

# INFERTILITY AND SEXUALITY



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Infertility brings about many changes in a couple's relationship. It may bond you closer together in unspoken sadness and hope, it may bring out feelings of resentment ... of guilt ... of mutual support and understanding—a sharing never before experienced. As the initial months of investigations turn into frustrating years it is not surprising that sex quickly loses many of its associations with pleasure and becomes instead an activity with a functional purpose.

Failure to conceive can test self esteem, self worth and sexuality. All these negative feelings are reflected in the bedroom, which is, after all, where all the “problems” started.

The psychological effect of a diagnosis of infertility on sexuality has largely to do with the self-image. Fertility is one very basic expression of sexuality. For example, we automatically assume a pregnant woman has had sexual intercourse to be in the condition she is in. The man with six sons in many cultures has more status than a man who has borne none. He is considered to be more potent, more virile. The old term for a woman unable to have children is “barren”, a word bereft of any sexual connotation.

The emotional response to a diagnosis of infertility has been described in the literature as a grief reaction. It involves many losses: those of potential children and the family planned and dreamed about, continuing future generations, genetic continuity, the experience of conception, pregnancy and birth, the gift of grandchildren to one's own parents, the central meaning of one's life plan and marriage, and the procreative potential in sexual relations. It is common for a woman to feel “less of a woman” and a man “less of a man”, at least for a time, when faced with infertility.

Many men describe feeling a “dud”, “sexual failure”, and many other expressions relating to feeling emasculated. If a couple is to proceed with Donor Insemination, the male partner must be on the way to re-integrating his sexual self-image if he is to accept the use of another man's sperm to achieve pregnancy in his wife.

Women, too, often feel their sexuality threatened when faced with the possibility of not becoming a parent. Women are probably more powerfully socialised into the expectation that they will reproduce than are men. When this is thwarted, there is often the feeling of having failed as a “proper woman”, as shown in this statement:

*“I saw the blood today. I feel weak and tearful. All the strength I'd thought I'd acquired just seems to have drained away. The discomfort serves as a reminder of my failure. So much for menstruation as a sign of femininity and potential for motherhood. All it signifies to me is my failure”.*

And another comment about sexual attractiveness:

*“I have always been told I was pretty. I like the way I look, and I feel confident in social situations. After my pelvic surgery, the Doctor told me he had never seen a worse mess of adhesions in his life. He said it looked like a little kid had gotten loose with a pot of glue and stuck everything all together. I am ugly on the inside and pretty on the outside. I would gladly have the reverse if it would make me a baby”.*

There are significant periods which impinge on feelings about sexuality of the individual or the couple faced with infertility.

These are:

1. Trying to get pregnant;
2. Investigation and diagnosis;
3. Treatment;
4. Development of children; and
5. Menopause.

## 1. TRYING TO GET PREGNANT

The usual advice for a couple trying to start a family is to have unprotected sexual intercourse (i.e. using no contraceptives) for twelve (12) months before having fertility investigations. This time-frame should be shortened, obviously, if the woman is in her 30's or one or both partners has some history of fertility problems.



Doubts about one's fertility almost always result in a heightened awareness of signs of fertility that surrounds us. Pregnant friends, noisy children in supermarkets, media coverage of new reproductive technologies, hints from eager parents wanting grandchildren—all these can begin to erode the sexual self-confidence of the man or woman wishing to have children. Inevitably, sexual intercourse is timed for the fertile time of the woman's cycle. Spontaneity goes out the window as the sexual life of a couple comes to be associated month after month with procreating and the failure to conceive. Men often come to feel like a stud bull, and women may feel it is pointless to engage in sexual activity when it is unlikely to result in pregnancy.

## 2. INVESTIGATION AND DIAGNOSIS

Those not faced with infertility would be staggered by the number, complexity, and invasiveness of medical procedures that a couple with a fertility problem go through in their search for an answer to why pregnancy is not occurring.

