

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

Infertility: Male and Female Perspectives

*A thesis presented in partial fulfilment
of the requirements
for the degree
of Master of Arts in Psychology
at Massey University*

LINH MY THI HAWKE

2000

Abstract

Although the experience of infertility has been a widely investigated phenomenon, the particular perspective of each gender has received little research attention. The primary objective of the present study was to generate a grounded theory regarding the lived experiences of infertility from male and female perspectives. Ten couples involved in varying stages of the infertility process participated in a series of interviews. Each interview was audio taped and transcribed verbatim. Participants collectively described changes over time in their reaction to, and experience of, infertility. A local theory was generated from the data which described an evolving process whereby participants adjusted to living with infertility. Hence, the core category of adapting to living with infertility emerged, as it clearly underpinned the participants' data when discussing the psycho-social experiences of infertility. For participants to deal with, respond to, and overcome the effects associated with the phenomenon in a productive manner, an adaptation to living with infertility was required. It was determined that the core category consisted of four pre-existing conditions. The first of these conditions contributing to the core category of adapting to living with infertility related to participants' rationale for desiring the parenthood experience. The second pre-existing condition was based upon the medical process undergone by all participants. Participants' attempts to make meaning of events comprised the third pre-existing condition, and finally, lifestyle adjustments constituted the fourth pre-existing condition involved in the core category of adjusting to living with infertility. The second objective of the present research pertained to gender specific experiences within these conditions. It was established that, although women and men experience some aspects of infertility in a similar manner, they are affected differently by the experience in some areas of life. The findings, together with implications for future research, and for working clinicians are discussed in more detail.

Acknowledgments

I would like to express my gratitude to those who have made this research project possible:

My thesis supervisor, Ms Cheryl Woolley, of the School of Psychology, Massey University, who was always encouraging of my ideas, and whose knowledge, wisdom and experience guided the research process. Without her enduring belief in my abilities, this project would not have been possible.

Those who participated in the research. I am especially grateful for their co-operation and warm willingness to open their lives and share their most personal and heartfelt experiences with me.

Anne Nation and Rosemary Pitt of Children's, Young Persons' and Their Families Agency; psychologists Janice Giles; and Chris Rogan from the New Zealand Infertility Society, for kindly taking time from their busy schedules to share their knowledge and expertise regarding infertility.

The committee and members of the Auckland Infertility Society, whose support was much welcomed and appreciated. Their endeavours to assist those experiencing infertility have touched the lives of many.

My parents, Ly and Paul Hawke, for their unconditional love and support throughout all that I do in life. My brother Tuan, and sisters Emma and Lei, for their encouragement (and pestering) whilst I completed my studies. (P.S. Thanks for all the hot dinners and laundry services, Mum!)

Table of Contents

Abstract		i
Acknowledgments		ii
Table of Contents		iii
List of Tables and Figures		iv
PART ONE:	INTRODUCTION	
<i>Overview of Introduction</i>		1
Chapter One:	Introduction and Literature review	3
Chapter Two:	Theoretical Models	26
Chapter Three:	Grounded Theory	36
Chapter Four:	Methodology	46
PART TWO:	FINDINGS	
<i>Overview of Findings</i>		57
Chapter Five:	Personal Profiles	59
Chapter Six:	Core Category and its Pre-Existing Conditions	73
Chapter Seven:	Parenthood	81
Chapter Eight:	Reactions to the Medical Process	90
Chapter Nine:	Making Meaning of Events	107
Chapter Ten:	Lifestyle Adjustments	129
Chapter Eleven:	Integration	142
Chapter Twelve:	Gender Specific Experiences	147
PART THREE:	DISCUSSION AND EVALUTION	
<i>Overview of Discussion</i>		158
Chapter Thirteen:	Discussion	159
Chapter Fourteen:	Evaluation of the Research	173
References		182
Appendices		189

List of Tables and Figures

Table One: Main Causes of Infertility	7
Table Two: Treatment, and Costs of Infertility Procedures in New Zealand	14
Table Three: Core Category and its Pre-Existing Conditions	73
Figure One: First Pre-Existing Condition of Parenthood Contributing to the Core Category of Adapting to Living with Infertility	81
Figure Two: Second Pre-Existing Condition of Reactions to the Medical Process Contributing to the Core Category of Adapting to Living with Infertility	90
Figure Three: Third Pre-Existing Condition of Making Meaning of Events Contributing to the Core Category of Adapting to Living with Infertility	107
Figure Four: Fourth Pre-Existing Condition of Lifestyle Adjustments Contributing to the Core Category of Adapting to Living with Infertility	129

PART ONE

INTRODUCTION

Overview of Introduction

Although the experience of infertility has been a widely investigated phenomenon, there has been a dearth of literature pertaining to the perspectives of both genders. While prior research in the field has focused mainly on the experiences of women, few studies have been conducted with the specific intent of examining men's responses to infertility.

There exists, however, a range of literature that bears relevance to the topic in general. A broad review is undertaken in the introduction to this study in order to cover multiple aspects of the experience. Together, diagnosis and treatment procedures are outlined. Advanced technology now offers a range of alternative choices for couples to consider when in pursuit of conception. These options are outlined. Literature that describes psychosocial aspects of infertility is surveyed, and the salient literature regarding gender specific experiences is examined.

The experience of infertility is characterised by a range of responses. To help define such reactions, researchers have attempted to categorise the responses to infertility into differing theoretical models. Chapter two reviews these paradigms (i.e. grief, crisis, developmental crisis, and cultural and medical models). These models are defined and discussed in relation to infertility, and their appropriateness of use is critiqued.

The following chapter establishes an understanding of the analytical methodology of qualitative research and the grounded theory approach. This is achieved through providing definitions and rationales for utilising a qualitative stance. The definition of grounded theory and its origins are outlined, followed by details of the procedures involved in undertaking this specific methodological approach. The criterion for assessing grounded theory research also is detailed.

