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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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## **Chapter 7 General conclusions and discussion**

This thesis explored involuntary childlessness amongst infertile Turkish migrant couples in the Netherlands. More specifically, this thesis focused on their parenthood motives, the psycho-social consequences and responses to involuntary childlessness, their help-seeking behavior and the role that culture and migration play in each of these factors. Several research methods were employed: a literature review, qualitative in-depth interviews and comparative quantitative methods.

In order to include a diverse sample of Turkish migrants, participants were recruited both within and outside biomedical systems in order to access patients who were not in treatment. Both Dutch and non-Dutch speaking Turkish migrants were recruited, and women as well as men were included in this research project. In the comparative studies, the involuntarily childless Turkish migrants were compared with involuntarily childless Dutch couples (Chapter 3) and with both involuntarily childless Dutch couples and with involuntarily childless Turkish couples living in Western Turkey (Chapter 5). While the data of the Dutch referent group has been collected in a previous study (Van Balen & Trimbos-Kemper, 1995), data regarding the Turkish couples and Turkish migrants was collected during this thesis.

The first two studies that make up this thesis examined two aspects that differ across cultures: parenthood motives and procreation beliefs (Nahar, 2007; Van Balen & Inhorn, 2002). In *Chapter 2* a literature study about non-biomedical procreation beliefs in the Middle East (including Turkey), and their connection with the biomedical model was presented. Also the existence of non-biomedical procreation beliefs among Middle Eastern migrants in Western countries and the possible influence of non-biomedical procreation beliefs on how migrants might perceive biomedical infertility care were discussed. In *Chapter 3* the parenthood motives of infertile Turkish migrant men and women in the Netherlands were compared with those of infertile Dutch men and women. The relationship between the importance of various parenthood motives

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of Turkish migrants and the degree of adaptation to Dutch culture was also examined. It was assumed that non-biomedical procreation beliefs and parenthood motives would influence help-seeking and the experiences of involuntarily childless couples (Purewal & Van den Akker, 2007; Van Balen, 2001). The next two studies (*Chapter 4 and 5*) examined the psychosocial consequences of involuntary childlessness. *Chapter 4* presented a qualitative in-depth interview study about the influence of involuntary childlessness on the lives of infertile Turkish migrants. Six aspects of infertility arose from this study: effects on self, effects on the relationship with the partner, effects on the relationship with others, disclosure, coping, and the future. These themes were further elaborated and possible underlying factors were discussed. *Chapter 5* focused on the differences in emotional distress between Turkish migrant men and women, Dutch men and women, and Turkish men and women living in Western-Turkey. The last study, *Chapter 6*, examined the help-seeking behavior of Turkish migrants, the decision-making process according to the typology of Verdurmen (1997) and their attitudes towards treatments involving gamete donation and surrogacy.

In this final chapter the results of the conducted studies will be brought together and discussed. Special attention is given to the influence of culture and the role of migration and being a migrant. Furthermore, the studies limitations, practical implications and research developments are addressed.

## **7.1 The role of culture**

In this thesis the role of culture in the experiences and help-seeking behavior of Turkish migrants was examined by focusing on possible underlying aspects that were expected to differ across cultural contexts (religious and traditional procreation beliefs and parenthood motivations), by comparing Turkish migrants with other involuntarily childless samples (Dutch and or Turkish people living in Western Turkey) and by studying the narratives of respondents and their references to their culture.

### *General conclusions and discussion*

In the Turkish migrant population beliefs about causes of fertility and infertility are not always in line with facts that in the indigenous Dutch population are common knowledge. The literature review shows that there are indications to suspect that monogenetic patriarchal procreation beliefs (e.g., the fetus develops out of the sperm of the man) might exist amongst some Turkish migrants in the Netherlands (Chapter 2). A number of the participants in this research project reported that in some parts of the Turkish migrant community Turkish migrants believe that fertility problems only concern the woman (Chapter 4), as often occurs in the case of patriarchal monogenetic procreation models (Delaney, 1991; Inhorn, 2003b). Chapter 6 showed that all Turkish migrants in this sample visited infertility services and had examinations and / or treatments, suggesting that they are aware to some extent about the biomedical model. Furthermore, lack of a genetic tie was often given as an argument against using donor gametes, suggesting the existence of biomedical procreation beliefs. Chapter 4 also revealed other misconceptions like the assumed relationship between infertility and impotency. This appeared to be particularly stigmatizing for men, and was the reason that some couples disclosed male factor infertility as female factor infertility. Nevertheless, in Western cultures infertility is also still associated with impotence for some people (e.g., Inhorn, 2003c; Peronace et al., 2007; Remennick, 2000; Throsby & Gill, 2004; Webb & Daniluk, 1999). There were also misunderstandings about the time it takes to become pregnant: almost all couples visited the doctor within a year after actively trying for a child (Chapter 6).