*"It is like donating your body to science while you're still alive!!"*

The most basic procedure, and usually the first, is the Basal Body Temperature Chart where the woman takes her temperature each morning before rising and marks this in a chart. This indicates if and when ovulation is occurring. Often the woman is asked to mark down if she has any illness, spotting, if she thinks she is ovulating, and when the couple has intercourse.

Although very useful from a medical point of view, it is also the surrendering of some very personal information about oneself, as shown by this extreme but valid point:

*"There is no inner recess of me left unexplored, unprobed, unmolested. It occurs to me when I have sex, what used to be beautiful and very private is now degraded and very public. I bring my chart to the doctor like a child bringing a report card. Tell me, did I pass? Did I ovulate? Did I have sex at all the right times as you instructed me?"*

The temperature chart becomes a way of ruling one's life. It is also a public declaration of making love. With the desire for a child becoming increasingly frustrated, life can become apparently cyclic—temperature, ovulation calculations, timing of sex and the disappointing signs of one's menstrual onset. Anxiety, depression and fighting over sex can often be traced to this source.

*"Ordinarily my husband was the instigator of sex. During my fertile time, I felt I had to seduce him. What quite often happened was that we'd end up fighting instead of making love".*

*"It was pretty hard to feel an urge to make love when your wife is expecting a command performance".*

It is not just the physical charting but the mental charting (which may continue indefinitely) that is a source of stress, even if the partner is not aware of what is happening.

*"One of the things that freaked me out about charting my temperature was the accompanying need for the X's. I guess that is what brought home to me that we had stopped making love as frequently as we had used to".*

*The ultimate moment for me was when I found myself "cheating" on the charts. I put in a few more X's here and there to make things look good . . . then I said to myself, "Good grief!—Has it come to this?"*

*At first, it was quite exciting - I felt as if I was actually doing something. We would both look at the chart and go for, say, six X's in a row—in fact our frequency of intercourse increased I'm sure. By now we've gone through the stage of "saving up sperm" and have hit the stage of almost total abstinence. I put in an occasional X so that the nurse doesn't get the impression that there's something wrong with our marriage."*

A semen analysis indicates the quality and quantity of sperm within the man's semen. It requires the man to masturbate either at home or at the fertility centre and then present the container to a laboratory technician.

*"I looked around desperately for something to turn me on—there was nothing—not even soap. After 15 minutes I gave up—literally sore as hell."*



Most men feel their masculinity is “on the line” when having this done, sometimes to the extent of being unable to produce the specimen. It is not uncommon for the man to become impotent for a short time while he is undergoing such procedures.

*“The first time it happened I thought “here it is—middle age. I’ll never get it up again”.*

Probably the most invasive fertility investigation is the Mid-cycle Post-coital Test. With this investigation, the cervical mucus is removed from the cervix a certain number of hours after intercourse and is examined under a microscope. The condition and the activity of the sperm in the cervical mucus are then assessed.

While post-coital tests are painless and physically unobtrusive many find them very difficult because they intrude so much on your relationship. There’s the need to comply with a specific time, the rush to the surgery or clinic to keep the appointment, the embarrassment and real fear of “failure” if all does not proceed as had been “instructed”.

*“They told us to make love first thing in the morning and then come in. Well, what if you don’t feel like it? We’re dreadful in the morning. We put the alarm on at 6 o’clock and we had the kettle on to make coffee... making love was the last thing we felt like doing . . . he hated it and I hated making him do it”.*

Other investigative tests include hormone assays, hysterosalpingogram, laparoscopy.

The power play dynamics in the doctor-patient relationship take on a new dimension when fertility is being investigated. Couples are desperate to find an answer to their difficulties and hence are compliant and rarely let the clinician know they are under stress (“not coping”). They must expose the most intimate aspects of their lives—their sexual relationship and their desire to have children.

