative experiences of Turkish migrants. Respondents reported several ways to cope to some extent with these negative experiences. These are discussed here.

4.1 Introduction

Involuntary childlessness affects the lives of people in all societies. However, studies into the socio-psychological aspects of involuntary childlessness (henceforth 'infertility') reveal a variety of meanings and responses across cultures (Inhorn & Van Balen, 2002). In Western Europe – a region that has become increasingly culturally diverse due to the influx of non-Western migrants since the 1960s – research has only recently begun to pay attention to the experiences of infertile migrants (Van Rooij,

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Van Balen, & Hermanns, 2007). With respect to Turkish migrants, who form one of the largest minority groups in Europe and are the focus of the present study, a number of explorative quantitative studies have been conducted (e.g., Kentenich & Yuksel, 1997; Van Rooij, Van Balen, & Hermanns, 2006; Van Rooij et al., 2007). The main focus of these studies has been the differences between infertile Turkish migrant couples and infertile indigenous couples. A number of differences are reported. Turkish migrants tend to be younger than Western couples when first confronted with fertility problems (Kentenich & Yuksel, 1997; Van Rooij et al., 2007). They also feel more social pressure to have children than do indigenous Western people (Gacinski et al., 2002; Schmid et al., 2004a, 2004b; Van Rooij et al., 2006). There are indications that this social pressure leads Turkish migrants to start infertility treatment sooner than indigenous couples (Scholtz, Bartholomaeus, Grimmer, Kentenich, & Obladen, 1999). Furthermore, differences in social pressure are also reflected in differences in parenthood motives: while infertile Western indigenous couples mainly have individual parenthood motives and give hardly any importance to social parenthood motives, infertile Turkish migrants have both social and individual parenthood motives (Van Rooij et al., 2006). Muslim migrant women (predominantly with a Turkish and Middle Eastern background) also report a greater need to conceal their childlessness than do Austrian women (Schmid et al., 2004b). Yuksel (1995) found that more than half of the infertile Turkish migrants in Germany do not disclose their infertility problems to others. A possible consequence of the described dissimilarities between Turkish migrants and indigenous couples is the finding that infertile Turkish migrants (particularly women) report higher levels of emotional distress than do infertile indigenous couples (Kentenich & Yuksel, 1997; Schmid et al., 2004a; Van Rooij et al., 2007).

In summary, comparative quantitative studies suggest that the social norm to have children is stronger in Turkish migrant communities than it is in the indigenous Western cultures of the countries of residence. It also appears that infertility has a more profound impact on the lives of infertile Turkish migrants. However, there is still a need for more understanding of the perceptions and the meanings and values concerning involuntary childlessness. Furthermore, little is known about possible variations within the Turkish migrant community regarding these aspects.

The aim of this study is to explore how Turkish migrants in the Netherlands make sense of the experiences of childlessness and how this influences their lives. Furthermore, the objective of this study is to highlight possible divergences among involuntarily childless Turkish migrants. Therefore, this study employed qualitative rather than quantitative research methods (Peddie & Van Teijlingen, 2005). The qualitative method was considered especially suited, as it allows respondents to introduce new and unexpected topics that subsequently can be explored (Berg, 1994; Smith & Osborn, 2004).

4.2 Methods

4.2.1 Ethical approval

The University of Amsterdam approved of the proposed study procedures. Furthermore, ethical approval was obtained from the medical ethical committees of the participating hospitals. All participants received written information about the project both in Dutch and in Turkish and gave written consent to join the study. Furthermore, participants were assured of anonymity and confidentiality.

4.2.2 Participants and Recruitment

Thirty-one respondents (11 couples, 9 women) participated in the current study. They were recruited from a wider sample of participants in a quantitative study (Van Rooij et al., 2006, 2007). Details regarding the recruitment of this first sample of Turkish migrants have been extensively reported (Van Rooij et al., 2006, 2007). Briefly, 56 persons (23 couples, 1 man, 11 women) who were involuntarily childless in their current relationship participated in the quantitative study. These respondents were recruited both within the biomedical system (hospitals; 52%) and outside it (Internet, Turkish (migrant) media, leaflets, snowball method; 48%). In the current study, seven couples and five women entered the study through biomedical entries, four couples and four women through other entries. Eight men did not join the study for various practical and emotional reasons, like having difficulties with talking about infertility.

