Bringing infertility out of the shadows

Keith Graber Miller

Periodically the media treat us to a new case in the annals of reproductive technology. Remember the Buzzancas? In 1998 they resorted to surrogacy after many years of failed infertility treatments. Conception occurred in a petri dish, using the sperm and the egg of anonymous donors. The zygote was then placed into a woman with no genetic ties to any of the parties. In a sense the child had five parents—John and Luanne Buzzanca, the anonymous donors of the sperm and the egg, and the surrogate mother. The story took an even more bizarre twist when John filed for divorce a month before the baby was born. Luanne sought child-support payments, but John said he wasn't the baby's father "in any legal sense," although he had signed a contract. The judge agreed. The judge also ruled that Luanne was not the legal mother: the baby had no legal parents.[1]

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As this case illustrates, the human desire to have children is strong. Also evident is the power of our reproductive technology, means we may turn to when our desire to procreate is painfully thwarted. And the story of the Buzzancas graphically displays the mess that sometimes results from indiscriminate use of that technology; the case serves as a textbook example of how advances in reproductive science race ahead of the law, leaving complex ethical and legal questions unanswered and leaving children in the lurch.

Such extreme high-profile cases claim our attention, while silence surrounds the common reproductive problems experienced by growing numbers of people in our congregations. Despite the Mennonite practice of congregational sharing about health concerns, many gut- and womb-wrenching experiences and

decisions related to the beginning of life remain in the shadows in our churches, sometimes unspoken even in small groups and with intimate friends. In our silence we fail to provide the pastoral care that couples need amid the losses of infertility, and we leave them alone and bereft of guidance as they confront a bewildering array of possible technological interventions.

In our congregations we urgently need to find ways of giving each other permission to speak about beginning-of-life issues and experiences. We need to explore together how biblical stories can best shape us and inform our choices around these matters. We need to enhance our ability to deliberate together about the ethical issues, so that we can be accountable with one another and support one another in the courses we pursue. We need to find ways to walk alongside each other through losses and moral dilemmas at the beginning of life.

Sermons that encourage openness

How do we open up conversation in our congregations about health care issues surrounding the beginning of life? Preaching that is sensitive, careful, and challenging is a critical step in bringing infertility out of the shadows in our churches. The Bible is replete with passages that provide fodder for stimulating sermons on procreation, infertility, and the beginning of life.

According to the Bible, the impulse to procreate is basic to human nature as created by God. The first chapter of our Scriptures includes a divine mandate, addressed to the newly created humans, to be fruitful and multiply (Gen. 1:28). This command is repeated to Noah and his family as they set foot on dry land again (Gen. 9:1). To have offspring, in the biblical view, is to carry on and support the work of creation. To procreate is, as the word's Latin roots indicate, to act in behalf of creation. According to the Old Testament, God is the ultimate source of all life, and all human procreation is therefore both gift and mandate from the life-giving God.[2] Preaching on these biblical materials can help us honor the strength of our desire for children, and see the basis for that powerful impulse in our biology and our theology.

But for many couples, the biblical directive to be fruitful is difficult, if not impossible, to follow. Approximately 15 percent of

married couples in North America experience infertility, which is defined as the inability to conceive a pregnancy after a year of trying, or repeated failure to carry a pregnancy to term. Secondary infertility, the inability to bear another child after a successful pregnancy, affects perhaps half of infertile couples. The incidence of infertility has nearly tripled in the last thirty years, because of a variety of environmental, medical, and sociological factors. These include later marriages, postponed attempts to conceive, sexually transmitted infections, and some forms of birth control. Ninety percent of the time a physical problem can be identified. Of that 90 percent, roughly a third of the time the difficulty can be attributed to the man, and a third of the time to the woman. In the remaining cases, it is a problem for both members of the couple—and in some sense, that is always so.[3]

Bible stories reveal the pain that accompanies an inability to conceive and bear children. Rachel's plea to Jacob offers an engaging title for a sermon on this subject: "Give me children, or I shall die!" she demands in desperation. Jacob angrily responds, "Am I in the place of God, who has withheld from you the fruit of the womb?" (Gen. 30:1–2). When biblical women are barren, and many are, God is identified as the cause; God is the one with power to close and open the womb. Sarah observes to Abraham, "You see that the LORD has prevented me from bearing children" (Gen. 16:2). The author of 1 Timothy writes, in what I hope was a weak moment, that women will be saved through bearing children (2:15). This passage seems to leave childless women doubly doomed, both here and hereafter.[4] To the natural pain of infertility and the accompanying sense of failure (the questioning of our virility, the loss of our dreams) such texts seem to add a theological condemnation. Pastoral preaching on infertility should sensitively address the various aspects of pain these texts engage.