Finally, the method applied in conducting the present study is outlined. Firstly, the objectives of the research are listed. This is followed by a brief discussion pertaining to the participants and ethical considerations. The method of data collection (interviews) is discussed, along with the rationale for using a semi-structured interview format. The precise process of data collection, entailing a description of the initial contact with participants, the interview process, transcription, and follow-up.

The introduction provides an insight into the background of the phenomenon under inquiry, that of the experience of infertility. It investigates the specific issues involved and critiques the models commonly applied in its research. It outlines the methodological procedure and provides a clear rationale for their application in relation to the present study.

CHAPTER ONE

Introduction and Literature Review

Having a child is an experience that is taken for granted by most people. The desire to have children, to become parents and raise a family, is something considered fundamentally human (Anderson, 1989). As such, a great deal of time, finance, thought, and energy are invested by many couples into planning a family. When it becomes evident that the natural course of conception may not result in a pregnancy, the couples find themselves on an emotional and often stressful path. Rather than the private, joyful experience expected, they are confronted with invasive medical intervention with high technology and crisis, all without any guarantee of the desired pregnancy or baby. This thesis will investigate the problems faced by this ever-growing population of people: the infertile.

While prior research in the field of infertility has focused mainly on the experiences of women, the present study aims to further examine the psychological effects of infertility from a couple's point of view. Through investigating the male perspective as well, the research postulates that men also experience psychological and emotional angst, despite the equation of reproduction with femininity. However, the present study did not attempt to confront accounts of women's ordeals in regard to infertility and its required treatments. Because infertility is, in essence, a dilemma that affects couples, the present study proposed that experiences from both sides should be acknowledged and assessed.

DEFINITION

The current accepted definition of **infertility is the inability to conceive after one year of unprotected sexual intercourse in the pursuit of a pregnancy** (Griel, Leitko & Porter, 1988). Yet this definition is arbitrary, and a two year definition is sometimes used for clinical reasons (Gillette, Peek & Lilford, 1995). However as Gillett and

associates (1995) note "the misery caused to a woman in her late thirties having to wait so long before entering the 'system' may not justify the use of a two year definition clinically" (p.13). A longer wait may add extra stress to their difficulties. At present, the one year wait enables many people to undertake investigations into the infertility within a reasonable time-frame.

Infertility problems can arise in terms of both primary and secondary conditions. **Primary infertility** relates to those who have never conceived. **Secondary infertility** relates to the inability to achieve a pregnancy after one or more successful pregnancies - therefore, it can occur after any number of children have already been born (Mortimer, 1994).

PREVALENCE

Impaired fertility has been described as a significant health problem with low visibility (infertile couples are not visibly ill) but high in prevalence (Gillett et al., 1995). The incidence of infertility has been reported to affect between approximately 10-20% of the population in regards to the definition (Brander, 1991; Graham, 1983; Gordon, 1982). In these terms, approximately one in six couples experience fertility issues (Brander, 1991). The prevalence of primary infertility, and secondary infertility after one year is given to be 16.1% and 15.8% respectively (Gunnell & Ewings, 1994). However, there appears to be a substantial lack of data to confirm the accuracy of such estimates (Brander, 1991). Brander (1991) notes further that, while there are frequent claims in literature that the occurrence of infertility is increasing (Elmer-Dewitt, 1991; Graham, 1983; Nicol, 1988), there are insufficient data, beyond that of service utilisation for diagnosis and treatment, to confirm such trends. Data available from US-based national surveys conducted in 1965, 1976 and 1982 suggested that the prevalence remained relatively consistent across this period (Mosher & Pratt, 1987). Comparative data obtained during 1988 also revealed that the percentage of infertile couples did not change significantly from 1982 to 1988. A significant increase was, however, observed for a particular group of women. In the age group 20-24 years, reported cases of

infertility increased from 4% in 1965 to 11% in 1982 (Mosher & Pratt, 1987). Mosher and Pratt (1987) suggest that the rise in tubal damage resulting from sexually transmitted diseases may constitute the major cause of increasing infertility in this age group.

In regards to New Zealand, the only data available come from a survey of contraceptive use by 1,000 New Zealand women aged 25-44 years over the period 1983-1986 (Paul & Skegg, 1988 cited in Gillett et al., 1995). They found that 3% of married women aged 25-44 years were classified as infertile but observed that a definition problem may have led to a heavy under-estimation. Gillett and associates (1995) note that there are an estimated 3,500 new referrals made for infertility services in New Zealand each year. Approximately 68% of these will proceed to the treatment stage. While about 50-60% of this number will eventually conceive and deliver, the remaining 40-50% will remain infertile (Abbey, Andrews & Halman, 1991). The only regular collection of information on New Zealand rates of infertility includes annual numbers discharged from public and private hospitals in addition to operations which 'may be' performed for the purpose of diagnosing and/or treating infertility within these institutes (Brander, 1991). This raises an obstacle in the interpretation of data as, many procedures - such as laparoscopy - are regularly performed for purposes other than investigation of infertility. Together with the limitation that such data merely represent incidences of reported cases presenting for diagnosis or treatment requiring hospitalisation, there is likely to be a misrepresentation of the true prevalence of infertility.

Most claims of an increasing incidence in infertility are related to the dramatic rise in demand for infertility services in recent years (Abbey et al., 1991). Abbey and associates (1991) explain this by both an improvement in the available medical technology and an increase in fertility problems associated with delayed child bearing, sexually transmitted diseases, environmental toxins, and an increased usage of intra-uterine devices and abortions. Brander (1991) states that there is evidence of a growth in services and medical consultation related to infertility within New Zealand. In 1984, the possibility of establishing private in vitro fertilisation clinics within New Zealand was still under discussion. Since that time, along with some development and expansion of public services, there has been a notable emergence of private infertility units offering

an extensive range of diagnostic and treatment procedures. The founders of Fertility Associates (New Zealand's main private diagnostic and treatment service) observe that the clinic was established in 1987 in response to the inability of the public health system to cope with the needs of infertile couples (Brander, 1991). Indeed, Fertility Associates has developed so extensively that it now undertakes contracted cases on behalf of the public system. The growth of infertility services within the main centres during the last five years and the formation of the New Zealand Infertility Society during 1990 further reflect a recent rise in supply and demand for services and information within this country (Brander, 1991).

