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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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## **6 Infertile Turkish migrants: help-seeking behavior and decision-making\***

*Help-seeking behavior, decision-making processes and acceptance of treatments involving a third party were investigated among involuntarily childless Turkish migrants in the Netherlands. Thirty-five couples (23 couples, 1 man, 11 women) were recruited within and outside biomedical services to participate in a structured questionnaire study. Twenty of the couples (11 couples, 9 women) also participated in a qualitative interview study about their decision-making processes regarding biomedical help. These processes were classified according to a typology developed by Verdurmen (1997): the 'follow the doctor', 'step by step', 'taking control' and 'setting limits' types. Findings show that all couples sought biomedical help in the Netherlands, and nearly half also used infertility services in Turkey. About half of the couples also used non-biomedical help. Other options like interfamilial adoption, adoption, fostering or pursuing other life goals were hardly considered. The most observed type was the 'taking control' type, followed by the 'step by step' type. Most couples were active in their help-seeking, sought help relatively early and set few limits (except on treatments involving a third party, as a result of religious and other motives such as desiring a genetic link).*

### **6.1 Introduction**

Infertility – defined as the inability to become pregnant after a year of trying to conceive a child through regular intercourse – affects a considerable part of the world population (Boivin et al., 2007). Particularly involuntary childlessness is usually a distressing experience and has far-reaching psychological and social consequences (Greil, 1997; Van Balen & Inhorn, 2002). This is especially relevant in developing

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countries, where involuntary childlessness often leads to serious stigmatization and marital or social violence, and often has legal, economic or religious consequences (Van Balen & Inhorn, 2002). Also for non-Western migrants in Western countries there are indications that involuntary childlessness has greater psychological and social consequences than it does for Western couples (Van Rooij et al., 2007).

Infertility experiences often extend over a rather long period, during which various possibilities emerge. Infertile couples may choose more than one possibility, either in parallel or in succession (Van Balen, Verdurmen, & Ketting, 1997). The decision-making process regarding infertility is special in several ways. For most people, the desire to have a child is a very essential desire (Dyer, van der Spuy, Maritz, & Mokoena, 2008). Nevertheless, one of the options is not to seek treatment or to stop at a certain point and try to learn to live with the infertility problem (Van Balen & Verdurmen, 1999). Furthermore, infertility and the resulting involuntary childlessness involve both partners. The decision-making process regarding handling infertility is more likely to be a joint process (Verdurmen, 1997).

Based on qualitative interviews with infertile Dutch couples regarding their help-seeking behavior and decision-making processes within the biomedical system, Verdurmen distinguished four types of infertile couples: the 'setting limits', 'taking control', 'step by step' and 'follow the doctor' types (1997). Couples of the first type are most skeptical regarding medical help, they set limits beforehand and seriously consider possible steps (like not having IVF). The taking control type couples are more positive towards medical help, are actively involved in the decision-making, take initiatives and may set limits after a while. The step by step type couples are less active, await the decisions of the physicians and then consider them. The follow the doctor type couples will do anything the doctor proposes, as 'the doctor knows best'. They are positive towards seeking help and do not initiate possibilities themselves. In the study by Verdurmen, eight (29%) belonged to the setting limits type, eight (29%) to the taking control type, four (14%) to the step by step type, and eight (29%) to the follow the doctor type.

There are indications that the help-seeking behavior of involuntarily childless couples differs across cultures, due to differences in explanatory models of infertility, dif-

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ferences in the cultural meaning of procreation and parenthood, differences in the availability and accessibility of infertility services, and religious regulations (Inhorn & Van Balen, 2002). With the exception of a few studies (Culley et al., 2004; Eggert, Li, & Sundquist, in press, Available online 19 September 2007; Yebei, 2000), little attention has been paid to the help-seeking behavior of non-Western migrants in Western Europe. Also in the Netherlands, where 11% of the current population is of non-Western origin, little attention has been paid to involuntarily childless couples of non-Western origin (Statistics Netherlands, 2007).