Barrenness often functions as the driving motif in a biblical narrative or a sequence of narratives: for Sarah (Gen. 11:30; 16:1), for the women of the house of Abimelech (Gen. 20:18), for Rebekah (Gen. 25:21), for Rachel (Gen. 29:31; 30:1), for the wife of Manoah (Judg. 13:2), for Hannah (1 Sam. 1:2, 5–6), and for Elizabeth (Luke 1:7). In all these stories, barrenness is not the final word; it is a foil for the life-giving power of God. In each case, through divine intervention the curse of barrenness gives

way to the blessing of conception and childbearing.[5] But in some of these stories, before God gets around to satisfying their desire for children, people take initiative to find a way. Despite its distance from our world in time and technology, the Bible also includes stories of people who, facing a life that isn't turning out as they expected, use their ingenuity to overcome their barrenness. Like us, the ancients wrestled with the perennial human problem of what to do when life fails to live up to our hopes and expectations, when it dashes our dreams. This dilemma is the stuff of good sermons.

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When Abraham and Sarah are not able to conceive their promised child, they use Hagar as a surrogate (Gen. 16:1–15). As in the Buzzanca story, this surrogacy arrangement has its complications. In the end, both Sarah and Abraham act with contempt toward Hagar and Ishmael, and shamefully drive them away (Gen. 21:9–14). Only because God steps in do Hagar and Ishmael survive and flourish. When Rachel, Jacob's beloved wife, finds herself barren, she says to Jacob, "Here is my maid Bilhah; go in to her, that she may bear upon my knees, and that I too may have children through her" (Gen. 30:3–7). Jacob's other wife, Leah, experiences some secondary infertility after birthing four children, so she gives Jacob her maid Zilpah, and births two more children through her before conceiving more on her own (Gen. 30:9–13). Deuteronomy 25:5–6 prescribes the practice of levirate marriage, a kind of surrogacy: "When brothers reside together, and one of them dies and has no son, the wife of the deceased shall not be married outside the family to a stranger. Her husband's brother should go in to her, taking her in marriage," and the first son whom she bears "will succeed to the name of his brother who is dead." These texts illustrate the possibilities for human intervention to overcome childlessness, as well as the complications that sometimes attend such arrangements.

This brief survey suggests an abundance of biblical stories which pastors can draw on to preach about God's care for human procreation and about the human pain and dilemmas surrounding

infertility. Other appropriate biblical materials for beginning-of-life sermons are birth predictions, announcements of pregnancies, birth stories, and texts expressing God's concern for life in the womb. Such sermons should introduce members to pastoral needs at the beginning of life, and to the complex ethical and health care issues surrounding infertility. Good pastoral preaching will create space for people to come forward with their own hurts, needs, and decisions, and will allow for ambiguity and the expression of unresolved anguish.

Resources that aid discernment

Twenty-five years ago, when a couple found they were infertile, they just didn't birth children. And they found ways to come to grips with their infertility, either remaining childless or adopting. Today the options have expanded dramatically, with the introduction of procedures such as in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and intracytoplasmic sperm injection (ICSI).[6]

When couples enter the arena of assisted reproduction, they inevitably face complex ethical problems. In addition to matters of justice and stewardship related to the high cost of treatment,[7] key issues include:[8] Do humans have a right to have children? If so, how far does that right extend? Why is it limited to the wealthy and the well-insured? May conception be separated from sexual intercourse? If God in love created all that is, and if our procreating is an expression of that love, should lovemaking always be a part of the process of conceiving a child? May infertile couples use donors' sperm or eggs, in nonmarital or extramarital reproduction? What is the status of surplus fertilized embryos? What are their rights? In a consumer society, how do we avoid treating childbearing and children as commodities to be bought and sold?