EPIDEMIOLOGY

A person's inability to conceive is formulated by gynaecologists as being contributed to by a female factor, a male factor, or a combination of unexplained problems in both partners (Stoudemire & Fogel, 1993). World Health Organisation (WHO) data revealed that female problems accounted for 30% of causes, in 30% the problem is predominantly male, and in 26.5% both partners contribute to the problem. The remainder have no clear-cut cause (World Health Organisation, 1987 cited in Gillett et. al, 1995). Published in Gillett et al. (1995, p.14), Table 1 lists the common causes and their prevalence.

Table 1: Main Causes Of Infertility

Cause	INCIDENCES PERCENTAGE			
	Who	Britain	France	Dunedin
Tubal/Peritoneal	36	16	26	30
Ovulation	33	21	32	14
Endometriosis	6	6	4	7
Sperm Transport		9	4	
Male	26	57	36*	
Other	11		4	
Unexplained/Unknown	13	28	8	9**
Female Alone	30		33	40
Male Alone	30		20	36
Mixed	27	15	39	15

* Represents male only causes, in contrast to the French statistics, which include all male causes.

** Includes cases of mild endometriosis.

As previously mentioned, other contextual factors associated with fertility problems include smoking, sexually transmitted diseases, environmental toxins, and an increased usage of intra-uterine devices, abortions, delayed child-bearing and age. The latter two of these impact highly on infertility rates (Seibel, 1993). During recent times the tendency to delay child bearing has increased. Seibel (1993) attributes numerous factors to this trend, including improved methods of birth control, increased numbers of women in the work force, and the choice by more people to delay marriage. The increasing frequency of divorce, with a desire to conceive in a subsequent marriage, also plays a role in the delay. As a result, couples find that they have a relatively shorter period of time in which to conceive. An increase in a woman's age can substantially affect fertility rates. Infertility statistics tend to increase with age. Approximately 10% of females ages 15-30 have fertility problems; rates for those 30-34 are 14%, and for those 35 and older are 25%. At age 22, a woman's fertility is at its maximum; at 37 it is reduced to 70%; it declines to 55% by the age of 40; and at 43 it falls to 30% (Mosher &

Pratt, 1987).

DIAGNOSIS AND TREATMENT

In terms of both the diagnosis and treatment of infertility, far fewer procedures exist for men and, with a few exceptions, treatments for women are more invasive and time-consuming (Meyers, Diamond, Kezur, Scharf, Winchel & Douglas, 1995). Treatments are typically preceded by extensive diagnostic procedures: hormone levels, daily body temperature, sperm antibodies, and even post-coital secretions are analysed. More invasive diagnostic examinations may include an endometrial biopsy, a hysterosalpingogram (X-ray of a dye injected reproductive tract), incision through the umbilicus to insert a laparoscope to view the reproductive tract, expanding the uterus with liquid or carbon dioxide, and inserting a hysteroscope through the cervix to view the uterus (Meyers et al., 1995). Some procedures may be both diagnostic and therapeutic.

The length of time taken, on average, to arrive at a diagnosis is 6 months for a woman and one month for a man. Diagnostic procedures for men include: assessment of hormone levels, sperm analysis (count and mobility), and, in rare instances, testicular biopsy and vasography to test for tubal obstructions. Treatments for male infertility include varicocelelectomy (a surgical procedure that legates varicose veins in or around the testicles), sperm washing to separate viable sperm, and donor sperm insemination (Meyers et al., 1995).

Should the work ups show no physical problem in the woman, and if the man's sperm is normal, drug therapies are utilised in conjunction with natural fertility methods in the aim to increase ovulation and cycle accuracy. However, fertility medications used to hyperstimulate ovaries can often cause side-effects such as depression, fatigue, nervousness, insomnia, headaches and nausea. Symptoms may range from no, or mild, discomfort to moderate, or severe, pains (Meyers et al., 1995).

Physical damage to the reproductive tract is treated by corrective surgery.

ASSISTED REPRODUCTIVE TECHNOLOGY

If the above treatments prove unsuccessful, couples may be candidates for **Assisted Reproductive Technology (ART)**. While only six ART procedures are currently in use, there are, theoretically, 24 variations depending on the source of gametes (female, male, egg donor, sperm donor), the site of fertilisation (female, laboratory, surrogate), and the site of gestation (female or surrogate). It is theoretically possible for a child to have as many as five 'parents' involved in its conception.

Intra-uterine Insemination

Should the work ups show no physical problem in the woman, and if the man's sperm is normal, **intra-uterine insemination (IUI)** (or **artificial insemination - AI**) can be performed by depositing (washed) semen in the uterus via a catheter. The next procedure in which intra-uterine insemination is used is in conjunction with hormonal stimulation to increase the number of ovarian follicles, thus generating more eggs. Intra-uterine insemination is the simplest of the new reproductive technologies, and the least costly since it involves neither egg retrieval nor zygote or embryo transfer (Cooper & Glazer, 1994).

Should there be problems with the viability of the partner's sperm, a couple can opt to undergo treatment with donor sperm (**donor insemination - DI**) from a third party source. Other forms of donor involvement are also possible. For example, a woman may be the recipient of donor egg fertilisation. This procedure requires the donor to undergo the same daily medications as the recipient in order to synchronise their cycles. Third party involvement opens a range of possibilities in treatment options. Those outlined below may utilise a number of variations on the source of egg and sperm.

Embryo or Gamete Transfer Procedures

For women with irreversible blockage of their fallopian tubes, failure to conceive with ovulation induction, or unexplained infertility, ART such as **in vitro fertilisation**

(IVF) or **gamete intra-fallopian transfer (GIFT)** may be recommended. Daily hormone injections are given to stimulate the development of multiple follicles, thereby increasing the number of eggs produced. Doses are adjusted according to the results of daily hormone blood levels and ultrasound study of the ovaries. With IVF, ovulation is induced and eggs are retrieved via laparoscopy or ultrasound and fertilised with the male sperm, which can be concentrated in cases in which the sperm count is low. When the pre-embryos have divided into four cells they are returned to the uterus via the endocervical canal.