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The age of the participating women ranged from 21 to 43 years ($M= 28.60$, $SD = 5.48$) and that of the men from 22 to 49 years ($M= 33.40$; $SD =8.40$). Twenty-five percent of the women and 0 % of the men had a low educational level (no or primary education, or lower theoretical and practical secondary school), 55% of the women and 60% of the men had an intermediate educational level (higher theoretical secondary or middle professional school), and 20% of the women and 40% of the men had completed higher education. The mean duration of the respondents' awareness of their fertility problem was 48.01 months ($SD=53.94$) for women and 24.67 months ($SD=27.69$) for men. In ten cases (five couples, four women) the fertility problem was attributed to female factors, in four cases (three couples, one woman) to male factors and in another four cases (two couples, two women) to both male and female factors. In two cases (one couple, one woman) the reasons for infertility were unexplained.

4.2.3 Data collection

Data were collected by means of in-depth interviews. The interview schedule comprised: an introduction; a time path related to the respondents' reproductive lives, starting from the moment they first discussed having children with their partners till the moment of the interview; and various topics based on the existing cross-cultural literature on infertility and reproduction. The topics were: influence on life; the future; differences between men and women; coping; and disclosure. Other topics related to infertility that were brought up by the respondents during the interviews were also discussed.

All interviews were conducted in the respondents' homes in their preferred language (Dutch or Turkish). Although the authors acknowledge the possible influence of the researcher identity in terms of gender, age, class and ethnicity on the production of accounts (Andersen, 1993), due to practical reasons all interviews were conducted by the first author (a Dutch female with knowledge of the Turkish language).

The initial research design was to interview couples together. There were several reasons for this decision. First of all, involuntary childlessness is a joint problem (Sandelowski, Holditch-Davis, & Harris, 1992; Verdurmen, 1997). Furthermore, partners can help each other to remind things, can supplement each others accounts and may correct each other (Allan, 1980). Besides, a higher response rate was ex-

pected, especially of men (Sandelowski et al., 1992). Nevertheless, in several cases the husbands were not willing to join the study. It was decided to include the single respondent interviews. First because also the interviews with the women provide information on the couple level and about the influence of involuntary childlessness on the lives of husbands and wives. Second, including these interviews might increase the diversity of the data and the range of information, as couples who do not want to have the interview together, might be different from other couples in several respects, for instance less cooperating as a couple regarding their involuntary childlessness.

A total of 20 interviews were conducted, comprising 20 cases. The interviews were audiotaped and transcribed verbatim. In two cases the interview could not be audiotaped; notes were therefore taken during the interview and further elaborated immediately after the interview. As the description of these interviews also contained rich information, the interviews were included in this study. All but one of the respondents gave permission to cite them. The length of the interview ranged from an hour till 3.5 hours.

4.2.4 Analyses

Interpretative phenomenological analysis (IPA) (Smith & Osborn, 2004) was used to analyze the experiences of the participating infertile Turkish migrants. It has been suggested that the IPA approach is particularly useful in exploring issues that are relatively new and possibly sensitive (Chapman & Smith, 2002). The IPA approach facilitates a detailed exploration of a respondent's subjective perception of an experience and his/her account of that experience (the phenomenon), as well as an interpretation of his/her thoughts and feelings about what is being discussed (Smith & Osborn, 2004). As IPA is an interpretative methodology, the outcomes of the analyses depend partly on the researcher's reference system. In order to increase transparency and to maximize the internal coherence and consistency of the analyses, the first author conducted the analyses; the second author then checked whether the superordinate themes and sub-themes were grounded in the transcripts. Verbatim extracts from the transcripts are given in the results section to support the findings. After every citation, the gender of the respondent and the number of the interview are indicated. All transcripts were entered in MAXqda 2 (Verbi Software, 2005), a computer program

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used to structure qualitative data. In conformity with IPA, the analysis started with a selection of a very extensive transcript. This transcript was thoroughly read. Annotations were made about interesting remarks related to our research question. The transcript was then reread and themes with a higher level of abstraction were formed. The emerging themes were listed and studied to see whether there were any connections between them. Themes that did connect were grouped into higher-order themes, which were rechecked against the primary transcript. Hereafter, the second transcript was analyzed. This transcript was coded according to the final themes of the first transcript. However, in line with IPA, the possibility to add new themes was kept open in order to take account of possible divergences in the data. Furthermore, it was possible that the existing themes would evolve due to the new transcripts. Similar procedures were followed until the last transcript had been analyzed using the interpretative process. Finally, a table of all themes was drawn up and all transcripts were reviewed using these superordinate themes (Smith & Osborn, 2004).

Following the recommendation of Sandelowski (2001) concerning operationally defined verbal counting, in the results section the word 'few' is used if a certain theme or finding emerged in 1–3 transcripts, 'some' if such emerged in 4–7 transcripts, 'several' if such emerged in 8–10 transcripts, 'many' if such emerged in 11–14 transcripts, and 'most' and 'majority' if such emerged in 15 or more transcripts (see also Dyer, Abrahams, Mokoena, & van der Spuy, 2004). These adjectives should, however, not be interpreted as generalizations to a larger population.

