



Fertility treatments among single mothers by choice in Israel, their experience and support systems

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DOI: <https://doi.org/10.33545/nursing.2020.v3.i2.A.100>

Abstract

Background: Purpose: the study examines the difficulties and support systems of single mothers by choice undergoing fertility treatments.

Design: A mixed-method research design was employed to collect quantitative and qualitative data simultaneously from single women undergoing fertility treatments.

Methods: A questionnaire that evaluates the women's coping with the fertility treatments and their support systems, where such systems exist, was distributed to a random sample of 150 single women, ages 34–45, undergoing fertility treatments in Israel. In addition, 5 interviews were conducted.

Findings: Many participants reported financial difficulties, lack of family support, and fear of being alone in the process and after giving birth. Despite these difficulties, 45% of the participants reported that they would not quit treatment but would continue intensively.

Conclusions: Single mothers by choice must contend on their own with the mental, physical, and financial burdens of prolonged fertility treatments. Often, they express their difficulties but avoid psychological treatment, even when it is offered. Clinical staff should be aware of their difficulties, offer explanations, and refer them for appropriate assistance.

Clinical relevance: The emotional aspects of fertility treatments are integral to coping with the difficulties such treatments pose, and many studies have indeed focused on them with respect to couples. This study, however, examines the coping of single women, specifically single mothers by choice who have undergone fertility treatments in Israel in which centrality of traditional nuclear family is dominant, and their various difficulties arise from their decision of choosing single motherhood.

Keywords: Single mother by choice, fertility treatments, coping strategies, support systems

Introduction

The 20th century saw many revolutions, but none with greater impact on the family in the industrialized world than the changes to the traditional familial framework: The traditional family structure has become less common and there has been an increase in other, diverse structures (Fogiel-Bijaoui, 2002) ^[4].

Nevertheless, in Israel, albeit an industrialized country, the traditional family structure remains dominant, parenthood is viewed positively, and heterosexual marriage is considered the most legitimate framework for having children. According to Israel's Central Bureau of Statistics, about 95% of couples in Israel are married. However, nontraditional family models have started appearing. These include lesbian mothers and single mothers by choice, minority groups that have been shunted to the margins of Israeli society (Shechner, 2013) ^[12].

Single mothers by choice are mainly heterosexual women in their late 30s and 40s, educated, and financially

independent. Most of them support the institution of marriage, which was their first choice. According to the literature, the decision to become a single mother is made when they consider that they have a very limited chance of finding a partner with whom to have a child before they are too old and their fertility has decreased, and they feel that time is running out (Graham & Braverman, 2012) ^[6].

In pursuing motherhood these women are not rejecting the nuclear family, but rather are reshaping the idea of motherhood and relationships with the aim of saving at least part of the ideal of the nuclear family that they have imagined for themselves (Graham, 2012) ^[5].

In Israel, family members and friends tend to react in one of two ways: In this society in which motherhood is a central value, many single mothers receive much support and sympathy for their decision to have children. But the decision may be met with offensive remarks, and some families exhibit disappointment because the woman will not be fulfilling their dream and giving birth within the

traditional marital system. there are also parents who feel sorry for their daughter who is a single mother because of the great burden they expect she will have to bear, but in contrast, other parents admire her for managing to do everything alone (Nevo, 2015).

These women can achieve motherhood in various ways, but they often do so by means of fertility treatments with donated sperm. As a pronatalist country, Israel funds fertility treatments for all its citizens—married couples, single women, lesbian women, Jews or Arabs, up to the age of 45 for a woman attempting to conceive using her own eggs and up to a later age for women using donated eggs (Hashiloni-Dolev, 2013) [8].

All fertility patients—from couples with difficulty conceiving to single women who choose this method of bringing children into the world—are affected emotionally. fertility treatments involve complex emotional coping, because they are demanding, complicated, and cumbersome to carry out, as well as damaging to the self-image (Schwerdtfeger & Shreffler, 2009) [11].

Often, single mothers who choose to have children outside the traditional family framework must contend not only with the emotional effect of the treatments but also with a lack of support from family members and friends who regard the choice with mixed emotions (Shechner, 2013) [12]. Therefore, the purpose of this study was to examine the various difficulties those women encounter on their way to motherhood.