Developments in reproductive technology have outpaced our ethical and theological reflection on these beginning-of-life issues, and we now have trouble distinguishing the extraordinary from the ordinary. Sociologist Donald Kraybill observes that

> *We are caught in . . . an ethical gap as technology races far ahead of our ethical forumulas of bygone years.*

> *Ironically, as the technological precision increases, the moral precision wanes. The old answers that prescribed the boundaries between right and wrong, good and evil, are suddenly blurred by the provocative questions stirred by the spiraling genetic technology. After four decades of playing theological catch-up with the nuclear age, we finally have realized that the old "just war" formula is archaic for fighting nuclear wars. Now we face a new game of ethical catch-up as we try to maintain stride with the technological leaps in [assisted reproduction and] genetic engineering.*[9]

We are facing more complex ultimate decisions at the same moment that we—at least in the west—are being stripped of communal support because of our individualism and our desire for privacy. Many people are struggling with their health care issues alone, or with health care professionals who have their own biases and vested interests. Contrary to what our culture may tell us, conception, birth, and death are not just private and personal experiences; these events occur in communities. In these events our lives are interconnected with others'. Pastors, health care committees, and others need to support and nurture people in our congregations, and raise tough questions with them.

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A 1990s case that caught the media's attention was that of Mandy Allwood, a British woman who took fertility drugs to get pregnant with her lover. When Allwood did become pregnant, she learned that she was carrying eight fetuses. Some 20 to 30 percent of the pregnancies achieved through drugs or in vitro fertilization yield more than one fetus. Because no one had ever birthed eight live babies, doctors recommended surgically reducing the crowd in Allwood's womb so that at least some of the fetuses would be viable. This technique—now performed more than 3,000 times a year in the U.S.—involves inserting a thin needle into the most accessible fetuses and injecting a small amount of the poison potassium chloride.

Physicians refer to this as selective reduction, a euphemism for abortion. Allwood refused to undergo the procedure, and eventually miscarried the entire octet.[10] This case may seem far-fetched, distant from the experiences of people in our congregations. It isn't. Mennonite couples have had to make decisions about selective reduction, about using donor sperm and eggs, and about other technological assistance in conceiving children.

In our own family, Ann and I struggled with both primary and secondary infertility. It was nineteen months before we became pregnant with our first son, Niles, and we had completely given up on birthing more children when we became pregnant with Simon, more than seven years after our first pregnancy. We only took the first steps down the road of infertility treatment, stopping after a semen analysis, hysterosalpingogram, and laparoscopy. Between the births of our two energetic and delightful boys, we adopted Mia Bei, our remarkable daughter from China, a process that traded one set of issues for another—issues related to out-of-country adoptions and our willingness to consider a child with physical "imperfections." Adoptive parents, too, need the support and wisdom of their pastoral caregivers and congregations.

The pastor's role is not to rubber-stamp whatever choices people make. Pastors need to ask difficult questions in order to help people discern appropriate steps and respond in faithful ways to the health care issues before them. Ministers can provide information about reproductive technologies, or discuss the possibility of adopting or remaining childless. They can address theological understandings of procreation and barrenness. They can reflect on waiting, on hoping, on giving up, on other avenues for expressing the human drive to create and nurture new life.

Some church leaders are advocating for and developing health care committees or task forces in their churches. These committees can advise, convey information, and offer support. They should include a health care professional, a person who has studied ethics, someone who networks well with the congregation and community, and a member who can work with local hospitals or health care institutions. When people face health care decisions, the committee can assist with counsel, support, companionship, and making connections.

A health care committee could produce congregational resources about ethical and pastoral considerations in health care matters. The caring commission of College Mennonite Church (Goshen, Ind.) has developed a booklet, *Dealing with Death: A Guide to Resources*, which includes theological reflections, a living will declaration, a health care power of attorney, and a bibliography. A task force could assemble resources for dealing with critical issues at the beginning of life.