4.3 Findings

Six superordinate themes emerged from the narratives of the respondents: 1) effects on self, 2) effects on the relationship with the partner, 3) effects on the relationship with others, 4) disclosure, 5) coping, 6) the future. These themes are described below.

4.3.1 Effects on self

The majority of the respondents verbalized changes related to their own person as a consequence of their infertility. Three aspects were distinguished: (i) emotions, (ii) health and (iii) self-image.

With respect to changes in emotions (i), there were many commonalities between the narratives. In the majority of the cases, the respondents expressed intense negative emotions, mainly in the sphere of depression:

‘Inside I’m broken’ (♀, 14).

‘Then suddenly I realized [that it would be difficult to have children]. I felt really bad. My husband was [feeling] even worse’ (♀, 17).

The shock of realizing that having children would be difficult was also mentioned in several other cases:

‘And then my world collapsed, because, what would I have to do now? I didn’t expect something like this’ (♀, 8).

Some couples were already aware that having children without medical assistance would be difficult due to various medical reasons. Most of them emphasized that when they were told that having children would be difficult, they were not really affected, as at the time they were not thinking about having children. However, this changed when they wanted to have a baby:

‘And I remember that my general practitioner said, that it also would be, also would be if, that it would be more difficult to have children, he said then. But, then, yes, then I was not at all busy with that. Yes, “So what?” I thought then. Yes, looking back, I thought, Jesus, that’s stupid, that I didn’t, that I didn’t go after it, I thought’ (♀, 5).

Many respondents also mentioned that they brooded about their infertility:

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‘You can’t share it with others. You can’t tell your worries to anyone. If you want to tell them, they don’t understand. So each time you keep it inside yourself’ (♀, 10).

Issues related to acceptance (of childlessness, having fertility problems, needing medical assistance) and loneliness were mentioned several times. Feelings of emotional pain, anxiety, stress, shame, guilt and jealousy were also mentioned in some transcripts. Several women, but none of the men, mentioned a negative influence on their physical health (ii). This was mainly due to the side effects of the medication women they were taking or had taken. However, a few of the women mentioned physical complaints as a psychosomatic reaction to their infertility:

‘In the end, I could no longer walk, I felt so bad’ (♀, 10).

Negative changes related to the self-image (iii) were mentioned in several transcripts:

‘When I didn’t become pregnant, I felt handicapped, like I didn’t have an arm, have a leg’ (♀, 4).

Besides feeling handicapped (some cases), feelings of inferiority to fertile people (some cases) and the feeling of not being a ‘real’ woman or man (some cases) were mentioned:

‘It’s like, like, your maleness is, like, harmed. That’s how you feel. Like you’re not a man. Not a real guy’ (♂, 10).

4.3.2 Effects on the relationship with the partner

The effects of infertility on the partner relationship were mentioned in the majority of the transcripts. Seven sub-themes emerged in those transcripts: i) differences between partners, ii) changes in patterns, iii) sexuality, iv) love, v) communication, vi) arguments, vii) considering divorce as a partial solution.

Many transcripts revealed that there was a distinct difference within couples in how affected they were by their infertility (i). In all but one of these cases it was mentioned that the women were more affected by the infertility than the men were. The respondents related these differences to dissimilarities in strength of the desire to have a child, character, confidence in a successful outcome, and in being the one undergoing treatment. Both positive consequences (e.g., support, the situation being put into perspective) and negative consequences (e.g., feeling lonely, feeling unsupported by the partner, distrust) of these differences within couples appeared in the transcripts.

Some respondents mentioned that the patterns in their relationships had changed due to their infertility (ii). The following illustrates this change:

‘She puts pressure on me, she wants me to give her all my time. Leave late for work, come home early, don’t go anywhere at the weekend, don’t visit friends, stay at home. This is firstly because of something in herself, how she is made. Second, the fact that we have not produced a child brought this all out’ (♂, 4).

Other examples of changes in patterns were: change in the division of domestic work as the woman was feeling too ill, one of the partners seeking distraction elsewhere, and staying at home more often.

Several stories indicated that fertility problems had a negative influence on the sexual relationships within couples (iii). The most mentioned reason was that people had to have sex in their fertile period or because they had to undergo examinations (e.g., post-coital tests). However, also stress and the feeling that sex was ‘useless’ were mentioned.

Some respondents said that their fertility problem influenced their love for each other (iv). However, while some emphasized that their love had become less as a consequence of their infertility, a few other couples mention that their infertility had had a positive influence on their relationship. The positive effects mentioned were: feeling more responsible for each other, a stronger relationship and feeling more united.

