

## **“I Asked for It”**

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### **How Women Experience Stigma in Their Transition from Being Infertile to Being Mothers of Multiples through Assisted Reproductive Technologies**

*Although researchers agree that infertility is a stigmatizing attribute, scholars are largely divided in their criticism of assisted reproductive technology (ART). Some criticize the increased and invasive medical interventions as disempowering women, whereas others argue that ARTs empower women by protecting their right to reproduce as they see fit. Research on the stigmatization of infertility and ART in the context of mothers of multiples is conspicuously missing from the literature a notable lacuna in knowledge given ARTs are more likely to result in multiple births. Drawing on in-depth semi-structured interviews with twenty-three mothers of multiples, we show how these women interpret the stigma of first being “infertile” to then being “artificially” fertile to becoming mothers of multiples. Interviewees reveal that despite the agential freedom they have in regard to choice in fertility treatments, they feel disempowered, even judged, when undergoing ART. Focusing on women who had twins or triplets after undergoing ART, we show how the alleged “empowerment” bestowed on women by providing the choice to use ART can transform into disempowerment.*

Over the past several decades, advances in assisted reproductive technologies (ARTs) have led to a significant increase in incidence of multiple births (Bhattacharya 541; Cook et al.). ART, the technology used to achieve pregnancy, includes any therapy directed toward improving the probability for conception. Technologies range from largely noninvasive interventions (i.e., a pill) to more invasive ones, such as in-vitro fertilization (IVF) (Sundarem et al.). Scientists have documented that ARTs such as IVF, IUI (intrauterine insemination), as well as medicines that stimulate ovulations (i.e., clomid) have an increased likelihood to result in multiple fetuses (Callahan et al. 244; Ellison et al. 1422; Cook et al). Statistics from a decade ago show that, following IVF, the chance

of conceiving twins is twenty times that of higher-order multiples and four hundred times higher than in general population (Bhattacharya 541). Multiple fetus pregnancy increases the health risk posed to the pregnant woman and the fetuses, which is compounded by the fact that most fertility treatments are directed at women; they are themselves gendered technologies with highly specific and differentiated application on men’s and women’s bodies. ARTs, then, it can be argued, disempower women.

ARTs are applied more invasively to women’s than men’s bodies; for example women are first given hormone injections or pills to hyperovulate and then invasive procedures are employed to harvest oocytes (i.e., egg cells) and later transfer embryos to the uterus (Bhattacharya; Inhorn). The consequence of such practices is the mistaken view that women bear the responsibility for reproductive problems. Women are then disempowered by their inability to conceive and, even if they are able to conceive but with a partner who cannot reproduce (in a heterosexual relationship), women are still held responsible and viewed as infertile because of their partner’s inability (World Health Organization; Dyer et al.; Inhorn).

Much of the earlier (feminist) discourse focuses largely on the use or rejection of ARTs. Many researchers have studied both the use of ARTs and the resulting (dis)empowerment of women with reference to patriarchal control and women’s agential freedom (Parry). In our study, we focused solely on the lived experiences of women who became mothers of multiples through ART—representing a lacuna in knowledge and literature—and sought to understand their experiences using ART. Drawing from a larger semistructured interview study of the experiences of forty-one mothers of twins or triplets, we focused on a subset of interviews that was limited to women who underwent fertility treatments that resulted in multiple fetus pregnancies and are now mothering multiples ( $n = 23$ ). To this end, we trace the various social dynamics, particularly stigma, and unpack any interpretations of empowerment or disempowerment described by women who first sought ART and later gave birth to twins or triplets after undergoing ART. We begin the article by discussing the disempowering stigma inferred from being unable to conceive or being infertile and how such a stigma impacts a person’s (here, women’s) behaviour through exerting stressors in four realms: namely, existential stressors, emotional stressors, physical stressors, and relationship stressors (Gerrity). After presenting our methods, we show how fertility treatment, broadly defined, is perceived as stigma and how women try to overcome the judgment of others through opting a “selective disclosure” approach (King and Botsford). We continue by using attributional theory to explain the stigma women experience when they cannot conceive and how the stigma changes form after having multiples. The article concludes with the discussion of the dichotomous categories of

“artificial-fertility” and “natural-real” mothers of multiples constructed by women for women who undergo fertility treatments and women who do not.

### Stigma Mechanisms and Processes

Stigma—defined as deeply discrediting traits that can reduce a “whole and usual person to tainted discredited one” (Goffman 3)—threatens what is at stake in the social world and endangers what is most valued in one’s innermost being. According to Bruce Link and Jo Phelan, stigma exists when a number of interrelated components converge (i.e., labelling, stereotyping, separation, status loss, and discrimination). These components include labelling individuals based on human differences, linking labelled individuals to negative stereotypes and the associated status results, and then using this label as justification for discriminating against them (Link and Phelan). A great deal of variability exists around these components. How different individuals experience stigma depends on the degree to which a stigmatizing attribute can be concealed.