Methods

Design and participants

A mixed-method research design was used in this study, and quantitative and qualitative data were collected simultaneously. Combining the data made it possible to better understand and deepen the interpretations of the findings. Participants were selected randomly. All the women had undergone fertility treatments (with medication) and IVF treatments, including frozen embryo transfer. Excluded from the study were women older than 45 who had undergone egg donation treatments

Measures

The quantitative data were gathered using a semi-structured questionnaire consisting of three sections:

- 1) A demographic section
- 2) A questionnaire based on the Fertility Problem Inventory (Newton *et al.*, 1999), providing a comprehensive evaluation of infertility-based stress by measuring the effect upon various dimensions of social life. The FPI scale contain 46 items, the scores for which are organized on five subscales which are: social concern (10 items), the need for parenting (10 items), rejecting lifestyle without children (8 items), the additional two subscales- sexual concern and relationship concern were not relevant to this study, and one global stress score composed of all the preceding factors. According to Newton *et al.*, Cronbach's α for these five indexes ranges between 0.77 and 0.87, showing good reliability (while the general stress scale has Cronbach α of 0.93).
- 3) coping section from Folkman and Lazarus' Ways of Coping Questionnaire and Charles Carver and

colleagues' Coping Orientation of Problem Experience (COPE). This questionnaire is composed of eight central indexes examining different coping strategies and coping functions with emotion regulation including: Confrontive coping (6 items), Distancing (6 items), Self-controlling (7 items), Seeking Social Support (6 items), Accepting Responsibility (4 items), Escape Avoidance (8 items), Planful Problem Solving (6 items), and Positive Reappraisal (7 items). The remaining 10 items are distractor items. Cronbach's α for these indexes ranges between 0.56 and 0.85.

Besides, for the qualitative study, a semi-structured interview format was used and followed an interview guide (Kvale, 2009), which characterized by flexibility and consisting of questions from different content fields and topics such as: difficulties and emotions accompanied the process, as well as coping strategies, support systems and continuing / quitting treatments.

Data collection

Data were collected between May 2018 and April 2019. 150 single mothers participated in the study. Participants who arrived the fertility clinic and met the study's criteria were asked to participate in the study. they received detailed information about the study's purpose and the anonymous questionnaire. After obtaining the participants' verbal consent and signing the informed consent form, then they were asked to fill out the questionnaire. once they have completed answering the questionnaire's questions, the questionnaires were returned within envelopes.

Conducting the interviews: prior to beginning of an interview, the participant's consent was needed, and had them sign a consent form to have the interview as well as recording it. The interview took place at the clinic or at the patient's home according to her preference. The duration of the interview was approximately 45–60 minutes.

Data analysis

All the data in the questionnaires were recorded in an Excel table, mostly based on the Likert scale, in accordance with the responses to the questions. Data analysis was conducted using SPSS software. To assess the correlation with categorical variables (for example, type of support) Chi Square tests were conducted.

A qualitative content analysis approach (Graneheim & Lundman, 2004) [7] was used to analyze the interview transcripts. Data processing began during data collection to determine when sufficient rich data were collected in relation to the study's purpose (Patton, 2002) [10]. Each interview was tape recorded, read multiple times to grasp the entirety of the data collected and transcribed verbatim. the written text was validated against the sound recordings. The text was further divided into meaning units – depending on content (Creswell, 2000) [3]

Ethical considerations

The ethics committee of the HMO in Israel (Helsinki Committee) approved the study on May 2018 after minor changes were made in the study's protocol and in the coding of the research questionnaire (for statistical analysis), and a signed informed consent form was obtained from each

participant.

Permission to conduct the study was given by the supervisors at eight women’s health centers across the country. Prospective participants who met the study criteria received detailed information about the study’s purpose, its importance, and the anonymous questionnaire. They were assured that complete confidentiality would be maintained regarding all the information gathered from them .

The interview did not begin until the participant signed a consent form .

Results

Quantitative study

A total of 150 women ages 34-45 (*M* = 39.5) participated in the study. Of these, 2% completed high school, 14% had a

non-degree certificate, 48% had a BA, and 35.3% had an MA or higher degree. As for children, 87% had none and 13% had one. About half of the total sample (54%) had tried to conceive for 1–2 years. Most of the women (73.3%) had undergone hormonal therapy and 23.3% had undergone IVF treatments .