GIFT is a similar procedure except that the retrieved eggs, together with a large amount of sperm, are placed directly in the fallopian tube via an incision in the abdomen. This limits exposure to any toxic effects of an artificial culture condition. Another variation on this is **zygote intra-fallopian transfer (ZIFT)**, in which the fertilised egg is returned to the tube.

Recently, fertility specialists have developed a technique called **intro-cytoplasmic sperm injection (ICSI)**. This is utilised for conditions in which the sperm is biologically incapable of penetrating the shell and substance of the egg. A microscopic needle is used to inject a sperm directly into the egg. If fertilisation is achieved, the procedure then follows the standard IVF protocol.

Any unused embryos resulting from these procedures may be cryopreserved (i.e. frozen) for implantation at a later time.

Surrogacy

Surrogacy as an option in the pursuit of a child is fraught with complexities and technicalities. Traditionally, Brander (1991) describes surrogacy as involving "a woman [the surrogate mother] who enters into an arrangement with a couple to bear a child by the husband and to give up the child on birth to be raised by the couple as their own" (p.36). The possibilities opened up by the use of IVF technology have resulted in significant variations of the traditional arrangement. Brander (1991) illustrates further:

"the wife of the couple may provide the egg, to be used with the

husband's sperm. Alternatively, the sperm of a donor may be used with the wife's egg. Neither the wife nor the surrogate may provide the egg; a different donor altogether may do so and the donor's egg may be fertilised by the husband's sperm or the sperm of a donor" (p.36).

Within New Zealand, under the 1955 Adoption Act, it is an offence to enter a surrogacy agreement providing for the 'birth mother' to receive monies in exchange for relinquishing the child for adoption, or to advertise for a surrogate in such a way as to involve adoption (Brander, 1991). However, while there are no surrogate mother agencies operating in New Zealand as there are in other Western countries, Nixon (1985) comments that "private arrangements are apparently made" (cited in Brander, 1991, p.36).

Adoption

Strictly speaking, adoption cannot be considered as a treatment for infertility. Instead, it offers an option for overcoming childlessness. Often, for infertile couples, adoption usually constitutes the final option in most infertility discussion. Brander (1991) comments that "while preference is presently given to infertile couples who apply to adopt a child, adoption is not a service for infertile couples, and can no longer be seen as an automatic alternative for couples who do not have children" (p.36). As Wannan (1988 cited in Brander, 1991) suggests, adoption should not be viewed as a means of placing children for couples, but as a means of finding the right family for a particular child. However, opportunities for adoptions are on the decline in most Western countries (Oke & Wood, 1987). Several factors have been cited as contributing to this trend including improved methods of contraception, greater availability of abortion and the desire of many single mothers to keep and rear their children (Brander, 1991). The decrease in availability of children for adoption has led to more couples undertaking the alternative of fostering in attempts to complete their families.

EFFECTIVENESS OF INFERTILITY TREATMENTS

Lilford and Dalton (1987) assert that many couples will achieve pregnancy independently of medical intervention. A recent survey of infertility treatments found that the pregnancy rate of untreated infertile couples was only 6% lower than those couples who are treated (Jones & Toner, 1993 cited in Meyers et al., 1995). However, due to the options that medically assisted reproduction offers for couples to achieve a child, it is the option which is most frequently pursued. For those who proceed with treatment, about 50-60% will eventually conceive and deliver. Of these couples who reach a successful full term pregnancy, approximately 80% will have conceived within 4 to 5 years (Meyers et al., 1995).

Currently, it is estimated that IVF and similar procedures have a success rate of 19%, GIFT treatment 28%, IUI 10% and ZIFT 24% rates of success (Meyers et al., 1995).

Although these statistics are impressive, it is important to note that 40-50% who undergo procedures will remain infertile (Abbey et al., 1991).

THE FINANCIAL COST OF INFERTILITY SERVICES

Infertility treatment with the new technology available is expensive. In vitro fertilisation and other advanced treatment procedures are costly due to their dependency on the skills of highly-trained personnel and the need for expensive medical equipment (Leiblum, 1997). Yet this does not deflect from the fact that the financial cost of undertaking fertility treatment impacts hugely on the decision to proceed for some, if not most, couples. Brander (1991) notes that, while some IVF services available in New Zealand are free, an extensive waiting period - up to 5 years in Christchurch Women's Hospital - is likely to render this option inaccessible to many couples. Costs per IVF treatment cycle of \$2,000 for medical school, or subsidised services to up to \$5,000 for private services, present a further barrier to those seeking this treatment option. In addition, some fertility clinics have instituted policies by which clients must now meet the cost of infertility drugs - which range from \$800 to \$1,500 per patient (Brander,

1991).

Moreover, IVF and other advanced reproductive procedures are, typically, not a standard benefit in the majority of health insurance programmes. Consequently, couples must often shoulder the cost of such treatment as, on national health care, provisions for only three attempts at IVF per couple are made. For many, the financial considerations involved in undertaking cycle after cycle of assisted reproduction where the likelihood of success can be variable, make it difficult to proceed.

Table 2 lists the current accepted costs for various infertility investigations and treatments in New Zealand. These costs are based on the information published in Gillette and associates (1995), having been up-dated by Fertility Associates.

It is important to note that the above procedures do not take into consideration the extra miscellaneous expenses of infertility treatment such as employment leave, travel costs, and accommodation.

Table 2: Treatment, And Costs Of Infertility Procedures In New Zealand.