In several cases the communication between partners was influenced by their infertility (v). In some cases, partners found it hard to talk about their fertility problem,

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mainly because they did not want to distress their consort. They were especially careful when their fertility problem was attributed to their partner:

‘I couldn’t talk calmly with my husband, because some things would hurt him a lot’ (♀, 10).

In this particular case, they also not discuss their infertility in their home because they wanted to keep it secret from his family, with whom they lived. In some cases, the communication about infertility was negatively influenced by limited Dutch or Turkish language skills due to migration to the Netherlands or due to growing up in the Netherlands, respectively. This limited language skills resulted for instance in difficulties in finding the right biomedical words in Turkish to translate or talk about their infertility:

‘But it does not always work, sometimes you can’t translate. Sometimes I do not understand him if he translates from Dutch to Turkish, sometimes he uses very different words. Then I ask him all the time, what it is it for instance’ (♀, 19).

Another example of the negative influence of limited language skills were distrusted translations by their partners:

‘I also did not trust my husband, because I thought that he was hiding things, some things. If he speaks to a doctor, he speaks really fast, I can’t understand that. If I ask him, then if the doctors, for example, talks for an hour, he tells me in ten minutes. Then I think if it takes an hour, it can’t be told in ten minutes, there has to be something behind that’ (♀, 4).

Furthermore, one woman mentioned that during her first marriage her partner deliberately mistranslated important information. As she did not know any Dutch at that time, she depended on the translations of her husband. However, when examination

results were discussed in the hospital, he did not translate to her that he was having fertility problems.

In some cases, the fertility problem caused tension and arguments between partners (vi). Various reasons were given for the arguments: the side effects of fertility drugs, distress about infertility, feeling isolated. The impact of these arguments differed strongly between the couples. In the cases of side effects, the impact of the quarrels was low:

‘Yes, I’m peevish sometimes [they both laugh]. That he thinks, what did I do wrong this time? ... But he also knows that it’s a side effect, that’s why he can ignore it. He doesn’t go on about or do something that will make it worse. But it’s not nice for you’ (♀, 7).

However, in a few cases arguments related to infertility had a more serious impact, resulting in partners considering relationship therapy, and seriously considering divorce or attempted suicide:

‘We quarreled, we made noises, we shouted, yelled, often she became depressed, even went as far as taking medicines’ (♂, 4).

In a few other cases, divorce was discussed as a possible option to give the partners the possibility to have children (vii).

4.3.3 Effects on the relationship with others

In the majority of the transcripts respondents mention the influence of their infertility on their relationship with others, in terms of reactions of others directly related to their infertility and in terms of their own behavior. In most cases, the reactions of others to the respondents’ childlessness play an important role. The following sub-themes were distinguished: questions (i), pressure (ii), gossip (iii) and stigma (iv). The majority were asked a lot of questions (i). Members of the family and the family-in-law often asked questions, as did friends and less close acquaintances. The questions ranged from ‘No children yet?’ (♀, 7) to more intrusive ones:

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‘Of course, then they ask what happened, what did you do, which medicines do you use, and then, do you have a sexual problem? What they think of, they ask’ (♀, 4).

It was explicitly mentioned in a few transcripts that women are asked more questions than men:

‘His family, they didn’t ask my husband, but me. Because they’re ashamed of my husband, because they lived far away for years, they didn’t ask him. And in Turkey, Turkish people, you can’t ask men there. A mother, an older sister might ask, but the family of my husband are not that kind of people. They asked *me*’ (♀, 4).

Furthermore, in some cases it seems more common for women than for men to ask questions:

‘But my father never said anything to me. Generally, I normally have my mother as a communication line. That’s common in every Turkish family’ (♀, 9).

Although in a few transcripts respondents mentioned that questions do not bother them, in most cases questions were perceived as annoying, difficult and/or unpleasant. The following citation illustrate this:

“‘Oh, I thought you had children”. A bit like. And then immediately they ask a second question, “Are you seeing a doctor?”, you know. Yes, and then I have the feeling, well, I only met this woman once, I really don’t want to tell my life history of eight, seven years. I won’t tell her. Maybe I’ll never see her again, why should I tell her? It also takes much of my energy and emotions, doesn’t it? I also suffer from telling my story every time, so to speak. I prefer to talk about other things, like soap operas for instance’ (♀, 9).

Many respondents also experienced these questions as pressure (ii) to become pregnant:

‘Those around you also put pressure on you, “Where’s your child, where’s your child?”’ (♀, 4).

Besides direct questions, several respondents were also aware of the gossip (iii) that not having children gives rise to, especially in the Turkish community:

‘But talking about gossip, because there are a lot of Turkish people here, especially in [name of neighborhood], everybody knows each other automatically, the good things the bad things, if you go or not, everybody knows each other. In the street it’s “Oh look, look, poor girl, she can’t become pregnant!” and so on. That’s something that bothers me, but I don’t want them to talk about me outside. So my family did not tell others’ (♀, 1).