*“There’s a coyness about the way they (the doctors) handle sex. It’s as if infertility has nothing to do with sex, yet it’s everything to do*

*with it. I never know whether I want them to assume that I don’t have any problems, or whether I want them to ask me if I do have any.”*

### 3. TREATMENT

A couple’s decision to commence a treatment program, such as IVF or Donor Insemination, signifies hope and excitement that they can overcome infertility and produce children like everyone else. However, like the investigative period, it again signals a further, if not more intense, invasion of their sexuality and sexual relationship.

Once accepted onto an IVF program, most women are confronted at each attempt with the barriers to becoming pregnant, to become mothers, and thereby expressing a major aspect of “femaleness”. The low pregnancy rate—about 15% per treatment cycle—means most will leave the program with a reconfirmed sense of failure, at least for a short time, and certainly if they have had little emotional support.

The use of donor gametes to cause a pregnancy, as in a donor insemination program where the male partner is infertile, brings home to the man his inability to reproduce. Some of the feelings of inadequacy may have been worked through during the period following diagnosis, but it is not uncommon for these feelings to be re-aroused when the program actually begins. At Canberra Fertility Centre the men are encouraged to be present while their wives are being inseminated. This encourages bonding between the couple at this time, and especially gives value to the participation of the husband in the act of conception of their child.

With nearly all forms of infertility treatment, rarely is the infertility cured, and clearly not so where donor egg or sperm is used. For example, women with blocked fallopian tubes who become pregnant on an IVF program, still face further IVF attempts if they wish to become pregnant again. A feeling of defectiveness may remain despite pregnancy and a live birth.



## 4. PSYCHOLOGICAL DEVELOPMENT OF CHILDREN.

For those who achieve pregnancy through treatment, and indeed for those couples who go on to adopt a child, there are several stages in the life of these families which will impinge upon feelings about infertility. Adopting mothers are often asked “Why don’t babies grow in your tummy?” And the child conceived by IVF may well want explanations of varying complexity as the years go by about how they were conceived. Simply talking about “the facts of life” with these children will touch on areas which, at least for a time, were very sensitive.

It has been suggested that, for families where adoption has occurred, a major point where infertility again becomes an issue is when the adopted child becomes sexually mature.

*“Parents may find themselves envious of their child’s supposed fertility and this may be expressed as a fear of sexual acting out by the child and often as a fear of pregnancy, but also enfolding the hidden wish of the parents that the child express the fertility that they do not possess”.*

This would not occur to such a large extent where infertility treatment has succeeded (i.e. produced a child), but there may be problems in families where there has been a denial of the effect of infertility on sexuality, when children become sexually active.

## 5. MENOPAUSE

**Menopause** is a time when all women are confronted by their sexual identity, because the physical signs of being a woman are changing forever. It is a difficult time of adjustment for many women, and for those with infertility it may mean saying goodbye, yet again, to motherhood.

It is ideal to give the individual, or couple, with infertility the opportunity to ventilate their feelings. These may include frustration, anger, feeling “taken over”, as their sexuality gets

trampled upon throughout the course of investigation and treatment. Much is done to restore a sense of personal worth and validation when these feelings are identified and accepted. Those experiencing infertility need to know that it is normal, expected and almost inevitable that their relationship with their partner and sex life will take a beating for a time.

It is useful to introduce couples affected by infertility to others with the same problem, so they can see with their own eyes that infertility does not mean being a failure. Infertility counsellors often encounter resistance in clients in the traditional counselling situation.

One of the goals of infertility counselling is to help the client separate sex from reproduction, so that sex is perceived as valuable and pleasurable for its own sake rather than a means to an end. On a practical level, this may mean throwing away the temperature chart for a while, or taking a break in the middle of a treatment program to have a romantic holiday. Intimacy needs to be re-kindled. A couple may need help to bring back the spontaneity into their relationship, e.g. by changing the location and time of sex. Occasionally couples may benefit from referral to a sexual therapist if their sexual problem has become entrenched or if their sexual problem is deep-seated and existed before the diagnosis of infertility.

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