The current study highlights the help-seeking behavior of one of the largest non-Western migrant communities in the Netherlands: Turkish migrants (Statistics Netherlands, 2007). The help-seeking of infertile Turkish migrants is of particular interest for several reasons. First, it provides an insight into infertile migrants' access to and use of biomedical infertility services (Dutch infertility services do not routinely collect data about the ethnic background of patients) (Evenblij et al., 2004). Second, there are indications that Turkish migrants differ from the indigenous Dutch regarding the choices they make (Kertenich & Yuksel, 1997). Turkish migrants may perceive fewer possibilities than do the indigenous Dutch regarding biomedical treatments, as Sunni Islam does not allow artificial reproductive technologies (ARTs) involving a third party. Also adoption is prohibited (Inhorn, 2006; Meirou & Schenker, 1997; Serour, 1996), although it is legal in Turkey. The degree to which Turkish migrants are aware of these fatwa's and adhere to them might vary (e.g., Isikoglu et al., 2006). Several studies suggest that interfamilial adoption is also an option among Turkish migrants (Gacinski et al., 2002). Furthermore, Turkish migrants might be more motivated to seek help than indigenous people are, as procreation is highly encouraged by both the Turkish community and the dominant religion, Sunni Islam (Husain, 2000; Statistics Netherlands, 2007; Van Rooij et al., 2006). Having children might therefore be not only of personal but also of social importance. Third, early studies indicate that the behavior of Turkish migrants differs from that of indigenous Western European couples in terms of decision-making processes and how long they wait before seeking help. Gacinsky and colleagues found that Turkish migrants in Germany are very willing to take any treatment and do not set limits (Gacinski et al., 2002). Therefore, the numbers of Turkish migrants belonging to the setting limits type might be lower than

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among infertile indigenous Dutch couples. It could also be expected that Turkish migrants take a more active stance than do the indigenous Dutch, as Turkish migrants might be accustomed to the Turkish medical system, which has a more, active, customer-centered, attitude to infertility treatment and focuses more on the desires of the patients than the Dutch medical system does (Hunault et al., 2004; Karaman, 2005). We hypothesize that there are fewer follow the doctor types than among indigenous Dutch couples. Finally, there are indications that Turkish migrants might seek help after a shorter period of infertility than is the case with indigenous Western European couples (Scholtz et al., 1999).

The first part of this study provides an insight into the initial thoughts about overcoming infertility, the willingness to have certain treatments and the actual help-seeking behavior of Turkish migrants. The second part focuses on the four types of treatment-seeking (Verdurmen, 1997) and on the timing of seeking help.

## **6.2 Methods**

### **6.2.1 Part 1**

#### *6.2.1.1 Recruitment*

Infertile Turkish migrants in the Netherlands who were involuntarily childless in their current relationship were recruited from both inside and outside the Dutch medical system. In total, 35 couples participated in the study; in 23 cases both partners participated, in one case only the man participated and in 11 cases only the woman participated. Eighteen couples were recruited through hospitals by a member of the medical team. He or she distributed a Dutch and Turkish information letter to all infertile Turkish migrant patients. Patients indicated their willingness or unwillingness to participate in the study on an informed consent form. As only a few hospitals reported the numbers of patients who chose not to participate, no response rates can be determined; however, the few hospitals that did mention the negative responses indicate that a majority of patients did not want to participate. The other 17 couples were recruited through other means, mainly through advertisements on the website of the

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Dutch patient association for people with fertility problems (Freya), through advertisements in Turkish-Dutch magazines and via Turkish migrant community workers.

#### *6.2.1.2 Procedure*

Participants completed a structured written questionnaire (in Dutch or Turkish) under the supervision of an interviewer. The interviewer was present to help, if necessary, and to certify that the partners answered the questionnaire separately when both participated. To obtain the Turkish version of the questionnaire, questions were translated into Turkish and independently back-translated. Additionally, several experts (medical, Turkish and anthropological) and laypeople were consulted on the cultural relevance and comprehensibility of the questionnaire (Van de Vijver & Tanzer, 2004). A preliminary version of the questionnaire was tested during a pilot study, but no changes to the questions were necessary.

#### *6.2.1.3 Instruments*

*Initial thoughts about overcoming infertility* were measured by asking ‘When you discovered that you did not become pregnant, did you have the feeling that this problem was solvable?’ (1= I believed we couldn’t do anything about it ; 2= I believed there would be little chance; 3= I believed there would be some chance; 4= I believed there would be a good chance; 5= Yes, I was convinced). They were also asked about what kind of help they thought about seeking (1= biomedical treatment; 2= non-biomedical treatment; 3= other).

*Willingness to use biomedical treatment involving a third party* was measured by asking ‘Would you use the following treatments to obtain a child?’ (1= no; 2= yes; 3= don’t know). The following treatments were presented: artificial insemination with donor seed (AID), egg donation, surrogate mother with couple’s sperm and egg, and surrogate mother with couple’s sperm and surrogate mothers’ egg. If people indicated ‘no’ or ‘don’t know’, they were asked to clarify their answer. The answers to the open questions were grouped into four categories: religious, emotional, genetic and other reasons.