About half of the sample (51%) reported that they had no need for psychological support, whereas 28% applied for support groups for single mothers .

As shown in Figure 1, 43 women (28.6%) reported that they had no support from their family, 30 women (20%) reported that their families were aware of their difficulties but did not provide support, and only 22 women (14.6%) reported that they received partial support (mainly financial) from their family.

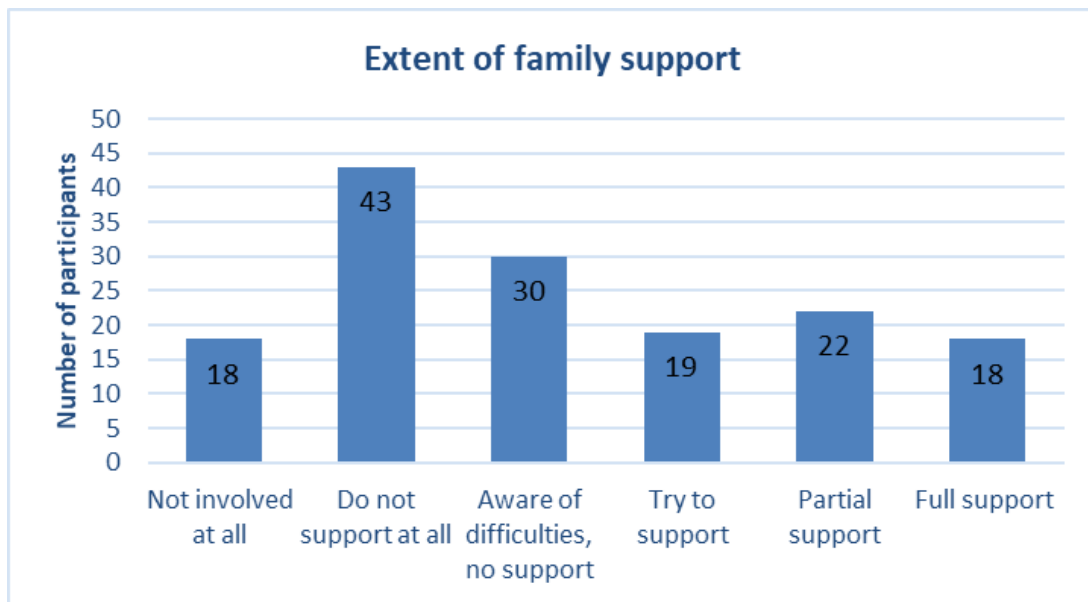


Fig 1: Extent of family support of single women undergoing fertility treatments

About 28.7% of the women reported that they did not share their emotions with anyone; the same percentage reported sharing their feelings with close friends; and only 27.3% said they shared their emotions with a family member .

As shown in Table 1, encouragement and empathy were rated as the most common type of emotional support: 20.8% received positive reinforcement. Nevertheless, 39.6% of women in the sample reported that they had no emotional support from their family.

Table 1: Type of family support of single women undergoing fertility treatments

Type of family support	Number of participants	Percentage
Encouragement / empathy	31	20.8%
Listening	11	7.4%
Giving advice	22	14.8%
Reinforcements	26	17.4%
No support	59	39.6%

Strategies for coping with failure in reproductive treatment: 36.7% of the sample reported not overcoming their emotions, while 29.3% of them felt optimistic.

Feelings during treatments described by the women as the most common were: Loneliness- 35.3%, Difficulty- 30.6%, and self-blame- 28.6%.

Nearly half the women in the sample (45%) reported that they would not quit treatment and would continue intensively. In addition, 25% reported that they had thought of quitting, but had not quit. Of the remaining participants, 12% had thought about quitting treatment after a certain number of treatment cycles, and 14.6% reported that they were considering quitting .