While individual parenthood motives were most important to both Turkish migrants and Dutch couples, the parenthood motives of Turkish migrants differed from those of Dutch couples with respect to social parenthood motives. Social parenthood motives amongst Turkish migrants were more important than for Dutch couples (quite important and unimportant, respectively) (Chapter 3). This indicates that within Turkish migrant culture, adult identity is to some extent reached through having children; there is a strong social norm to have children (i.e. a high degree of pronatalism); and having children to continue the family line is still important, while this is less applicable to the Dutch culture. The significance of the pronatalist social norm also surfaced in Chapter 4. Many Turkish migrant couples were faced with numerous questions relating to their involuntary childlessness from a wide variety of people.

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They also received a relatively high degree of pressure to conform to this social norm and to seek help, and many reported being stigmatized by their childlessness. This appears to lead to an extremely selective disclosure of their involuntary childlessness to others. This is in line with findings amongst other studies about involuntarily childless migrant from pronatalist cultures (e.g., Schmidt et al, 2006b; Culley & Hudson, 2006). The findings of Chapter 3 and Chapter 4 reveal that Turkish migrant couples might experience losses on more domains (both the social and individual domain) and more consequences than childless Dutch couples. This also appears to be reflected in the study about emotional distress: Turkish migrant women (and Turkish women) reported more emotional distress, than Dutch women (Chapter 5). However, few differences were found between the men of the three groups. Where there were differences between the men, Turkish migrant men had the most emotional distress and Dutch men the lowest. However, the findings suggest that there is less difference between men than between women across cultures.

The strong pronatalist culture and the resulting pressure and misconceptions about the duration of becoming pregnant also appeared to lead to early help-seeking and possibly to the positive attitude towards invasive treatments. Options like adoption that did not lead to the pronatalist goal of a genetically related child were seldom chosen. The high acceptance of invasive treatments is also found among other migrants with a strong pronatalist culture (e.g., Culley et al., 2006). In this study, no follow the doctor types were found amongst Turkish migrants and only one Turkish migrant couple belonged to the setting limits type. Involuntarily childless Dutch couples, however, appear to set more limits regarding invasive treatments and more couples await the doctors to initiate treatments (Verdurmen, 1997).

## **7.2 The role of migration and being a migrant**

This study also aimed to examine the influence of migration and being a migrant on the experience of and responses to involuntary childlessness. In order to fulfill this aim, Turkish migrants were compared both with Turkish people living in Turkey and

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with Dutch couples. The process of acculturation was explored and other migrant-related factors were identified. In general, the Turkish migrants in this study were moderately adapted to the Dutch culture. Most had the skills to participate to some extent in Dutch society. It is therefore likely that they might have been educated regarding the biomedical model of procreation and infertility during their stay in the Netherlands (in line with David et al., 2000). If so, non-biomedical procreation beliefs and misconceptions about infertility might have been reduced as a consequence of living in the Netherlands. They have perhaps also learned by visiting biomedical services. This is also supported by the lower levels of feelings of blame and guilt about the fertility problems among the Turkish migrant sample as compared to Turkish couples living in Turkey (Chapter 5). Also the importance of social parenthood motives was found to relate to coming into contact with Dutch culture. Migrants who were more adapted to Dutch culture found social parenthood motives less important (Chapter 3), possibly resulting in less emotional distress than among Turkish migrants who are less adapted to Dutch culture.