In a few cases, respondents were not only afraid of or were expecting gossip, but had actually heard other people talking about them:

‘Then a lady behind me said: “Is that her child?” Two ladies were talking. “Is that her child?” she said. The other said: “It’s a pity, she can’t have children.” That really affected me. We’d only been married a couple of years. It wasn’t yet ten or eleven years. We’d only been married three or four years’ (♀, 10).

The above two accounts also exemplify that they are stigmatized (iv) – that is, seen by others as ‘a poor girl’ or ‘someone to ‘pity’ – because they can’t have children. This was mentioned many times. Respondents said that other people labeled them as, for example, pathetic, not fully male or female, not belonging or different, and not able to say anything about children.

‘Well, it, yes, it is... in our culture, yes I call it culture, it’s nothing to do with Islam, it’s seen totally differently. Between people. Like, “Why can’t

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they have children?’’ They won’t comfort you, but look at you in a different way’ (♀, 15).

In many cases, respondents related the questions, pressure, gossip and stigmatizing to the fact that in the Turkish migrant culture, having children is a part of marriage and is expected within a few years after getting married:

‘It’s generally obvious. You marry, and after a year or two, there will be children, as a matter of course. It’s self-evident in our culture’ (♀, 9).

One of the accounts illustrates that they also internalized this pronatalist norm:

‘But with Turkish youth, with Turkish families, the following is logical: if you’re married, then after say three to five years, or two years or one year, whatever, you start to think about having a child. That’s logical, and we also followed that logic, we also thought like that’ (♂, 19).

In many transcripts respondents mentioned that their own behavior towards others changed due to their infertility. A few women mentioned that they were not in the mood to see their family as often as they did before:

‘You know, they expect me to come over, to chat with them, to be sociable. But then I say, I can’t be sociable, leave me alone’ (♀, 2).

Also the relationship with friends was mentioned in some transcripts as being affected by their infertility. Although one man saw his friends more often because they distracted him from the fertility problem, the other transcripts revealed a more negative influence of infertility on the relationship with friends: they did not feel like seeing their friends, wanted to avoid questions or felt excluded. Especially, the relationships with people with children who did have children was mentioned as a complicated relationship in several transcripts:

‘Yes. Then, my eyes are on that. Then I become emotional and I see my husband finally pat my back and say, come on, it will be okay – one day. Yes. But, yes, deep in his heart it also hurts [interviewer: he also finds it difficult to see pregnant people?] Yes, because his own wife isn’t’ (♀, 15).

4.3.4 Disclosure

Decisions related to disclosure are closely linked to the previous theme. Issues related to the decisions about disclosure play an important role in the majority of the transcripts. The following subthemes were distinguished: i) to whom respondents disclose their infertility, ii) what they disclose and iii) excuses and deception. Just a few of the couples were open to everybody about their infertility, their treatments and the causes of their infertility. Most couples, however, were very selective about to whom they disclosed their infertility (i):

‘We told it to our immediate circle. . . . My parents, my husband’s parents, brothers, sisters and a couple of friends know. Real close friends. Besides them, nobody knows’ (♀, 12).

In some cases, however, respondents said that they were hiding their fertility problem from their parents because they did not want to hurt them. Additionally, in a few cases respondents were afraid that their parents or their parents-in-law would pressure them to divorce. In some cases, respondents had disclosed their infertility to their employers, as they had to ask for time off to visit the hospital. Of the couples who did disclose their infertility to certain others, some were selective about what they said (ii): they did not give exact information about causes or treatment. The reasons given for not providing exact information were related to existing misconceptions about treatment and the lack of biomedical knowledge about infertility among others:

‘Because some people, especially older people, they don’t know what IVF is, or they think that it’s from different seed. And then you don’t explain fully, or you don’t waste your time on it’ (♀, 9).

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In a few cases, respondents lied about to whom their fertility problem could be attributed, transferring the cause of the infertility from the man to the woman:

‘They [her parents] think it could be attributed to me. And actually I want them to think like that. ... Yes, in our culture it’s worse for a man than for a woman. For a woman, they can accept it, but if it’s a man... Okay, I do think differently about it, but other people don’t’ (♀, 14).

‘Especially. Look. Especially there are still people who, who don’t know what they’re talking about, and they really say stupid things. And yet you feel they’re talking about you? You go to the coffee house; only men go there. Well, look, all kind of subjects are discussed, sport, everything, then they also talk about...that. Yes about, about a man, who, I don’t know, can’t have children. They won’t say. They. They immediately think, that he doesn’t have genitals. They think something like that. Or that it’s far too small’ (♂, 10).