Individuals susceptible to being “discredited” bear a stigma that is predominantly visible, such as race, ethnicity, or physical disability. In contrast, individuals deemed to be “discreditable” have a stigma that is predominantly concealable, such as a criminal past or sexually transmitted infection (Goffman). Along similar lines, infertility manifests itself as an acute and unanticipated life crisis: “because it is unanticipated, may be unexplained, and lasts for an indeterminate length of time, infertility creates overwhelming stress and tests normal coping mechanisms” (Forrest and Gilbert 42). Beyond being disempowering, for many women, infertility is a secret stigma; it is distinguished from more obvious examples of stigmatization because it is invisible. Women do not display obvious features that indicate they cannot conceive, only their own knowledge of their condition distinguishes them from others. Some women do feel infertility is a highly visible stigma because they are childless. Thus, being infertile can leave a woman feeling ready to be outed (discreditable), or a woman who does not have any children, in certain scenarios, can feel discredited (Becker; Goffman; Throsby). Furthermore, a woman’s status continues to transition as she undergoes ART. For example, if she chooses not to disclose her use of ART, she may feel discreditable. However, if she is forthcoming about her use of ART, she may feel discredited and vulnerable to public evaluations of her fertility status and medical history (Ellison and Hall 412).

What is consistent here, however, is that to be childless in a pronatalist society—one where socialization dictates from early years that motherhood and being a “woman” are nearly synonymous—is to run against the norm, with all its concomitant sanctions (Miall; Parry 208). According to Jean Veevers and Charlene Miall, two dominant norms frame procreation in North American

society: the first is that all married couples should reproduce and the second that all married couples should want to reproduce. These norms—in conjunction with probirth governmental policies, such as income tax deduction or fertility credits, that encourage and reward the image of parenthood—form the basis of a pronatalist society (e.g., public funding provided by Ontario and Quebec<sup>1</sup> to partially cover the cost of one cycle of IVF) (Ferguson).

As members of such a society, many women respond positively to the cultural pressure to have children. To overcome childlessness because of infertility and to achieve biological motherhood, many infertile women take an active role in acquiring an understanding of their medical situation and make informed decisions to undergo fertility treatments. Charlotte Bunch and Samantha Frost posited that this “empowerment” has “enabled women to move from seeing themselves simply as victims to seeing themselves as self-conscious actors” who can make their own decisions (555). In doing so, these women develop and illustrate their right to determine their own choices in life (Parry 205). But this alleged empowerment does not sustain for long for some women, it is quickly transformed into disempowerment, as women succumb to condemnation by others (their friends, family) for going against “the course of nature” (i.e., undergoing fertility treatments); they then take measures to conceal their stigmatized identity (Quinn and Chaudoir 635) of being a “fertility mom,” and hide the reality that they underwent fertility treatments.

The stigma-related stressors of infertility are manifest in existential, physical, emotional, and interpersonal realms and may be beyond the average person’s usual coping abilities (Gerrity 151). Existential stressors pertain to loss of pride, confidence, self-image, identity, and self-esteem due to the experience of being infertile (Greil; Abbey et al.). Such stressors also refer to feeling of defectiveness, unattractiveness, and unacceptability to others. A major physical stressor of infertility is the diagnostic and medical treatment regimen, which beyond being invasive, interferes with the daily life of the couple, particularly the woman (Blenner 92; Carmeli and Birenbaum-Carmeli). This is likely one reason various scholars have found women tend to be more stressed than men by their infertility, which also leads to such emotional responses as feelings of guilt, anger, and depression (Abbey et al). Over thirty years ago, for example, Linda Forrest and Mary Gilbert found that experiences of infertility can cause marital problems and lead the fertile partner to reevaluate his or her affiliation with their chosen partner. These relationship stressors manifest themselves when the person with the reproductive problem is considered at fault or blamed for the couple’s inability to have biological children, and, consequently, the person feels guilty for not fulfilling his or her role as a partner. Linda Burns and Sharon Covington have mentioned shame, guilt, anger, and self-blame as emotions that affect the couple’s relationship.

## Attributions Translate to Internalized Stigma

Besides the concealability and nonconcealability of stigmatized attributes, controllability and uncontrollability also have a role in determining the intensity of a stigmatizing label. The attributional theory of stigma originates in the finding that people are more likely to help individuals whose distress originated in an uncontrollable rather than controllable manner (Piliavin et al. 289). Bernard Weiner and colleagues have argued that attributes determine reactions to stigmatized individuals and groups. Uncontrollable stigmata elicit pity, sympathy, and helping behaviour, whereas controllable stigmata elicit anger and refusal to extend aid. Attributions of controllability then affect the degree to which stigmatized targets are blamed for their own fate (Weiner). Individuals with addiction or mental illness, for example, are treated better when their stigmatized attribute is understood as having originated in uncontrollable biological factors rather than in personal choices (Hegarty and Golden 1024).