*Help-seeking history.* The following aspects were assessed: chosen options (biomedical help, non-biomedical help, adoption, interfamilial adoption, fostering, pursu-

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ing other life goals); steps used within biomedical system (GP, specialist, examinations, treatments); country in which help was sought. If they were using infertility services in Turkey they were asked to indicate their reasons for doing so. Help-seeking history is reported at couple level.

*Socio-demographic variables.* The following socio-demographic variables were assessed: ethnicity, age, educational level, religion, religiosity, residence, duration of awareness of infertility (months), and attribution of infertility (to man, woman, both or unexplained; as reported by the participants), place of birth, place of upbringing, reasons for migration to the Netherlands, duration of stay in the Netherlands. Ethnicity was assessed by the country of birth of the participants and of their parents. Participants were defined as Turkish migrants if they were living in the Netherlands and they or one or both of their parents had been born in Turkey. Educational level was assessed by grouping the participants' highest level of completed education into three categories: low (no or primary education, and lower academic or lower vocational secondary school), intermediate (higher academic secondary or middle-level vocational school) and high (education on a higher academic or vocational level). Religiosity was assessed by the question 'How important is your religion in your daily life?' (1= very important; 5= not at all).

#### *6.2.1.4 Analyses*

Descriptive analyses were conducted using SPSS. Wilcoxon matched-pairs signed-ranks test was used to assess the differences between partners regarding willingness to use treatments involving a third party.

#### *6.2.1.5 Demographic background*

The socio-demographic characteristics of the Turkish migrants regarding age, education, religion, urbanization and infertility history are given in Table 6.1. No differences were found between women and men regarding the attributed cause of the infertility.

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*Table 6.1 Socio-demographic characteristics of participants*

		Women (N=34)	Men (N=24)
Age	<i>M (SD)</i>	29.26 (6.73)	33.46 (7.78)
Education:	Low	32%	33%
	Intermediate	53%	42%
	High	15%	25%
Religion:	Islam - Sunni	80%	83%
	Islam - Alevi	6%	0%
	Islam - other	6%	4%
	None	9%	13%
Importance of religion	<i>M (SD)</i>	2.19 (0.54)	2.10 (0.44)
Residence:	Large cities	71%	68%
	Small cities	24%	25%
	Villages	6%	8%
Awareness of infertility (months)	<i>M (SD)</i>	50.51 (54.64)	37.16 (39.07)
Attributed cause of infertility:	Female	53%	61%
	Male	12%	17%
	Female and male	15%	9%
	Unexplained	21%	13%
Born and predominantly raised in:	the Netherlands	15%	17%
	Turkey	85%	78%
	Other		5%
Raised in Turkey in:	Large cities	52%	45%
	Small cities	19%	30%
	Villages	26%	20%
	Cities and villages	4%	5%
Migration reasons: or family reunion	Together with family or family reunion	46%	15%
	Marriage	41%	50%
	Economic		15%
	Other	7%	20%
Length of stay in the Netherlands:	<10 years	46%	55%
	>10 years	54%	45%

## **6.2.2 Part two**

### *6.2.2.1 Recruitment*

Thirty-one respondents (11 couples, 9 women) from the first sample agreed to participate in the in-depth interview study. For various practical and other reasons (e.g., ‘Too hard to talk about it’), nine men did not participate.

### *6.2.2.2 Procedure*

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 when they first discussed having children with their partners until the time of the interview; and their help-seeking behavior (chosen options, steps, timing). A total of 20 interviews were conducted, comprising 20 cases. The interviews were audiotaped and transcribed verbatim. In two cases the interviews could not be audiotaped; notes were therefore taken during the interviews and further elaborated immediately afterwards. All interviews were conducted by the first author in the respondents’ homes in their preferred language (Dutch or Turkish). When both partners participated, they were interviewed together (Van Rooij, Van Balen, & Hermanns, submitted for publication).

### *6.2.2.3 Analyses*

All transcripts were entered in MAXqda 2007 (Verbi Software, 2005), a computer program used to structure qualitative data.

*Timing of seeking biomedical help.* This was calculated on the basis of the couples’ information regarding when they actively started to try to conceive and when they first sought biomedical help.

*Typology.* To typify the biomedical help-seeking behavior of the couples according to the typology of Verdurmen (1997), the transcripts were first coded on four dimensions that constitute the types: active involvement, thinking about how far to go in order to become pregnant, reflecting on steps, and obviousness of steps. Subsequently, each couple/case was classified as one of the distinguished types: setting limits, tak-

ing control, step by step, and follow the doctor types. Intercoder reliability was sufficient ( $\kappa=.67$ ).