A few women also mentioned that taking the responsibility for the fertility problem would also protect them from being accused of adultery when they do become pregnant.

For many couples infertility led to the concealing of an important part of their lives from certain others. Many couples kept quiet about their infertility, while several others made up stories and told lies (iii) when asked about their childlessness:

‘Yes, in the beginning, right in the beginning, I told them, “No, we don’t think about it. First he’s got to find a job” and things like that. And then, I told them, yes, you know a bit, ignore it. Erm, led them on to a different subject. “Yes, in the future. We’re not thinking about whether or not we want children” and that kind of things. But at a certain moment. Yes’ (♀, 9).

In a few cases, respondents said that they do not like to lie:

‘You don’t want that, because I don’t like to lie’ (♀, 15).

4.3.5 Coping

Throughout the transcripts, eight themes were distinguished that helped the respondents to deal with their infertility: (i) hope and confidence, (ii) faith, (iii) support from others, (iv) patient solidarity, (v) media, (vi) distraction, (vii) proactive attitude, (viii) other sources.

Statements of hope and confidence (i) in a positive outcome – namely a biologically related child – run through the majority of the transcripts:

‘That, that feeling that some day it will happen. I think, that hope, you just hold onto it’ (♀, 12).

Nevertheless, in several cases also moments of despair and a lack of hope were mentioned.

Additionally, several transcripts revealed a high level of trust in technological developments in the medical world and in the medical world itself. One man put it as follows:

‘And I don’t believe the following: that there won’t be a solution. Why? The technology is improving every day, surely they will come up with something’ (♂, 19).

Another aspect that helped many of the respondents to cope with their infertility is support from others (ii). The most mentioned sources of support were: partners (in many cases), family (many cases), doctors (many cases), friends (many cases), work (some cases), psychologists (a few cases) and neighbors (a few cases). Besides support from persons, in several cases respondents also felt supported by their faith (iii):

‘I believe and therefore I still have hope’ (♀, 6).

Also having contact with or knowing about other people who have fertility problems was a source of support in many cases (iv):

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‘That’s quite useful, that’s a positive thing, the feeling that you’re not the only one’ (♀, 12).

In many cases, respondents referred to the growing interest in fertility problems on the part of the Turkish media (v), especially Turkish television. This provided them and others in the Turkish and Turkish migrant community with knowledge about infertility:

‘It was not normal that. But now you hear about it daily. Those doctors... Those doctors are all on television, so’ (♀, 18).

Some respondents mentioned seeking distraction (vi) as a way of getting their fertility problem temporarily off their minds. Furthermore, in some cases respondents said that they felt supported by a proactive attitude (vii):

‘Yes, we got our referral immediately. I think I, said that instead of six months, we’d been trying for eight, nine months. . . . Actually, I’d already made an appointment with the gynecologist. This is, yes, perhaps it’s the Turkish way’ (♀, 16).

Other less often mentioned sources of support (viii) were, for example, the idea that it could be worse, the idea that it would be treatable, knowing the cause, the idea that at least they had tried everything, and the fact that postponing parenthood is common in the Dutch culture.

4.3.6 The future

With respect to the influence of infertility on ideas about the future life of the respondents, it appeared from the transcripts that several couples did not consider or discuss a future different from their original plan, that is, a future with a child who is biologically related to both partners. The reasons given were: confidence and hope that they would have a child, confidence in medical possibilities and technical developments, only thinking about the present, and too afraid to think about the future

During the interview the following themes emerged when discussing their future: i) life without children, ii) life with adopted children, iii) life with partly biologically related children, iv) work and schooling/education, v) lacking of a goal in life.

Two couples in this sample had already decided to continue their lives without children (i). Both gave priority to their own health above having a child. In many other cases the possibility of a future without a child was mentioned. In many cases it was mentioned that marriage and life amount to more than having children:

‘I didn’t marry to have a child’ (♂, 1).

‘He told me a couple of times that if it doesn’t work, we’ll stay together and we’ll be happy together, and that sort of things’ (♀, 12).

Interestingly, men more often brought this up. Not wanting to have children after a certain age was mentioned in some cases. In a few cases, respondents mentioned that they did not want to have to undergo treatment after treatment. Furthermore, in a few cases remaining childless was mentioned as something that, in the end, one has to accept:

‘I have. I have the feeling that it will be alright. Yes, and if not, so, it’s something that God wants, then we’ll accept it. I mean, what else can we do?’ (♀, 14).

In many cases, one or both partners had considered adoption (ii). However, only a few couples seriously considered it and agreed that adoption was a possibility for their future. Regarding a child who is only partly biologically related (iii), only a few couples agreed on gamete donation (namely egg donation) as a possible treatment to obtain a future life with a child, and none of them saw inter-familial adoption as a feasible option.