Moreover, “stigma schematicity,” the process where people internalize the beliefs associated with their stigma (Jones et al.), may be intensified by the societal pressure exerted on infertile women, a consequence of how most women experience considerable pressure to bear and/or raise children. This pressure may become nearly intolerable at times, as parents and relatives [and society] convey the notion [directly or indirectly] that women ‘owe’ their family children (Fisher 46). Such interpretations increase the potentiality for women to internalize their feelings of inadequacy and the associated stigma (Fisher 46). Thus, despite the broadening roles available to women in North America, failing to achieve the primary social role of motherhood can have negative effects on self (Jordan and Revenson 341). The interpretation of infertility as a disempowering and stigmatizing attribute is internalized such that a woman who experiences it may view herself as deviant. In response to perceived shortcomings, she may assert her agency and take measures (i.e., ART) to liberate herself from the stigmatizing label.

## Disclosure Dilemma

As discussed above, becoming a mother has been considered the fundamental, defining characteristic of femininity. From this perspective, pregnant women or mothers are fulfilling the expectations of their gender and social roles (King and Botsford 315). Yet judgments are associated with how motherhood or pregnancy is achieved. The potentiality for judgment is rather pronounced when a woman has multiples because it is well known that many forms of ART strive for the fertilization of more than one embryo to achieve a viable pregnancy. This may encourage people to view multiple fetal pregnancies or births with

skepticism. Mothers of multiples, who have undergone ART, face a dilemma of disclosure (Kelland and Ricciardelli; King and Botsford 315)—do they reveal or not that they underwent ART to achieve pregnancy? The dilemma of disclosure involves dual (and inherently contrary) motives of authenticity and self-protection. On the one hand, individuals are motivated to be authentic in their interactions to maintain and verify their sense of self and to build open relationships with others (Creed and Scully). On the other hand, concerns about how one is perceived by others and to avoid judgment are particularly salient. Pauline Slade et al., for example, in their study of new attendees at an infertility clinic, found a high perception of stigma associated with reduced disclosure to others, leading to lower social support and higher distress.

### Current Study

Although there is a plethora of research on ART and women who undergo fertility treatments, few researchers have focused on the interpretations and experiences of ART among mothers of multiples (e.g., Callahan et al.; Ellison et al.; Cook et al). Mothers of multiples and mothers of singletons who undergo fertility treatments tend to be studied together, which fails to account for the particulars of the multifetus pregnancy—such as the associated higher risk to the woman and fetuses, the resulting more intensive monitoring during pregnancy, and the greater potentiality for people to assume ART was involved in conception. In this study, we recognize the uniqueness of the experience of a multifetus pregnancy and focus on how women who undergo ART to become pregnant with multiples feel. We unpack how mothers of multiples interpret the stigma tied to the association of ART with multiple births, and explore how this stigma may represent another way that women, seemingly empowered by an ability to have some control over reproduction, are instead disempowered, even stigmatized, in society. Drawing on in-depth semistructured interviews with a sub-sample of twenty-three women who had undergone some form of ART to become pregnant with multiple fetuses, we focus on their interpretations of the stigmatization as they experience their transition from being infertile to undergoing ART to being mothers of multiples.

### Method

Our study on women with multiples who had undergone fertility treatments is a part of a greater study of forty-one mothers of multiples, in which in-depth, semistructured face-to-face or telephone interviews were conducted. To be eligible to participate, interviewees had to have given birth to twins or triplets, identify as female, and live in southwestern Ontario. In the full

sample, the majority of respondents have twins (95 percent;  $n=39$ ) and two respondents have triplets. A total of 24 percent ( $n = 10$ ) of the interviewees had identical twins, and of these women, 20 percent ( $n = 2$ ) had undergone fertility treatment that resulted in the multiple fetus pregnancy, whereas the other 80 percent ( $n = 8$ ) had not used fertility treatments. The other 76 percent ( $n = 31$ ) respondents had fraternal (nonidentical) twins, of which 68 percent ( $n = 21$ ) had undergone fertility treatments, and the other 32 percent ( $n = 10$ ) had not. In our study, our sample is limited to the two women with identical twins and to the twenty-one women with fraternal twins who had their multiples after undergoing ART ( $n = 23$ ).

**Table 1**

	Women with identical twins	Women with fraternal twins	Total
ART women	2	21	23*
Non-ART women	8	10	18
Total	10	31	41**

\*Our sample; \*\*Original sample

Of this group of women who had undergone fertility treatments, interviewees ranged in age from twenty-six to forty-eight years. (Two respondents were in their twenties while the majority were in their late thirties to mid-forties.) A total of 88 percent of respondents self-reported their race/ethnicity as white and the other 12 percent as nonwhite (i.e., Indian, Asian, black). Most respondents (85 percent) were legally married when interviewed and had also been when they conceived multiples; for some, it was their second marriage.