TREATMENT	COST (\$)
Infertility clinic, first visit	120
Infertility clinic, subsequent visits	70
Blood work	35
Semen analysis	17 / sample
Semen analysis with trial wash	71 / test
Full antibody test	98
Postcoital test	53 / test
Progesterone assay	17
Endocrine assessment for amenorrhoea	40
Hysterosalpingogram	180
Hysteroscopy	750
Laparoscopy, no surgery	720
Ultrasound	50
Therapeutic counselling	60 / visit
Laparoscopy including other surgical procedure	2025 / procedure
Microsurgical repair of fallopian tube	3880 / procedure
Donor insemination with cervical insemination	418
Donor insemination with IUI	488
IVF	4200
GIFT	4440
ICSI	5800
Embryo freezing	290
Embryo thawing cycle	395
AIH & ovarian stimulation (hMG)	890
AIH without stimulation	300

(Gillett et al., 1995)

MAJOR ISSUES IN INFERTILITY

There exists a substantial body of research, clinical and anecdotal literature that supports the contention that infertility exacts a heavy toll on couples. Daniluk (1998) reports that inability to conceive, together with the ongoing invasive and time-consuming medical investigation and treatment of infertility have been reported to have far-reaching negative consequences in terms of emotional and psychological angst. In comparison with their fertile counterparts, infertile men and women have been found to consistently demonstrate elevated levels of distress (e.g. Abbey et al., 1991; Berg & Wilson, 1991; Daniluk, 1988). Couples undergoing treatment for infertility commonly report feelings of anger, betrayal, powerlessness, isolation, depression, hostility, and diminished self-esteem, as well as difficulties in their intimate relationship (Abbey et al., 1991; Link & Darling, 1986). Being infertile has been found to profoundly challenge individuals' basic assumptions regarding justice, fairness, and the meaning of life (Daniluk, 1991; Greil, 1991; Mahlstedt, 1985; Menning, 1980). Some men and women experience infertility as an assault on their identity (Daniluk, 1991; Menning, 1980). Many report acute feelings of loss and grief in being unable to fulfil their hopes and dreams of having a child that represents their love (Daniluk, 1991; Menning, 1980).

Daniluk (1991) notes other factors which appear associated with negative responses to infertility. They include being the partner with the identified fertility factor (Mason, 1993); age and duration of infertility (Berg & Wilson, 1990); ambiguous diagnosis such as unexplained infertility (Abbey et al., 1991; Mahlstedt, 1985); and gender (Abbey et al., 1991; Daniluk, 1988; Greil et al., 1988; Link & Darling, 1986).

The main aspects of infertility responses are elaborated upon further below.

OBSERVED PSYCHO-SOCIAL EFFECTS OF INFERTILITY

In their review of research studies, Dunkel-Schetter and Lobel (1991) note the effects of infertility which are mentioned most frequently in literature are emotional reactions, feelings of loss of control, effects on self-esteem, identity and beliefs, and effects on social relationships. These can be further differentiated and elaborated.

Emotional Effects

Infertile couples experience a wide variety of negative emotions including anxiety, fear, isolation, depression, guilt, frustration, and helplessness. Authors have found that infertile women experience more negative affect than their partners. Infertile women have been found to be more depressed, anxious, guilty, frustrated, and isolated than infertile men (Bresnick & Taylor, 1979; Daniels, 1989; Daniluk, 1988).

Dunkel-Schetter and Lobel (1991) list five recurrent emotional themes in infertility. They include grief and depression, anger, guilt, shock or denial, and anxiety. Menning (1980) and Mahlstedt (1985) comment that depression and grief are the most common reactions observed in both genders following diagnosis of infertility. This may include common expressions of mourning, sadness, disappointment, loss, disillusionment, and hopelessness in reaction to infertility. Mahlstedt (1985) suggests that depression is caused by both the loss that infertile individuals feel as well as the chronic strains that are experienced during infertility diagnosis and treatment.

In addition, anger and guilt are also common emotional responses. These may range from reports of unfairness or resentment (Mahlstedt, 1985) to more intense embitterment or rage (Dunkel-Schetter & Lobel, 1991). Dunkel-Schetter and Lobel (1991) note that infertile individuals may direct their anger toward partners, themselves, other family members or friends, even couples with children, doctors, or society.

Feelings of guilt, self-blame, or personal responsibility are often experienced as well. These can be in relation to guilt over prior sexual practices, contraceptive methods, or life-styles that they believe have contributed to their infertility, or because they delayed trying to have children (Dunkel-Schetter & Lobel, 1991). Guilt can also be experienced with no specific source, or infertility felt as punishment for a previous transgression (Dunkel-Schetter & Lobel, 1991).

Less frequently cited are the emotions of shock and denial which tend to be experienced in relation to responses to the diagnosis of infertility. Dunkel-Schetter and Lobel (1991) suggest that individuals may under-report these experiences, as their initial reactions of shock and denial become overwhelmed by more prevalent feelings towards the infertility process.

Anxiety, worry, anguish or desperation are most commonly experienced by those undergoing investigations and treatments - particularly about whether or not they will be successful in becoming parents (Dunkel-Schetter & Lobel, 1991). Several authors observe that infertile people are anxious about their body image, their sexual adequacy, or the status of their marital relationship (Valentine, 1989). Some report monthly cycles of anxiety or anticipation surrounding ovulation, followed by disappointment and depression when pregnancy is not achieved (Mahlstedt, 1985; Valentine, 1989). Dunkel-Schetter and Lobel (1991) note that these changes in emotions have often been referred to as the “roller-coaster” of hope and despair (p.35).

Loss of Control

Dunkel-Schetter and Lobel (1991) observe that there are two responses to infertility that involve loss of control. One concerns control over events that are current, including a loss of control over one’s daily activities, bodily functions and emotions. The second concerns control of the future, specifically the ability to predict or plan the future and meet life goals.

Infertility is accompanied by a real or perceived loss of control over the present (Mahlstedt, 1985). Dunkel-Schetter and Lobel (1991) illustrate, “because of the chronic stress associated with infertility, some individuals feel that they are unable to control their emotions and complain of mood lability” (p.33). Treatment may dictate the scheduling of work-related or social events and thereby individuals may feel that they have relinquished control over these domains as well (Mahlstedt, 1985). Further, control over sexual relations and privacy may be lost as many details must be reported to their physician. Treatment procedures often involve ‘assignment’ or ‘homework’ like activities such as when, and how often, to have intercourse (Mahlstedt, 1985). Women appear to be extremely susceptible to control factors. A poorer adaptation has been reported for women who experience their fertility outcome as being out of their control (Stanton, Tennen, Affleck & Mendola, 1992), in comparison to men.