It is remarkable that only a small number of differences were found in levels of emotional distress when Turkish migrants were compared with Turkish couples living in Western Turkey. It might be that if adaptation to Dutch culture continues, significant differences between Turkish migrant couples and Turkish couples become more apparent. Also, most Turkish migrants in this study appear to maintain strong bonds with Turkey (contact with family and friends, television etc.): individuals or couples may have changed their values about having children, but they might still receive pressure from Turkey and from the wider Turkish migrant community to conceive. Another possible explanation that might at least partially explain the high levels of depression, anger-hostility and anxiety found in this study, are that these high levels reflect other stressors in addition to infertility, which might have differed among the Turkish migrant and Turkish samples. Possible additional stressors for Turkish migrants are for instance stress brought about by the acculturation processes. The strong links with Turkey were also apparent in the help-seeking behavior of Turkish migrants and in their perceptions of Dutch infertility services (Chapter 6). All couples visited infertility services in the Netherlands, however, about half additionally visited infertility services in Turkey. Whilst the first finding indicates that Turkish migrants

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at least enter the Dutch health care system, the latter suggests that a substantial proportion are also seeking help elsewhere. This may suggest that they do not have access to all relevant information (wanting information in their own language), are not satisfied or have doubts about the Dutch care they receive (wanting a second opinion, or faster medical help). Not having access to relevant information appears to be mainly caused by language problems. Other studies showed that communication problems due to language problems or due to differences in cultural explanatory models, expectations and values, might result in a poor mutual understanding, in less effective communication, in less satisfaction with caregiver, in inappropriate use of health services and non-compliance (Culley et al., 2006; Meeuwesen et al., 2006; Van Wieringen, Harmsen, & Bruijnzeels, 2002). The dissatisfaction and doubts of Turkish migrants about Dutch infertility services might be caused by the fact that the Turkish medical system and information sources are often faster and more focused on the desire of the patients, than the Dutch infertility services (Dutch and Turkish) (Chapter 6). Being acquainted with and visiting both hospitals in the country they live in and in the country of origin was also found in other studies about non-Western infertile migrants (see also Culley et al., 2004; Gacinski et al., 2002; Yebei, 2000). Nevertheless, indigenous Dutch people also sometimes utilize infertility services in other countries. Reasons for such travel are the availability of certain treatments which are not available in the Netherlands, or are limited, the belief that their chances of pregnancy will be higher elsewhere, or because Dutch infertility services do not want to treat them: either because of a very low chance of pregnancy, or because of the high chance of a spontaneous conception without intervention (Kremer, 2007).

Some participants also mentioned communication problems with their partner due to a limited common biomedical vocabulary (as one of the participants spoke better Turkish and less Dutch than the other) or due to a dependency on the other for correct translations (Chapter 4). Culley et al. (2006) found that some patients who translated for their partners felt that having to both listen, understand and translate caused them an additional burden.

### **7.3 Involuntarily childless Turkish migrants: conclusions**

The Turkish migrants in this study had multiple motives to become a parent. When they did not succeed in becoming a parent, the lives of most, but not all, Turkish migrants were deeply affected. In general, involuntary childlessness had a profound and negative influence on both the individual and the social domain. Turkish migrants felt grief about their unfulfilled desire to have a child. In addition, their partner relationship was often negatively influenced by their involuntary childlessness, and they were also confronted with serious social repercussions (questions, pressure, and stigma). This appeared to result in, amongst other things, a relatively high level of emotional distress. Furthermore, the social repercussions also appeared to influence the biomedical help-seeking pattern of Turkish migrants. This pattern was characterized by an early start, active involvement, 'reproductive tourism' (visiting infertility services in other countries) and a high acceptance of invasive treatments (with the exception of donated gametes and surrogacy) in order to reach their ultimate goal: a child that is genetically related to both parents and carried by the mother. Non-biomedical treatments were only used in complement with biomedical treatments. Options like adoption were seldom chosen. Furthermore, this study showed that most Turkish migrants show certain resilience; they have found ways to help them to deal with negative experiences (e.g., turning to their faith or seeking distraction) and are to some extent able to resist the pressure brought about by their surroundings (e.g., few mentioned divorce and many mentioned continuing their relationship also when not being able to have a child) (Chapter 4).

### **7.4 Practical implications**

The studies that constitute this thesis provide health care providers with knowledge about the experiences and background of involuntarily childless Turkish migrants. For instance, this study showed that health care providers could expect strong negative emotions when Turkish migrants are confronted with their infertility and might be confronted with a request for a fast medical solution. This should be compre-

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hended in the context of the strong pronatalist social norms and the related strong social pressure and stigmatization. Understanding this might improve the doctor-patient relationship. In addition, there are several practical implications. First, health care workers need to be aware of the possible existence of non-biomedical procreation beliefs and limited biomedical knowledge among some Turkish migrants. In response, health care providers should adapt their information in order that patients can understand possible causes and treatments. Furthermore, explaining how infertility care is organized in the Netherlands and informing patients in more detail about the likely timescale of examinations and treatment might lead to less doubts and dissatisfaction among Turkish migrants. This might also result in less procreative tourism. Also, the confidential nature of infertility services and trained interpreters should be emphasized.