Participant recruitment occurred at the community level and was made possible by parents of multiples associations in Toronto, ON, and the surrounding area that agreed to circulate an email advertising the study to their members. Given the advertisement was emailed to potential participants through confidential member databases, we cannot state for certain the number of persons who declined to participate. To counter this limitation, we ensured that theme saturation was apparent in all reported findings before ceasing to interview, despite many persons continuing to show interest in participating. No discernible differences were found between the transcripts of persons interviewed

in person and those by telephone. Perhaps this is due to most respondents electing to be interviewed by telephone for the convenience and the flexibility it provided—a choice given to respondents because many suggested it was difficult and costly to find childcare to do the interview in person or preferred to minimize travel time.

Interviews were conducted between February and April. In-person interviews were conducted in private at the home of the participant or interviewer, and sometimes children were present. Interviews ranged in duration from 50 minutes to 150 minutes depending on a variety of factors including the following: depth of family history, multitude of experiences, and general talkativeness—however a short open-ended item guide was available for use. This guide was abandoned once conversation began to flow, which gave the interviewer flexibility to probe emergent conversational paths.

Interviews were voice recorded and followed by a verbally administered demographic survey documenting age, number of children, pregnancy-related medical history, education, income, religion, ethnicity, and occupation. This particular study emerged entirely from the data as our attention was drawn to the ways participants spoke about the topic in question (Charmaz; Glaser and Strauss; Strauss and Corbin). Transcripts were coded based on emergent themes. Select coding followed (e.g., less relevant data was omitted), and central themes—composed of multiple respondents describing similar experiences, views, and feelings regarding a topic of interest—became the focus (Strauss and Corbin; Charmaz). The interviews were coded and the interviewer, with knowledge of the data, reviewed the coding to ensure the responses of the participants were interpreted in context.

Informed consent was obtained. Participants were offered an honorarium for their time. This manuscript uses pseudonyms to protect the identities of the respondents. To stay true to the voices of the respondents, quotes are presented with minimal edits. However, to assist with comprehension and flow, some quotes have been edited for speech fillers and grammar.

## Findings

The responses and narratives expressed by interviewees, as they described disempowering and stigmatizing experiences during their transition from “infertility” to motherhood, are analyzed thematically and framed using Link and Phelan’s five components of stigma: labelling, stereotyping, separation, status loss, and discrimination. First, the public and self-stigma of infertility, which may motivate women toward motherhood at any cost and to undergo ART, is discussed. Second, we present attribution theory in practice and how it translates into internalized stigma—how most women feel at loss for being

infertile and how after becoming mothers of multiples, some continue to identify as being disempowered and discreditable in their new positioning. Third, the stigma management strategy used to avoid judgment and condemnation from others for being mothers of multiples is examined.

### Labelling and Stereotyping: Infertility as Stigma and Stressors

The stress of being infertile, and the associated experience of stigma, is a ubiquitous theme across interviews. Women described emotional vulnerabilities tied to being unable to conceive without ART as disempowering, which created a sense of being less than a biologically sound woman. Jenna, for example, explained: “it really made me feel like a genetic misfit, that how we naturally reproduce and I’d never have children.” Jenna, echoing others, perceived herself as inferior; with a deviant body. Many women expressed feeling guilty, depressed, and had reduced self-esteem as they experienced their infertility. Most pronounced here was the view enforced on women, perhaps unintentionally that their purpose as they age and marry is to have children and start a family, not doing so—and being stripped of the ability to choose if or when to start a family—was attributable to personal failure and tied to an inability to acquire, let alone lose, the status of mother. Ivy articulated the difficulties she experienced because of the disempowered position she occupied, unable to control her own body:

*It [being infertile] was very hard on me, I was actually seeing a therapist. I was very depressed. I felt like I prepared my whole life for this moment, got married, bought a house, got good jobs, want to start a family and we [she and her husband] couldn’t. It was really hard on me emotionally.*

Through socialization, women develop societally imposed expectations that achieving (or not achieving for the matter) may generate stress, a sense of failure and a degree of social exclusion. This social exclusion results from being unable to continue to participate in life transitions—to be a part of the institution of motherhood. It becomes even more pronounced when alongside peers who do have children as well as peers who do not by choice; at least initially or until they come to terms with their infertility and the associated identity, removal of agency, and exclusion from experience.

The stresses of infertility and the forced exclusion from motherhood serve the function of encouraging women to undergo ART. ART represents a woman’s journey from being “discreditable” to “discredited.” Specifically, the decision to undergo ART transforms a woman’s secret and concealed stigma of being infertile into one that can no longer be concealed if medical intervention is to

be sought. During this transformation, the social and societal stigma infertility imposes is internalized and translated into self-stigma.