Ethicist Maura Ryan argues that infertility has become, in part, a "socially constructed impairment." She writes that "the availability of technology increases the burden many patients feel to pursue all methods of conceiving a genetically related child." Now, she says, "not even menopause releases the infertile woman from the 'obligation' to continue trying." Says Ryan, "When reproductive medicine denies finitude, when it denies 'the law of the body,' it fails patients in the area where they most need assistance: in discerning what is an appropriate pursuit of fertility."[11] Congregations need to find sensitive ways of assisting couples in such discernment.

Pastoral care that makes room for distress and grief

Pastors and other caregivers need to be sensitive to the emotional distress, anxiety, pain, and sadness experienced by both men and women as a result of infertility. I remember well the years of grieving every twenty-eight days over the loss of a potential life. During our decade of primary and secondary infertility, we didn't live by the year but by the month. "A couple exploring their infertility will experience physical, emotional, spiritual, and, perhaps, financial stress. The medical investigation may be protracted, intrusive, and at times like trying to finish a jigsaw puzzle without all of the pieces. Each month means a rollercoaster of hope and disappointment. Anger, fear, sadness, failure, helplessness, guilt, embarrassment, loneliness, and envy form a constellation of intense feelings."[12]

As a couple's infertility becomes apparent, they may feel isolation during social discussions of pregnancy, childbirth, and child-rearing. Well-meaning people often say insensitive things to struggling couples about God's will, about just needing to relax, or about being grateful for having at least one child.

Studies indicate that infertile couples often experience some sexual dissatisfaction or dysfunction.[13] The medical procedures used in infertility diagnosis and treatment often disrupt a couple's sexual spontaneity and privacy: "have sex repeatedly during this 48-hour period," "masturbate into this cup." When all attention is focused on sexual activity for the purpose of reproducing, intercourse outside the fertile period can seem futile or meaningless. Sex can become mechanical. Taking basal body temperature daily and timing intercourse can create performance anxiety that interferes with arousal and emotional closeness. Caregivers need to be sensitive to the tensions that may develop in the infertile couple's relationship.

Coming to terms with infertility is a process of mourning. For infertile couples, the anguish is compounded by having nothing tangible to mourn, and having no rituals to facilitate their grieving.[14] We have watched many friends experience the pain of miscarriage, a form of infertility with additional grieving. It has always been striking to me that in the church, where many people speak critically about elective abortion as "taking a life," we so readily shrug off a miscarriage as a bundle of expelled cells. Most churches provide no ritual to mark the loss, and the couple is expected to move on with life. The grief for those who experience miscarriage, and for those who never experience pregnancy at all, is profound, because infertility means "the loss of an image, of a dream, of a family—the joys and trials of parenthood and of genetic continuity—a link with the past and future."[15]

Pastors can contribute to healing by helping couples talk together about their feelings and the meaning of infertility for them, helping them understand their different perceptions and experiences, helping them renegotiate the meaning of their relationship. Often pastors will need to take initiative in these conversations because couples may keep their problems hidden.[16]

Rituals that mark transitions and resolutions

Our churches have many rituals and practices that celebrate the goodness of life—baptisms, communion, baby showers, weddings, flowers near the pulpit for a newborn child, public announcements of pregnancies and births. We do well to celebrate life. We also need to recognize how painful many of

these celebrations are for those who have experienced miscarriage, infertility, the death of a child, or other trauma related to the beginning of life. Most infertile couples I have spoken with say they can barely attend church on Mother's Day or Father's Day. The church has become more sensitive at marking these days than we once were, but I have been in services where all the mothers were asked to come forward to sing, or were all given a flower. Non-mothers remained seated, silent, flowerless.

As an adoptive parent, I am also conscious of how the adoption process is honored differently than a pregnancy. When we adopted Mia in 1998, about half of Goshen College's faculty families were pregnant—or so it seemed. In actuality, seven other couples were expecting. The college newspaper ran a story on the expectant parents. Whom did they leave out? Ann and me, who had been in the process of becoming parents for two years, and were within months of receiving our daughter.