#### *6.2.2.4 Demographic background*

The men and women in the subgroup did not differ from the men and women in the whole sample regarding age, religiosity, duration of infertility, place of birth or migration reasons. However, there were significantly fewer low educated men,  $X^2=18.14$ ,  $p<.01$ , fewer men who grew up in villages,  $X^2= 9.60$ ,  $p<.05$ , and fewer women who reported unexplained infertility,  $X^2=5.66$ ,  $p<.05$ .

## **6.2 Results**

### *6.2.1 Initial thoughts regarding overcoming infertility*

Both men and women believed that they had a good chance to overcome their fertility problems when they were first confronted with them (respectively,  $M=4.25$ ,  $SD=.94$ , and  $M=4.12$ ,  $SD=1.05$ ). All women (100%) and almost all men (96%) thought that biomedical treatment would be the best solution for their fertility problems. A minority of women (19%) and men (17%) also believed that non-biomedical treatment would solve their problem.

### *6.2.2 Willingness to use biomedical treatments involving a third party*

The willingness to, if necessary, use several biomedical treatments is reported separately for Turkish migrant men and women in Table 6.2. No significant differences were found between women and their partners in the percentages willing or unwilling to use such treatments (donated eggs, donated sperm, surrogacy). Reasons for answering ‘no’ or ‘don’t know’ were clustered around four types of motives: religious, genetic, emotional and other. The frequencies of these motives are presented in Table 6.2.

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*Table 6.2 Treatments involving a third party: willingness and motives regarding doubts or rejection (more than one motive possible)*

		AID	Egg donation	Surrogacy: couple's egg/sperm	Surrogacy: other's egg and own sperm
<i>Willingness</i>					
Women (N=29-32)	Yes	21%	27%	17%	7%
	Don't know	7%	13%	17%	17%
	No	72%	60%	67%	77%
Men (N=20)	Yes	5%	20%	35%	20%
	Don't know	0%	5%	20%	10%
	No	95%	75%	45%	70%
<i>Motives</i>					
Women (N=13-17)	Religious	39%	24%	23%	20%
	Emotional	23%	12%	46%	26%
	Genetic	31%	41%	31%	60%
	Other	23%	24%	23%	13%
Men (N=6-8)	Religious	63%	29%	17%	13%
	Emotional	13%	43%	50%	0%
	Genetic	13%	29%	17%	13%
	Other	25%	29%	50%	75%

*6.2.3 Help-seeking history*

*Biomedical treatment.* All couples had accessed the Dutch biomedical system because of their fertility problems. The majority (97%) first went to their GPs; a minority directly contacted their specialists as they were already consulting them for related problems. In the end, all couples consulted specialists and had examinations because of their infertility (with the exception of two men). All but one couple were having treatment or had completed treatment for their infertility. One couple was on a wait-

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ing list. Five couples had stopped having treatments (three definitely and two temporarily). Of all couples, 43% had also consulted infertility specialists in Turkey. Four types of reasons were given: give it a try, information in own language, second opinion, better or faster medical help.

*Non-biomedical treatment.* In addition to biomedical care, 49% of the couples had also used at least once some sort of non-biomedical treatment. Of these couples, 56% had consulted a homeopathic doctor or acupuncturist in the Netherlands or Turkey; 38% had consulted a religious healer in the Netherlands or Turkey; 31% wore a religious amulet (muska) related to their involuntary childlessness; 31% had visited hot springs because of their infertility; and 50% had visited tombs. Two couples had used all five non-biomedical options, two couples had used three options, five couples had used two options and eight couples had used one option.

*Adoption, interfamilial adoption, surrogacy and pursuing other life goals.* Of the three couples that had stopped having treatment, one couple had decided in favor of adoption. At the time of the data collection, the couple were on a waiting list to adopt a child. The other two couples had chosen to focus on other life goals. None had opted for surrogacy or interfamilial adoption.

*Timing of seeking biomedical help (N=20 couples).* Three couples had sought biomedical help directly after deciding to have a child as they had been aware of their infertility. One couple had sought help three months after having a miscarriage. Of the remaining 16 couples, eight had sought help within 6 months after actively trying for a child, five within 7-12 months and three waited 13-36 months.

*Help-seeking typology (N=20 couples).* The majority (13 couples) were classified as the taking control type; six couples were classified as the step by step type; one was classified as the setting limits type; and none belonged to the follow the doctor type.