### Separation and Status Loss: Construction of Categories and Attribution Theory

Interviewees constructed categories to define their own positioning in relation to motherhood, their ability to have children, and their own multiples. Most often, women elaborated on the dichotomy of “natural-real” or “fertility-artificial” when explaining their own experiences of becoming mothers. Many women who underwent fertility treatment categorized, at times intentionally and other times unintentionally, all mothers in two categories: “fertiles” and “infertiles.” Interviewees, echoing Jill Allison’s findings, felt strongly that those in the fertile camp could never understand the isolation, pain, and frustration of those who were infertile. The carving out of a particular social niche for infertile mothers stemmed from the sociological imagination that assumes all men and women are capable of becoming parents (Allison 13). It was something they struggled with repeatedly as they sought motherhood. They felt disempowered by their inability to conceive, disempowered by their detachment from the status of motherhood, and disempowered by a society that suggests they failed to live up to the socialized role expectation attributed to their gender. In a response to persons having multiples but not disclosing the use of ART (i.e., whether or not they had undergone fertility treatments), interviewees sought to constitute those who had *not* shared their experiences with ART as “the others.” This was either because they did not understand the pain that drove them to fertility treatment or because the pain was deep enough that it resonated as shame and thus prevented some women from disclosing their use of fertility treatments, which is even more isolating and sad.

The binary identity of fertile-infertile also, at some point, transforms into a hierarchy among women, where fertile women are placed higher on the ladder rungs than those women who identify as infertile. The fact that such a hierarchy exists reveals the shame tied to the inability to conceive, to biology, and to the disempowered position—one that has shaped women over history (World Health Organization; Abbey et al.). For women who cannot conceive, to even try to meet the standards of idealized motherhood is an impossibility in itself. This hierarchy is further intensified when the women in question are mothers of multiples—women who have the less common opportunity to birth more than one baby. Perhaps, the fact that multiple births are more common today because of the use of fertility treatments lends insight into why there is a hierarchy among these mothers. Those who have multiples

after ART may be perceived as making something rare, something special and unique, all the more common.

Contrary to the popular belief that women opting for ARTs represent agential freedom and decision making that gives them empowerment (Parry 206), for many women in our sample, choosing ARTs to alleviate childlessness is perceived as a deviant and unnatural act by others. In resonance with attribution theory, many of our interviewees echoed that being a “fertility mom” is seen by some as a denigrating label in its own—avoidable, by not opting for ART. This position appears further aggravated when fertility mothers of multiples are juxtaposed with natural mothers of multiples. Non-ART conceived multiples are seen to be an uncontrollable reality, unlike multiples conceived through ART; hence, the former evokes more understanding from others than the latter. Most women in our sample, appearing to internalize this position, felt they deserved less support and empathy from family, friends, or support groups because they had “asked for” multiples by opting for ART, and that mothers of multiples who did not undergo ART are more deserving of support. For instance, when talking about how she felt about being in a support group for mothers of multiples, Emma commented:

*So, to me it's almost like they're there to support someone unlike me that went through all of this paid for it... And I don't know sometimes I think that I'm less deserving of a club that we have because of that ... even my dad made a comment one time like 'well this is what you wanted, you know' ... But I think that what I said about the whole multiples club, even you know that other moms need the help, need the support, more than me because I'm the one who asked for this, do you know what I mean? And that's just my own issue.*

Emma, in her words, reveals the apparent public stigma of being a mother of multiples through ART as well as the public notion that a mother of multiples requires more support and help than a mother of singleton.<sup>2</sup> However, the women in our sample internalize the stigma tied to undergoing ART and hold themselves responsible for having twins. Fertility treatment, of course, does not mean one will have twins or even become pregnant, yet these women feel responsible for getting into it.

### Disclosure Dilemma

In addition to infertility as a stigma, the remedy to being unable to conceive without intervention is also stigmatized, which serves to further disempower and injure women by creating shame and destroying pure agency. This inter-

nalized experience is apparent from women’s attitudes toward not disclosing or selectively disclosing that they are undergoing (or had undergone) fertility treatment. To avoid judgment from others and to establish themselves as moral and nondeviant individuals, some women did not discuss that they had undergone fertility treatments to anyone. They only disclosed because of the confidentiality tied to the interview experience. (These mothers presented as needing to take the opportunity to talk about this decision and to unbottle their feelings about their experiences.<sup>3</sup>) Lara, in response to our question about her open-ness (of disclosure) with the use of ART, said:

*No! I don't discuss it [fertility treatment] openly. [Because I have multiples] that's the first question everyone asks [if they were conceived through fertility treatment]. People have become more judgmental, and I find it very rude. I mean, it's nobody's business. And I deny it [that I went through fertility treatment], I'm like no!*

Lara’s decision to not discuss her choice of ART stems from some degree of “stigma schematicity” (Pinel; Jones et al.). She appears to have internalized the social learning that ART use is somehow not right, and in response, she feels the need to resort to complete denial to protect herself from being labelled as a fertility mom. This is a recurrent theme among many interviewees who selectively disclose because they feel the stigma attached to infertility—a stigma with which they seek to disassociate.