Just as we need rituals to celebrate the children we birth, we also need rituals for anticipating adoptive life, for mourning the loss of early life and potential life, and for acknowledging the pain we feel and the adjustment we make when life is different than we hoped. We need to develop rituals for mourning the loss of dreams, and for marking the resolution of infertility through a decision to remain childless. These intangible losses are difficult to grasp for those who haven't experienced them. Some couples may choose to perform these rituals in an intimate setting, with a small group or a few faithful friends and family members. At other times the ritual may belong in the context of public worship, so that those grieving may experience the support of the larger congregation. Pastors have their ritual work cut out for them.

Does God care how we make babies? Yes, indeed. Does God want us to embrace the gift of life? Yes, clearly. Does God want us to walk alongside those who experience infertility, miscarriage and birth trauma, problematic multiple births and unintended pregnancies, seriously disabled children and the anticipation of disabilities? Absolutely. May God give us strength, wisdom, and grace to open the doors of conversation around beginning-of-life issues, so that we all may find space for hope and healing.

Notes

[1] Donna Foote, "And Baby Makes One," *Newsweek* (2 February 1998), 68.

[2] Dorothy Jean Weaver, "Biblical Perspectives," in *Bioethics and the Beginning of Life: An Anabaptist Perspective,* ed. Roman J. Miller and Beryl H. Brubaker (Scottdale: Herald Pr., 1990), 16.
[3] R. O. Evans, "Infertility," in *Dictionary of Pastoral Care and Counseling,* ed. Rodney J. Hunter, et al. (Nashville: Abingdon Pr., 1990), 579.
[4] Historically, Catholic tradition (and Protestant, to an extent) regarded procreation as the primary purpose of marriage and a major justification for sexual intercourse, which many church fathers deemed morally ambiguous. Most traditions, Catholic and Protestant, now recognize both procreative and unitive purposes in sexual intercourse.
[5] Weaver, "Biblical Perspectives," 17–19.
[6] In vitro fertilization involves combining a man's sperm with a woman's ova in a laboratory. After the eggs have been fertilized and the embryos reach the correct stage of development, the appropriate number of embryos are transferred into the woman's uterus. Gamete intrafallopian transfer involves removing eggs from the woman's ovary, combining them with sperm, and using a laparoscope to place the unfertilized eggs and sperm into the woman's fallopian tube through small incisions in her abdomen. Fertilization occurs in the fallopian tubes as it does in natural reproduction. Zygote intrafallopian transfer is a procedure in which the woman's eggs are fertilized in the lab using the man's sperm (similar to IVF). The fertilized eggs, called zygotes, are then placed in the fallopian tubes and travel by natural process to the uterus. Intracytoplasmic sperm injection is a procedure used when the male does not have enough active sperm to fertilize an egg in the normal way. A single sperm is injected into a mature egg and the fertilized egg is then transferred into the woman's uterus.
[7] Each attempt at in vitro fertilization, for example, costs $6,000–$10,000, and most couples make several attempts. See Robert Crooks and Karla Baur, *Our Sexuality,* 8th ed. (Pacific Grove, Calif.: Wadsworth Pub., 2002), 335. They document that most methods of assisted reproduction have a success rate of between 20 and 28 percent. Success rates drop dramatically for women over forty. When donor eggs are used with IVF, GIFT, or ZIFT, $3,000–$7,500 is added to the cost of each attempt.
[8] See L. S. Cahill, "Infertility Therapies, Moral Issues in," in *Dictionary of Pastoral Care and Counseling,* ed. Hunter, 579–80.
[9] Donald B. Kraybill, "Communal Responsibilities," in *Bioethics and the Beginning of Life,* ed. Miller and Brubaker, 194.
[10] Geoffrey Cowley and Karen Springen, "More Is Not Merrier: When Fertility Drugs Work Too Well," *Newsweek* (26 August 1998), 49.
[11] Maura Ryan, "The New Reproductive Technologies," in *Moral Issues and Christian Response,* 6th ed., ed. Paul T. Jersild, et al. (Fort Worth: Harcourt Brace College Pubs., 1998), 382.
[12] Evans, "Infertility," 579.
[13] Crooks and Baur, *Our Sexuality,* 332.
[14] Evans, "Infertility," 579.
[15] Ibid.
[16] Ibid., 580.

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