A few couples mentioned that they focused more on work and schooling (iv) because they did not have children. In some transcripts, not having children was equated with lacking a goal in life (v):

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‘But it also influences your outlook on life. For example, more like, what use is it to save money? Sometimes we talk about it, and then I say “Yes, but what’s the point?”’ (♀, 12).

4.4 Discussion

This study investigated the experiences of 20 involuntarily childless Turkish migrant couples in the Netherlands. The experiences of the Turkish migrants concerning their infertility were clustered around six superordinate themes: effects on self; effects on the relationship with the partner; effects on the relationship with others; disclosure; coping; and the future. These superordinate themes correspond with dominant themes in the literature on other involuntarily childless samples (both Western and non-Western) (e.g., Dyer et al., 2004; Greil, 1997). However, the extent to which the themes played a role in the experiences of the involuntarily childless Turkish migrants in this study reflect certain characteristics of the Turkish migrant culture that distinguish their experiences from those of other involuntarily childless couples (particularly Western couples). The characteristics, or underlying aspects, that come to the front most in the narratives are: the strong pronatalism, misconceptions about infertility, and specific migration related aspects.

4.4.1 Pronatalism

In this study, the existing pronatalist social norm in the Turkish migrant culture played an important role. A majority of the respondents referred either implicitly or explicitly to the social norm to have children who are biologically related to both partners. This pronatalist social norm appears to be even stronger than the pronatalism mentioned in studies among Western couples (e.g., Miall, 1994). Interestingly, none of the respondents explicitly referred to the religious duty of Muslims (Islam is the main religion among Turkish migrants) to procreate, which has been put forward as an important contributor in other studies (e.g., Gunay, Cetinkaya, Nacar, & Aydin, 2005; Schmid et al., 2004a, 2004b). In the present study, the strong pronatalist social norm appears to give rise to a large number of questions related to their childlessness

from a wide variety of people, and a relatively high degree of pressure (both from in and outside the family and the family-in-law) to conform to this social norm. There are some indications that women are asked more questions about their childlessness than men are, which might intensify the negative experiences of Turkish migrant women. Fear to be pressured by their families to get divorced if they disclosed their partners' infertility was mentioned now and then. Their fears are supported by several studies about infertility in Turkey (Gulseren et al., 2006; Guz et al., 2003).

Failing to conform to the strong pronatalist social norm, probably led to gossip about and the stigmatization of a sizeable proportion of this sample. The influences of a strong pronatalist ideology on a high degree of stigmatization of childless couples has also been reported among previous studies among Turkish migrants outside the Netherlands (e.g., Kentenich & Yuksel, 1997; Schmid et al., 2004a), other non-Western migrants (e.g., Culley & Hudson, 2006) and non-Western couples (e.g., Daar & Merali, 2001; Inhorn & Van Balen, 2002). In this study the stigma of childlessness was gendered to some extent (see also Culley & Hudson, 2006). For women, the stigma tends to be associated with not being a mother and being responsible the infertility, while for men it tends to be associated with virility. In order to reduce gossip and stigmatization, the majority of the respondents disclosed their fertility problem only to a very selective group and were also selective in what exactly they told others about their fertility problem (in line with Schmid et al., 2004b). However, very selective disclosure might not reduce questions and stigmatization: Whiteford and Gonzalez (1995) found that when couples did not tell others about their fertility problems they also suffered from joking questions regarding, among other things, their sexual behavior. Moreover, concealing a part of your life and making up stories might also lead to negative complications, such as having to remember what you said to whom, causing difficulties by being inconsistent and feeling bad about not telling the truth. Smart and Wegner (2000) also emphasized the psychological costs of secrecy. Nevertheless, studies about the relationship between disclosure of infertility and distress do not show unanimous conclusions regarding the direction of the relationship (cf. Slade, O'Neill, Simpson, & Lashen, 2007; Van Balen & Trimbos Kemper, 1994). In this study, the pronatalist Turkish migrant culture and the resulting stigmatization seem to intensify the personal grief arising from the inability to have a child, resulting in in-

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tense emotional distress in those who fail to conform to those norms. This is in line with findings in other studies (e.g., Slade et al., 2007). Lastly, the high degree of pronatalism is related to constraints for Turkish migrants in their thinking about their future in ways other than with a child who is biologically related to both parents (see also Gacinski et al., 2002; Kentenich & Yuksel, 1997)

Nevertheless, it is remarkable that most couples in this study were able, to some extent, to resist the pressure brought about by their surroundings: the majority has found ways to alleviate their involuntary childlessness, few mentioned divorce, some mentioned strengthening of the relationship, and many people mentioned that they would continue their marriage when not being able to have a child. Especially the latter suggest that Turkish migrants are to some extent able to challenge dominant norms and may resist pressure and stigma (see also Culley & Hudson, 2006).