Next, in this thesis communication problems between health care providers and patients with limited Dutch language skills were identified. In addition, communication problems between some partners, due to a limited common biomedical vocabulary were also found. Although these problems diminish when Turkish migrants learn sufficient Dutch, it might in the meantime be useful to use a trained interpreter (in person or by phone) or develop information booklets that are parallel in Dutch and Turkish (see also Culley et al, 2006). This might enhance patients' understanding of examinations, causes, treatment options, and possible side effects. It might also enhance shared decision making and real informed consent.

Finally, a substantial proportion of the Turkish migrants (especially women) reported serious emotional distress. Also their request for a fast medical solution should be understood in the context of the large social pressure to have a child. Health care providers could increase the awareness of the existence of support groups and counseling facilities among their patients, stress the confidential nature of the latter and support them in accessing these facilities.

## **7.5 Limitations**

This thesis has some limitations. First, the Turkish migrant sample might not be representative for the whole Turkish migrant community in the Netherlands. A substantial number of the patients approached in hospitals were reluctant to participate in this study. Hospitals reported that patients mentioned that the topic was too sensitive, too emotional or too private, or they were too busy. It is likely that people willing to participate and discuss their experiences with an outsider differ to some degree from the non-participating patients. The Turkish migrant sample in this study was also more highly educated than the general Turkish migrant community (common in quantitative studies; Picavet, 2001). Also relatively more couples with female infertility than with male infertility participated. This might be because of the strong stigma associated with male infertility. Finally, the study included relatively small sample sizes and therefore caution should be taken when generalizing the findings.

A second important aspect concerns possible method biases. Possible method biases might be different response styles (e.g., Phalet & Verkuyten, 2001; Van de Vijver & Tanzer, 2004). Also, some of the instruments used have not been validated for Turkish migrants or Turkish couples (e.g., IFQ and Parenthood Motivation list). The reliability of some of the subscales of the IFQ were low or just sufficient and no norm scores were available for the SCL-90-R for the Turkish migrant and Turkish sample. Furthermore, there might be a bias through differences in administration places (Turkish migrants and Dutch couples (in their homes) vs Turkish couples (meetings or in hospitals)), time (Turkish migrants and Turkish couples vs Dutch couples) and single versus couple interviews. There might have also been an interviewer effect on answers (Van de Vijver, 2003).

## **7.6 Further research**

The studies in this particular thesis give rise to explore certain issues in future research. Firstly, this thesis indicated that some Turkish migrants perceive problems in Dutch infertility services. This will be studied more in-depth in a forthcoming article

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about the perceived problems in infertility treatment to Moroccan and Turkish migrants in the Netherlands, based on not yet published data collected during this thesis and on a recent study conducted by Korfker, van der Pal-de Bruin, Detmar and Buitendijk (2008) (Van Rooij & Korfker, Forthcoming). Furthermore, this thesis showed a high number of Turkish migrants with considerable emotional distress. Future research needs to investigate the barriers in accessing counseling. Also, further research is necessary to explore the influences of being confronted with and making use of different health care systems on patients and to explore the implications of reproductive tourism for the Dutch health care system (see also Kremer, 2007).

Finally, the last years the interest for the psychosocial sides of involuntary childlessness among non-Western couples living in Western settings has gradually grown in Western societies, resulting in an increasing number of publications in this field (Ahmed, 2005; Culley & Hudson, 2006; Culley et al., 2004; Inhorn & Fakih, 2006; Schmid et al., 2004a, 2004b) and in several international collaborations (Culley, Hudson, & Van Rooij, Forthcoming; Culley & Van Rooij, 2006; Van Rooij et al., 2005). Within the Netherlands, however, there is still limited attention for infertility amongst other non-Western migrants. Further research about the experiences of other infertile non-Western migrants in the Netherlands is necessary to enable health care providers to better accommodate these patients as well.