## **6.4 Discussion**

This study examined the help-seeking behavior of involuntarily childless Turkish migrants in the Netherlands. All respondents counted on overcoming their infertility by means of biomedical treatment. The biomedical option also appears to be the most common option in studies among other populations (Van Balen et al., 1997). How-

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ever, it is expected that the number of participants choosing other options increases over time when the duration of infertility becomes longer and they do not succeed in having a child through biomedical treatment (Gunay et al., 2005; Van Balen et al., 1997).

All couples in this study, including those recruited from outside the biomedical services, had sought biomedical help in the Netherlands. This indicates that Turkish migrants know how to seek biomedical help and that the Dutch biomedical system is accessible to Turkish migrants. In this, it is helpful that the Dutch national health insurance system covers several infertility treatments (Eggert et al., in press, Available online 19 September 2007). However, monitoring and registration of ethnicity by the biomedical services is recommended in order to establish whether these findings are generalizable to the whole Turkish migrant community. Such registrations would also provide insight into the utilization of treatment among other ethnic groups.

The results of this study also suggest that more Turkish migrants than indigenous Dutch seek biomedical help. In a study by van Balen and colleagues, 86% of Dutch couples sought medical treatment (Van Balen et al., 1997). This might be explained by the higher degree of pronatalism within the Turkish migrant community, the higher social importance of having children in that community (Van Rooij et al., 2006) and the pressure from their community to seek biomedical help (Bunting & Boivin, 2007; Scholtz et al., 1999). Also, Islam – which is of importance to the majority of this sample – is not obstructive regarding seeking help (Husain, 2000). The above aspects might also partially explain the early start in seeking help. However, the early start might also indicate possible misconceptions about how long it normally takes to become pregnant. It is important to explore this further, as interventions could be developed to overcome this possible misconception.

In line with findings among Turkish migrants in Germany (Gacinski et al., 2002), a substantial part of the sample had also used the biomedical system in Turkey. Three of the motives given for doing so appear to be important to discuss: information in own mother tongue, second opinion, and better or faster medical help. Regarding the first, although Turkish migrants do access Dutch medical systems, there are often linguistic barriers between Turkish migrants and their physicians, resulting in insuffi-

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cient information. Studies among other medical disciplines report that communication problems might have a number of negative consequences, like increased chances of non-compliance, feelings of fear and despair, problems in achieving rapport, and dissatisfaction (Flores, 2005; Meeuwesen, Bruijnzeels, Harmsen, & Bernsen, 2006; Schouten & Meeuwesen, 2006). Motives like second opinion and better or faster medical help imply that people have their doubts or are not satisfied with the Dutch system. These doubts might be caused by, for example, differences between the Dutch and the Turkish medical system.

In line with expectations, few setting limits types and no follow the doctor types were found among the subsample of Turkish migrants. Most couples exhibited the taking control pattern (showing initiatives, looking up information, searching for other options). Furthermore, it might well be that the differences between the findings of this study and the study by Verdurmen and colleagues (1997) can be explained by the time of recruitment of the respondents (1993 versus 2004/5). It seems plausible that with the growing access to the Internet, people in general are more likely to seek information outside the hospitals they visit than was the case a decade ago. In addition, there is a trend towards more customer-oriented care. Furthermore, the general climate towards more invasive fertility treatments like IVF might have become more positive, resulting in people setting fewer limits. However, the majority of the Turkish migrants in this study do set limits regarding the acceptance of gametes donation and/or a surrogate mother: only a few are willing to use them. There are no differences between husbands and wives regarding this acceptance, and their religion is not the only reason for them to reject these options: motives in the sphere of emotions, a missing genetic link between the child and one of the partners, and other motives also play an important role. The low willingness to use treatments involving gametes donation is also a common finding among non-Islamic people (Kentenich & Yuksel, 1997).

It should be noted that the current study was not population based and was relatively small. Furthermore, the sample is relatively highly educated compared to the general Turkish migrant population in the Netherlands (Statistics Netherlands, 2007). Gunay and colleagues (2005) found that among infertile Turkish couples in Turkey, people with a lower level of education were more likely to turn to non-

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biomedical traditional practices besides biomedical practices, than were people with a higher level of education.

All the Turkish migrants who participated in this study had sought biomedical help in the Netherlands, and a sizeable number had also done so in Turkey. The moment of seeking help was relatively short after becoming aware of their fertility problems. Within infertility services, few of them set limits beforehand regarding treatments (with the exception of treatments involving a third party) and they do not passively follow the doctor: the majority are active in their help-seeking.