In addition to losing control over these aspects, there is a reported loss of control experienced by infertile couples regarding their future (Sandelowski, 1987). Infertility

eliminates the ability to initiate pregnancy and parenthood which are often central goals in life (Dunkel-Schetter & Lobel, 1991). Career progression may be interrupted by infertility. Dunkel-Schetter and Lobel (1991) observe:

“because primary life decisions about marriage and career are often tied to having a child, the loss of control experienced due to infertility may be particularly distressing. Infertility for some couples brings about a radical change in their perspective of the future and their perception that life goals are under individual control” (p.34).

Effects on Self-Esteem, Identity, and Beliefs

A diagnosis of infertility threatens an individual's self-esteem. Feelings of failure and inadequacy are often engendered (Mahlstedt, 1985; Mathews & Mathews, 1986). Studies have found that infertile women experience lower self-esteem than men (Bernstein, Potts & Mattox, 1985; McGrade & Tolor, 1981). An even greater distress is reported by those women who have a poorer self-esteem (Link & Darling, 1986), as well as by those who are primarily invested in the motherhood role in terms of their identity and self-image (Berg, Wilson & Weingartner, 1991; Greil et al., 1988). Such feelings of low self-worth are not limited to reproductive functioning but extend also to perceived physical attractiveness, performance, and productivity in other spheres (Mazor, 1984).

In addition to reduction in self-esteem, extended infertility produces identity changes or changes in self-concept. Infertile individuals frequently report feeling inadequate, damaged, or defective as a woman or man. They perceive their inability to reproduce as evidence that they are not quite whole and are a failure (Seibel & Taymor, 1982). This diminished sense of femininity or masculinity negatively influences body image (Menning, 1980) and leads to a questioning of gender identity. This furthers itself with role performance and expectations, or specific identities as spouses or parents being queried (Dunkel-Schetter & Lobel, 1991).

As well as changes in perceived identity, Mathews and Mathews (1986) describe a major reconstruction in perceived reality occurring following a diagnosis of infertility.

This reconstruction can involve the meaning of marriage, parenthood, and existence itself. In examining motives for pregnancy and parenthood, infertile individuals are led to question societal views of children and presumed idealisation of parenting.

Social and Relationship Effects

There are several ways in which infertility is reported to have social and relationship effects. Effects on marital interactions and satisfaction, effects on sexual functioning, and effects on social network interactions or feelings towards network members have all been well-researched areas (Dunkel-Schetter & Lobel, 1991). Dunkel-Schetter and Lobel (1991) demonstrate that the effects on marital interaction and satisfaction appear in four varieties. . Firstly, increase in anger, hostility, or resentment toward their partner has been reported. . Conflict and arguments regarding the infertility can drastically reduce marital well-being (Abbey et al., 1991). This may result from blaming a partner or feeling blamed, from feeling a lack of spousal understanding or emotional support, or feeling that one's mate is not equally committed to having children (Mahlstedt, 1985).

Second, some partners are anxious about the status of their relationship, and they occasionally report fears of abandonment or break-up (Mahlstedt, 1985). If infertility was due to only one partner, as it is in 70% of couples (Benson, 1993), this individual feels particularly guilty (Seibel & Taymor, 1982). Andrews (1981 cited in Seibel & Taymor, 1982) argues that the infertile individual almost always tells their partner that it is understandable should they wish to divorce. Menning (1980) suggests that infertile individuals may be so concerned about being deserted by their partners that they may create a self-fulfilling prophecy for themselves.

The third and fourth effects are closely related. Research suggests that individuals feel unable to disclose their feelings to a spouse, thus increasing a sense of isolation from their partner (Mahlstedt, 1985). True emotions experienced may be withheld from partners in an attempt to protect them from negativity. This in itself creates a dilemma regarding support networks. The private nature of infertility, together with the emotions of exclusion it may produce mean infertile couples are frequently unwilling to confide in

others. Thus they must rely on each other for their emotional support (Menning, 1980). While sometimes this can strengthen the relationship, it places an enormous burden on it. Because each partner is in crisis himself or herself, it may be difficult for them to meet each other's needs. Often they may be at different stages of adjustment to the infertility, and what is helpful to one partner may be harmful to the other (Abbey et al., 1991). Contrarily, in some instances, the effect on relationships is seen as positive rather than negative. Several studies describe individuals as feeling an increased closeness, love, and support from their partners (Dunkel-Schetter & Lobel, 1991). For some couples, the infertility experience has either brought them closer together and led to mutual support during this stressful period, or has provided an opportunity to reflect on their attachment to their partner. Berg and Wilson (1990) report that as many as 50% of couples felt infertility affected their marital relationships, with the effect being positive (e.g. improved communication) while 20% reported negative relationship difficulties associated with infertility.

In contrast to there being both positive and negative effects of infertility on marital relationships, virtually all research which discusses the sexual ramifications of infertility describes it as negative (Dunkel-Schetter & Lobel, 1991). Many individuals report a loss of sexual desire, pleasure, or spontaneity. Sex is perceived as a chore rather than a pleasure (Seibel & Taymor, 1982). Reports of sexual dysfunction have also been noted (Spencer, 1987). Studies found that compared to infertile men, infertile women reported a greater loss of interest in sexual relations (Daniluk, 1988; Lalos, Lalos, Jacobson & von Schoultz, 1985). These concerns can be attributed to fears of sexual inadequacy and to the fact that infertility treatment results in a loss of privacy, control, and the reduction of intercourse to a clinical reproduction (Dunkel-Schetter & Lobel, 1991).