Other women choose the more common strategy of selective disclosure to manage the stigma associated with having multiples through ART. Tina, who selectively disclosed her fertility status to only family or close friends, said:

*I did tell, yeah, I took an ovulation stimulation drug. I have PCOS [polycystic ovary syndrome], they [people] didn't really follow. They were like Oh! Fertility, you know. Like there's such judgment.*

Tina’s words reinstate the strength of the stigma tied to fertility treatments. She not only practices selective disclosure but also makes a point to rationalize to people through her medical condition (PCOS) that she has a qualified medical need for ART. Her syndrome prevented her from becoming pregnant without intervention and rationalized the “need” for ART. She medicalized her inability to conceive as a health problem, an illness, or a symptom of a treatable illness paralleling it to how any illness would be treated, and as such, the natural next step would be to treat her condition as well. Echoing other interviewees, she illustrates that some women felt a need to justify their discrediting choices as normative and nonaberrant, despite the supposed

agential freedoms granted by access to fertility treatments.

Fertility treatments may liberate women from the infertile stigma, but at the same time, they impose on them the stigma of being artificially fertile, the solution to which is a variant of a stigma management strategy that the women themselves employ. As evidenced above, and earlier argued by Slade and colleagues, high levels of fertility-related stress are associated with reduced disclosure, and women take action to mask or hide their infertility (or, here, use ARTs as well)—a form of resistance to or negotiation of stigma and the associated disempowerment.

## Discussion and Conclusion

During the past few decades, the enhancement of women's agential freedom should have, theoretically, mitigated stigmata attached to infertility. Instead, such stigma has intensified or has changed form when women exercise their agency and choose ART to alleviate childlessness. Through our interviews, we learned individual women go through a wide variety of experiences as a result of infertility and in taking measures (fertility treatments) to achieve motherhood. Interviewees expressed both stigma and judgment tied to infertility and ART, specifically having multiples after undergoing ART. The stigma of using ART is arguably an extension of the stigma of experiencing infertility, which exerts stressors in different realms of women's lives—the ramifications of which are loss of self-esteem, pride, and confidence that lead to a disempowered position or status loss. Rather than responding to the disempowered position of women who are unable to conceive, our interviewees revealed that women are potentially either discreditable or discredited because of the process they underwent to become mothers. They still were not able to become mothers without intervention. Moreover, the fact that multiple fetus pregnancies have become more common with the use of ART (Sunderam et al. 1) may ignite a new source of stigma, that is tied with fetal reduction—a process of aborting one or more fetuses to reduce their number for medical or non-medical reasons. The essence of this stigma is readily apparent in the shame some interviewees reported when asked about their use of ART; in essence, they feel labelled and separated from mothers of multiples who did not undergo ART to conceive and, for some, judged.

Women who become mothers of multiples after undergoing ARTs see themselves in a socially disadvantaged position (i.e., with a vulnerable or loss of status) because of the societal judgment attached to the unnaturalness of the interventions. They take steps to manage or avoid the anticipated stigma associated with ARTs by denying it completely or by selectively disclosing it to people who are very close to them. The concern that others will look

down upon, shun, or discriminate against them is at the heart of the anticipated stigma. An interesting and novel finding of our study was that fertility mothers of multiples thought of themselves as less deserving of support or help when compared to other (non-ART) mothers of multiples. They tend to degrade themselves because they think they had “asked for it” deliberately, whereas for other mothers, it had happened naturally. This abasement of self is arguably the result of internalized stigma imposed by the society on fertility moms because they were unable to meet the natural standards of idealized motherhood. In essence, these mothers self-discriminate; they perceive themselves as less eligible for the supports offered to mothers of multiples because of their own use of ART. However, at no point did the discussion centre on if these women actually have a choice in using ART. To fulfill their desire to be a mother, their only option for a biological child was the use ART. Thus, if that is their dream (and society pressures individuals to seek their dream at all costs), what is the actual degree of agency these mothers have? And in light of the apparent expense and time commitment—which we refer to as sacrifice—required to undergo many forms of ART, cannot their sacrifice to become pregnant be interpreted as making these mothers even more entitled to supports?