4.4.2 Misconceptions

A second aspect underlying the experiences of involuntarily childless Turkish migrants seems to be misconceptions about infertility and infertility treatment. In the present study, misconceptions about infertility and its possible treatments in the wider Turkish community and the Turkish migrant community, led in particular to selective disclosure. Most misconceptions that were mentioned concerned men in particular: men can't have fertility problems, all male fertility problems being untreatable and infertility being equated with impotence. In the majority of the cases with a male cause in this study, couples decided to disclose their fertility problem as a female problem to protect the men from slander about their sexual functioning and sometimes also to protect the women from being accused of adultery when becoming pregnant, as those around them were unaware of the treatment possibilities for male fertility problems. It should, however, be mentioned that disclosing male infertility as female infertility to protect men from being joked about their sexual functioning is not a typical Turkish mechanism; it has also been observed in other, Western and non-Western studies (e.g., Inhorn, 2003c; Peronace, Boivin, & Schmidt, 2007; Remennick, 2000; Throsby & Gill, 2004; Webb & Daniluk, 1999). Suggesting that also within the Western world male infertility is still associated with impotence.

Possible reasons for the existence of misconceptions among a part of the Turkish migrants and Turkish people, are that people who have grown up in Turkey might have had little opportunity to acquire knowledge about bodily functions, infertility and infertility treatments, as this is not included in the educational system (Gacinski et al., 2002).

4.4.3 Migration related aspects

A third type of characteristics of Turkish migrants that seem to be influencing their experiences, is directly related to their migrant status and might therefore also be applicable to other migrant groups. First of all, the contact with the Turkish culture in Turkey is seems omnipresent among most Turkish migrants. For example, the Turkish migrants in this study mention reactions of Turkish people in Turkey and are watching Turkish television. Furthermore, the influx of new Turkish migrants due to marriages is still very high (Hooghiemstra, 2003). Therefore, improving knowledge about infertility and infertility treatments should come as well from Dutch sources as from Turkish sources. There are indications that Turkish migrants are acquiring more knowledge about infertility as they become better informed about reproductive issues during their stay in the Netherlands. For example, the Dutch educational system addresses reproductive issues, and a variety of other information on reproduction is readily available in Dutch society. Fortunately, the Turkish media have been paying increasing attention to infertility which might also result in fewer misconceptions among Turkish people and Turkish migrants.

The present study also found another interesting contributing migrant-related aspect: the role of deficiencies in language skills in the communication with the partner about their infertility. In consultations with doctors, it is common that one partner translates everything for the other partner if only one of them is able to understand Dutch. However, this study showed that not all Turkish migrants are able to translate everything resulting in miscommunications due to a limited knowledge of the language of origin: mastering medical vocabulary is not the same as mastering communications about daily issues. This might also influence their daily communication about their infertility. Furthermore, this study also indicates that sometimes translations are distrusted by partners or that partners are intentionally withholding informa-

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tion from their partners. Health care workers should be alert to these possible problems. Identical information folders in both languages would help to overcome these problems to some extent.

Limitations of this study should be mentioned. Firstly, the sample was obtained through double self-selection (Smith, 1999): people first agreed to participate in the questionnaire study and later decided to also participate in the interview study. As the personal demands on respondents were high in both studies, the sample obviously comprised respondents who were rather more motivated to discuss their experiences. The respondents also had a relatively high educational level compared to the total Turkish migrant sample in the Netherlands, as they were recruited from a sample with a high level of education (Van Rooij et al., 2007). Both factors might have caused a less diverse sample than the existing diversity in the Turkish migrant community at large, and therefore might represent only a subset of the experiences that exist in the Turkish migrant community. Besides, couples where male fertility problems play a role are relatively underrepresented. Furthermore, a different researcher identity might have yield somewhat different accounts, but might also have led to less people joining the study: a number of our respondents mentioned that they were less worried that the interviewer would know other people they know, and this encourages them to join the study and to speak more frankly (in line with Elam & Fenton, 2003). Next, the accounts of couples interviewed together might differ from the accounts of women interviewed alone. Nevertheless, sensitive issues like negative effects on the relationship with partners were mentioned in both couple interviews and single interviews.

In conclusion, though not all infertile Turkish migrants are equally affected, involuntary childlessness is a very problematic experience for most infertile Turkish migrants, strongly influencing their current life as well as their future. Pronatalism, misconceptions about infertility and its treatments, and migrant related aspects like deficiencies in mutual language, appear to be important cultural aspects influencing the experiences of involuntarily childless Turkish migrants.