Correlations between coping subscales and support

Five interviews were conducted (saturation of data was obtained after 5 interviews) The respondents’ ages ranged from 37–44 (*M* = 40. 5 years). Of these, 20% had completed high school, 20% had a diploma, 40% had a BA, and 20% had an MA or higher degree. None had children. All had undergone fertility treatments (with medications) and IVF treatments, including frozen embryo transfer. All reported that they had wanted to have children within a relationship, but their ticking biological clock and unfulfilled hope of finding a partner left them no choice but to have a child alone. In addition to their difficulties with the fertility treatments, many reported financial difficulties, lack of

family support, and fear of being alone in the treatment process and after giving birth. All but one reported that they did not need professional emotional support. One of the interviewees even said that this was due to her fear of being stigmatized. Only one interviewee had decided to quit treatment.

Discussion

The results indicate that many single mothers by choice choose this route to motherhood as their final option. This complex decision requires giving up the common fantasy of having a child in a stable family unit based on loving parity. Despite the intense yearning for a child, choosing to become a single mother is accompanied by many dilemmas, starting with the method of conception through sperm donation (anonymous or from a known person), concerns about their ability to raise the child on their own, fear of not having the financial resources for raising a child, and fear that their child will be adversely affected by growing up without a father figure. Single mothers by choice are often accused of irresponsibility, selfishness, and parasitism (“If you can’t raise a child, don’t get pregnant”). Also, the family and society may express disbelief in the mother’s ability to raise a child on her own and even declare that they will not bear the burden of caring for the child (Baron, 2008). According to Naor (2012), the choice to become a single mother can be due to several causes—societal pressure, the woman’s age, or fear of being lonely—and is not necessarily the desire to be a mother.

In Israel, lesbian as well as single mothers by choice belong to marginalized minority groups in the society. Childbearing outside of the traditional family model is frequently greeted with ambivalence of family and friends and insufficient support (Ben-Daniel *et al.*, 2007). Single mothers often report contradictory perceptions of the legitimacy of being a single mother and the fact that this must occur within a dominant culture that emphasizes motherhood in the context of marital status (Ben-Arieh & Khoury-Kassabri, 2007) ^[1].

There is a direct relation between supportive relationships and mental health. Social support produces a sense of identity, a sense of purpose, self-worth, and emotional regulation, moreover, social support provides material and psychological resources that enhance the ability to cope with stress. Single mothers tend to receive less social support and are more vulnerable to stress. In a recent study conducted in Israel, single mothers by choice reported higher levels of distress as a result of lack of social and familial support and a need for social support from other single mothers (Shechner, 2013) ^[12]

Most of the women underwent hormonal therapy repeatedly for two reasons: First, older women respond less than younger women to gonadotropins and produce fewer follicles despite higher dosages. They also require a greater number of treatments as a result of the decline in fertility that begins in their early 30s and significantly increases in their late 30s. Second, due to the state’s generous funding of fertility treatments, these women are determined to pursue motherhood at any cost, in keeping with the values of Israeli society, even when their chances of conceiving are low (Hashiloni-Dolev, 2013) ^[8].

The feeling of loneliness is intensified, especially among women who go through the entire process of fertility

treatments on their own without support. Although their decision and desire to bring a child into the world led them to this process, these women are sometimes at risk of developing depression and anxiety disorders because of the difficulties, stress, and anxiety that accompany the treatments (Tal, 2015) ^[13]. Despite the women’s striving for motherhood at all costs, a large part of them express great difficulty but do not admit they need psychological support and avoid accepting psychological treatment when offered. This could be because of fear of stigma or lack of trust in the therapist’s ability to understand their situation, as several interviewees reported. They feel more comfortable sharing their experiences with other single mothers.

Conclusions

The current study identifies the complexity of single mothers who have undergone fertility treatments in Israel. Because of difficulties in conceiving, they must cope with prolonged fertility treatments and the difficult decision to become a single mother. This decision has a heavy cost, whether financially, emotionally (the fear of being alone), and a lack of support, especially from family members and the society.

Choosing to be a single mother by choice in Israel involves various difficulties resulting from that decision, as well as blaming themselves for wasting precious time in waiting for the right guy instead of starting treatments at earlier age. Considering the fact that single mothers are often more sensitive to their lack of ties within the community broadly and their extended families, clinical staff should be aware of their physical, psychological, and financial needs at every stage of the treatment, giving them the appropriate information about the current and future consequences and referring them to appropriate assistance although their need for support groups is apt to vary.

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