Overall, mothers of multiples who undergo ART face numerous challenges in every stage of their transition to motherhood. They are, or feel at times, labelled and stereotyped. They feel separated from non-ART mothers of multiples and experience a perceived or real loss of status (Link and Phelan). These mothers either feel, self-discriminate, or are discriminated against in terms of accessibility or deservingness of support. Yet despite the increasing number of mothers of multiples, directly tied to the use of ART, a lack of research in the area remains. Thus, it has become necessary to study mothers of multiples as they are gradually growing in number and constituting a significant proportion of the population. It is time that the devaluation and disempowerment of fertility moms be addressed, not only from a biomedical or feminist perspective but also from a holistic psychosocial perspective—one that takes into account the dynamics of the stigma associated with infertility as well as with ART and the resulting multiple births.

## Endnotes

<sup>1</sup>Québec dropped the funding in 2016 which has led to dramatic decrease in births due to IVF treatments in the province ever since (Hendry).

<sup>2</sup>The views presented do not represent those of the authors.

<sup>3</sup>Most pronounced among these interviewees was a need for reassurance that their stories were confidential.

## Works Cited

- Abbey, Antonia, et al. "Psychosocial Predictors of Life Quality. How Are They Affected by Infertility, Gender, and Parenthood?" *Journal of Family Issues*, vol. 15, 1994, pp. 253-71.
- Allison, Jill. *Motherhood and Infertility in Ireland: Understanding the Presence of Absence*. Cork University Press, 2013.
- Bhattacharya, Siladitya. "Assisted Conception and Multiple Pregnancies: Methods of Reducing Multiples from Assisted Reproduction." *Expert Rev. Obstet. Gynaecol*, vol. 2, no. 5, 2007, pp. 541-44.
- Becker, Gaylene. *The Elusive Embryo: How Women and Men Approach New Reproductive Technologies*. University of California Press, 2000.
- Blenner, Janet L. "Stress and Mediators: Patient's Perceptions of Infertility Treatment." *Nursing Research*, vol. 41, 1992, pp. 92-97.
- Bunch, Charlotte. and Samantha Frost. "Empowerment." *Routledge Encyclopedia of Women: Global Women's Issues and Knowledge*, edited by C. Kramarae and D. Spender, Routledge, 2000, pp. 554-55.
- Burns, Linda Hammer, and Sharon N. Covington. *Infertility Counseling: A Comprehensive Handbook for Clinicians*. Parthenon, 1999.
- Callahan, Tamara, et al. "The Economic Impact of Multiple-Gestation Pregnancies and the Contribution of Assisted Reproductive Techniques to Their Incidence." *New England Journal of Medicine*, vol. 331, 1994, pp. 244-49.
- Carmeli, Yoram S., and Daphna Birenbaum-Carmeli. "The Predicament of Masculinity: Towards Understanding the Male Experience of Infertility Treatments." *Sex Roles*, vol. 30, 1994, pp. 663-77.
- Charmaz, Kathy. *Constructing Grounded Theory*. Sage Publications Ltd., 2006.
- Cook, Jocelynn L., et al. "Assisted Reproductive Technology-Related Multiple Births: Canada in an International Context." *Journal of Obstetrics and Gynecology Canada*, vol. 33, no. 2, 2011, pp. 159-67.
- Creed, Douglas, and Maureen A. Scully. "Songs of Ourselves: Employees' Deployment of Social Identity in Workplace Encounters." *Journal of Management Inquiry*, vol. 9, 2000, pp. 391-412.
- Dyer, S., et al. "'You Are a Man Because You Have Children': Experiences, Reproductive Health Knowledge and Treatment-Seeking Behaviour among Men Suffering Couple Infertility in South Africa." *Human Reproduction*, vol. 19, 2004, pp. 960-67.
- Ellison, Marcia A., and Janet E. Hall. "Social Stigma and Compounded Losses: Quality of Life Issues for Multiple-Birth Families." *Fertility and Sterility*, vol. 80, no. 2, 2003, pp. 405-14.
- Ellison, Marcia A., et al. "Psychosocial Risks Associated with Multiple Births Resulting from Assisted Reproduction." *Fertility and Sterility*, vol. 83, no.