Dunkel-Schetter & Lobel (1991) observe that difficulty in social interactions and relationships within the social network have also been widely reported. One type of difficulty involves feeling socially unworthy or isolated. In regards to social support, Miall (1985) vividly described how childlessness disqualifies infertile women from being part of the "in-group of mothers" (p.391). Women with children frequently treat them as second-class citizens who cannot contribute to conversations about child rearing (Abbey et al., 1991). This, in turn, leads infertile women to be sensitive to fertility-

related stimuli (e.g. pregnant women, babies) (Daniluk, 1991), and distressed by comments of others regarding their childless status (Mahlstedt, 1985; Menning, 1980). Infertile individuals report feeling unaccepted or scorned by others and feeling pressured by the expectations of their family, friends, or society in general. Many do not feel understood by their friends or family and therefore express an inability to disclose their feelings to others. Sometimes the difficulties appear insurmountable and individuals withdraw from these relationships completely.

A second difficulty noted by Dunkel-Schetter and Lobel (1991) relates to social interactions involving feelings of jealousy, rivalry, resentment, and envy of people with children (Spencer, 1987; Valentine, 1989). Spending time with people who have children may be uncomfortable because infertile people are probably making comparisons during these interactions (Dunkel-Schetter & Lobel, 1991).

GENDER ISSUES

A number of authors have described differences in women's and men's responses to infertility. These can make it difficult for spouses to fully understand and support each other. Bernard (1972) contends that "his" and "her" marriages are well documented, showing that partners are often less than perfectly aware of each other's perceptions of the dynamics of family life. For this reason, studies that purport to describe couples on the basis of one spouse's responses have been roundly criticised (Boekemeier & Monroe, 1983; Greil et al., 1988). Thus it is no surprise that men and women perceive and respond to infertility in radically different ways.

While parenting is a central component of society's expectations for both sexes, motherhood is traditionally perceived as the central role for women, while paid employment is traditionally the central role for men (Russo, 1976). Many infertile women state that they cannot imagine a life without children (Mahlstedt, 1985). Freeman, Boxer, Rickels, Tureck, and Mastroianni (1985) found that half the infertile women they interviewed viewed infertility as the most upsetting experience in their lives, as compared to only 15% of the infertile men.

However, the picture for infertile women is not all bleak. While women report more overt distress in response to their inability to produce a child, they tend to employ more problem-focused coping strategies and escape coping when dealing with infertility than their partners (Abbey et al., 1991). Infertile women appear to more actively seek information and solutions to the couples' fertility problems than their male counterparts, potentially serving as a buffer against feelings of powerlessness and uncertainty (Abbey et al., 1991). This would suggest that while being faced with the inability to reproduce is a difficult and often distressing life experience, women have important resources that may help them cope with, and adapt to, the stress, pain and loss associated with being infertile (Leiblum, 1997).

From an anecdotal perspective, infertile women are often quoted as lamenting that their partners appear to be less sensitive to, and less distressed by, the couple's childlessness (Greil, 1991; Mahlstedt, 1985; Menning, 1980). Although few studies have been conducted with the specific intent of examining men's responses to infertility (Leiblum, 1997), a review of the literature would tend to support the contention that men do not appear to respond as negatively to infertility as their partners do. Several authors have found that infertile men reported being less disappointed by the likelihood of a life without children than did their partners (Batterman, 1985; Greil et al., 1988). Leiblum (1997) notes that men are more likely to define themselves in terms of occupational success rather than the identity of fatherhood. Infertility may be experienced as an "unfortunate circumstance" but one that can be dealt with and overcome (p.100). It has been suggested that, for husbands, the main problem with infertility is coping with their unhappy partners and stressed home life rather than with the assault on their self-esteem (Greil et al., 1988). Men not only report less overt distress in response to their experience of being infertile, but also appear to adapt with considerably greater ease to failed treatment and the prospect of permanent biological childlessness (Greil, 1991; Mahlstedt, 1985). In terms of coping, infertile men appear to engage in denial, distancing, or avoidance (Abbey et al., 1991) strategies that may exacerbate marital tensions and prolong the pursuit of alternate solutions to the couple's childlessness. Infertile men also appear to remain considerably more isolated in this area of their lives, emphasising privacy relative to the couple's fertility struggles and turning to their

partners as their primary source of communication and emotional support (Collins, Freeman, Boxer & Tureck, 1992). However, Leiblum (1997) notes that communication between partners in infertile relationships about these issues are often strained, as couples appear to adopt gender specific ways of dealing with the pain and stress wrought by infertility. Mahlstedt (1985) found that her male clients were not willing to express their fears as openly as were female infertile clients. This left the women upset because they felt their partners were not adequately concerned. The general literature on gender comparisons suggests that women may be more expressive than men (Abbey et al., 1991).

The one factor that appeared to be associated with the more negative male response to infertility is the receipt of a male factor diagnosis. Men in infertile relationships characteristically assume that their partners are the source of the couple's fertility problem and are often disbelieving of a male-factor diagnosis (Abbey et al., 1991; Mahlstedt, 1985). The few studies that have been conducted with the specific intent of examining men's responses to infertility suggest that receipt of the news that they are unable to produce a child is as distressing an experience for a man as it is for infertile women (Berger, 1980; MacNab, 1986). However, despite this factor, several investigations have found that women more often than men take the responsibility and initiative to obtain treatment when pregnancy is not achieved, and make the majority of the decisions about which treatments to pursue (Greil et al., 1988; McGrade & Tolor, 1981). This can be seen as essentially due to the physical nature of infertility and the emphasis it places on the female body for investigations and treatment options. As such, infertility is still viewed as primarily a female domain. These findings for infertile couples reflect general gender differences in the way in which men and women have been socialised to cope with negative affect.

Pantesco (1986) pointed out that literature on infertility emphasises the role of the woman while ignoring the man's role in the infertility system of the couple. A review of 121 articles published between 1948 and 1985 revealed that 18% emphasised the male partner, most of these have been written since the late 1960's (Seibel, 1993). Research in the field of infertility that has focused mainly on the experiences of women has been criticised by many (Boekemeier & Monroe, 1983; Greil et al., 1988). Meyers and

associates (1995) go so far as to state "the latent biases of the researcher may also influence the focus and the 'finding'" (p.226). Women in infertile couples have been studied longer and in greater detail than men, and are more responsive to, appreciative of, and benefited by, the opportunity to describe their experiences (Nachtigall, Becker & Wozny, 1992). In regards to the male experience, there is a dearth in the literature. Studies that purport to describe the experience of infertility, a dilemma that affects couples, on the basis of one partner's responses have been roundly censured for their methodological flaw.