- 5, 2005, pp. 1422-28.
- Ferguson, Rob. "Ontario to Cover In-vitro Fertilization Treatments." *The Star*, 1 Oct. 2015, [www.thestar.com/news/queenspark/2015/10/01/ohip-to-cover-in-vitro-fertilization-treatments.html](http://www.thestar.com/news/queenspark/2015/10/01/ohip-to-cover-in-vitro-fertilization-treatments.html). Accessed 7 Oct. 2017.
- Fisher, B. "Against the Grain: Lives of Women without Children." *IRIS: A Journal about Women*, vol. 12, no. 2, 1992, pp. 46-51.
- Forrest, Linda M. and Mary S. Gilbert. "Infertility: An Unanticipated and Prolonged Life Crisis." *Journal of Mental Health Counseling*, vol. 14, 1992, pp. 42-58.
- Gerrity, Deborah A. "A Biopsychosocial Theory of Infertility." *The Family Journal: Counseling and Therapy for Couples and Families*, vol. 9, no. 2, 2001, pp. 151-58.
- Glaser, B. G., and A. L. Strauss. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine Publishing Company, 1967.
- Goffman, Erving. *Stigma: Notes on the Management of Spoiled Identity*. Prentice Hall, 1963.
- Greil, Arthur L. *Not Yet Pregnant: Infertile Couples in Contemporary America*. Rutgers University Press, 1991.
- Hegarty, Peter and Anne M. Golden. "Attributional Beliefs about the Controllability of Stigmatized Traits: Antecedents or Justifications of Prejudice?" *Journal of Applied Social Psychology*, vol. 38, no. 4, 2008, pp. 1023-44.
- Hendry, Leah. "IVF Treatments Drop Dramatically Since Quebec Funding Cut 6 Months Ago." *CBC News*, 12 May 2016, [www.cbc.ca/news/canada/montreal/ivf-quebec-funding-1.3577865](http://www.cbc.ca/news/canada/montreal/ivf-quebec-funding-1.3577865). Accessed 7 Oct. 2017.
- Inhorn, Marcia. "The Worms Are Weak: Male Infertility and Patriarchal Paradoxes in Egypt." *Men and Masculinities*, vol. 5, 2003, pp. 236-56.
- Jones, Edward E., et al. *Social stigma: The Psychology of Marked Relationships*. Freeman, 1984.
- Jordan, C., and T.A. Revenson. "Gender Differences in Coping with Infertility: A Meta-Analysis." *Journal of Behavioral Medicine*, vol. 22, 1999, pp. 341-58.
- Kelland, J., and Rosemary Ricciardelli. "Mothers of Multiples' Perspectives on Fetal Reduction and Medical Abortion: Medical and Non-Medical reasoning." *Journal of the Motherhood Initiative*, vol. 5, no. 2, 2015, pp.123-140.
- King, Eden B., and Whitney E. Botsford. "Managing Pregnancy Disclosures: Understanding and Overcoming the Challenges of Expectant Motherhood at Work." *Human Resource Management Review*, vol. 19, 2009, pp. 314-23.
- Link, Bruce G., and Jo C. Phelan. "Conceptualizing Stigma." *Annual Review of Sociology*, vol. 27, 2001, pp. 363-85.
- Major, Brenda, and Laurie T. O'Brien. "The Social Psychology of Stigma." *Annual Review of Psychology*, vol. 56, 2005, pp. 393-421.
- Miall, Charlene E. "Perceptions of Informal Sanctioning and the Stigma of

- Involuntary Childlessness.” *Deviant Behavior*, vol. 6, no. 4, 1985, pp. 383-403.
- Parry, Diana C. “Women’s Experiences with Infertility: Exploring the Outcome of Empowerment.” *Women’s Studies*, vol. 34, no. 2, 2005, pp. 191-211.
- Piliavin, Irving M., et al. “Good Samaritanism: An Underground Phenomenon?” *Journal of Personality and Social Psychology*, vol. 13, no. 4, 1969, pp. 289-99.
- Pinel, Elizabeth. “Stigma Consciousness: The Psychological Legacy of Social Stereotypes.” *Journal of Personality and Social Psychology*, vol. 76, no. 1, 1999, pp. 114-28.
- Quinn, Diane M. and Stephanie R. Chaudoir. “Living with a Concealable Stigmatized Identity: The Impact of Anticipated Stigma, Centrality, Salience, and Cultural Stigma on Psychological Distress and Health.” *Journal of Personality and Social Psychology*, vol. 97, no. 4, 2009, pp. 634-51.
- Slade, Pauline, et al. “The Relationship between Perceived Stigma, Disclosure Patterns, Support and Distress in New Attendees at an Infertility Clinic.” *Human Reproduction*, vol. 22, no. 8, 2007, pp. 2309-17.
- Strauss, A. L., and J. Corbin. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Sage Publishing Ltd., 1990.
- Sunderam, S., et al. “Assisted Reproductive Technology Surveillance—United States 2013.” *Morbidity and Mortality Weekly Report Surveillance Summaries*, vol. 64, no. 11, 2015, pp. 1-25.
- Throsby, Karen. *When IVF Fails: Feminism, Infertility, and the Negotiation of Normality* Macmillan, 2004.
- Veevers, Jean E. *Childless by Choice*. Butterworth, 1980.
- Weiner, Bernard, et al. “An Attributional Analysis of Reactions to Stigmas.” *Journal of Personality and Social Psychology*, vol. 55, no. 5, 1988, pp. 738-48.
- World Health Organization. “Mother or Nothing: The Agony of Infertility.” *Bulletin World Health Organization*, vol. 88, 2010, pp. 881-82.