It is also important to note here that, of the research with infertile couples that compared the experiences of women and men against each other, significant differences may not have been observed - as it is necessary rather to examine the gender of the partner who is diagnosed as infertile (Meyers et al., 1995).

As is yet to be outlined in the upcoming chapters, the present study will take these points into consideration in an attempt to further add to the body of knowledge regarding the infertility experience, especially from the perspective of both males and females.

SUMMARY

This chapter attempts to provide a background of information to the phenomenon of infertility. Defined as the inability to conceive after one year of unprotected sexual intercourse, infertility affects between 10-20% of the population. The prevalence of infertility is discussed with particular relevance to a New Zealand population. Epidemiological information related to infertility is outlined. Infertility can be divided into female (30%), male (30%), and a combination of both (26.5%) or unknown cause (14.5%). The specific causes of infertility are given, together with diagnosis and treatment options available. Here, fewer procedures exist for men, and with a few exceptions, treatments for women are more invasive and time consuming. Recent advances in technology have enabled a wider variety of possibilities in producing a child. While there are six main assisted reproductive techniques available (including intra-uterine insemination, embryo or gamete transfer procedures, and surrogacy), it is

possible to have up to 24 variations on the birth combination. Non-medical methods of securing a child involve either adoption or fostering. The effectiveness of infertility treatment is also discussed, as well as the financial costs of these services. Although a limited number of subsidised medical procedures are provided in New Zealand, a waiting list which may last up to five years has led many to undertake private treatment. This also is constrained by the high financial cost of infertility procedures, some as expensive as \$5,000 for one cycle. A survey of literature follows, investigating the observed psycho-social effects of infertility (i.e. emotional effects, loss of control, effects on self-esteem, identity, and beliefs, and social and relationship effects) and gender issues related to infertility.

CHAPTER TWO

Theoretical Models

This chapter introduces the paradigms commonly applied in research into infertility, and critiques the appropriateness of their application to the experience.

The experience of infertility is characterised by a range of responses. To help define such responses, researchers have attempted to fit the experience of infertility into differing theoretical models. However, due to the chronicity and complex nature of infertility, it does not yield itself easily to such manipulation (Mortimer, 1994). While some people's experience may readily conform to a particular model, other individuals' experiences may fit only to a degree, or even not fit at all. As outlined in Mortimer (1994) a brief overview follows on the grief model, situational crisis model, developmental theory, cultural paradigm and the medical model. These models appear to constitute the main paradigms used in the literature to further add to the knowledge and understanding of the experience of infertility.

GRIEF MODEL

The grief model and its outline of the bereavement stages is a commonly used paradigm when discussing the experience of infertility (Menning, 1980; Mahlstedt, 1985). Menning (1980) asserts that grieving is "the appropriate and necessary response" (p.316).

As determined by Kubler-Ross (1969), the stages of grief are: denial and isolation, anger, bargaining, depression/mourning, and acceptance/peace. These stages are examined together with Kast's (1988) phases of grief.

Grief models are crucial at the end of unsuccessful treatment, when that couple must 'bury' their hopes of a biologically related child, mourn, and then go on to choose one of the other alternatives. Adoption, sperm donation, and other 'third party' methods are satisfying alternatives, yet will not cure the couples' infertility (Zoldbrod, 1993).

Choosing to remain childless does not negate the infertility. They must first grieve not only for the child they could not produce together, but also for the loss of their planned hopes and dreams.

However, a grief model is not sufficient to fully comprehend the experience of infertility. Increased advances in technology have led people to extend the period of attempting to conceive for longer and longer, and to seek more technically advanced medical interventions (Zoldbrod, 1993). The longer the uncertainty, the more disorganised life becomes. Ambiguous events are more stressful than predictable ones (Taylor, 1990). The experience of infertility begins to appear more like a chronic illness with which people have to cope, rather than a single dramatic diagnosis.

Along a similar vein, the initial stage of the grief model is characterised by shock. The unexpectedness of the loss, numbness, disbelief and denial may no longer be adequate in regards to infertility. Kast (1988) contends that the reactions of numbness and denial arise from an individual's not coping with the overwhelming emotion associated with the shock. For a person experiencing fertility issues, one may initially deny such a problem, without suddenly experiencing the infertility. It is a gradual awareness over a period of time, thus affecting one's reactions differently (Mortimer, 1994).

The stage of anger, or emotional chaos (Kast, 1988) can be accompanied by despair, fatigue, sadness and helplessness. Such are common reactions experienced by many infertile people. As infertility diagnoses are often of an inconclusive nature, these feelings may become prolonged if there is a perceived possibility that one may still eventually be able to conceive (Mortimer, 1994). As stated, grief reactions are more likely to be experienced after some time of attempting to conceive. For some, the feeling of loss regarding a potential child may be experienced, while others may not have reached beyond the stage of believing 'this month I'll conceive'.

The acknowledgment of loss is reflected also in the anxiety associated with separation reactions. A couple is rarely informed during investigations and treatment that 'you will never conceive'. Consequently, the recognition of a loss may take a longer period, even years, to occur (Mortimer, 1994). Modern technology offers greater hope for infertile people in comparison to several years ago. Reading (1991) reflects

“the hope arising from each new medical breakthrough is a double-edged sword. It offers the promise of success, but also perpetuates the struggle” (p.185). Such hope can block grieving.

The phase of searching is the next to be experienced (Kast, 1988). Here, the person longs for the lost and is often subject to much weeping. Mortimer (1994) expresses the view that some people may experience this but on a “different dimension” (p.11). The yearning here is for the potential child and all that it would bring and fulfil, rather than a tangible loss.

Lastly, the reintegration or resolution stage relates to the acceptance of a loss, or, in some cases, the development of pathological outcomes. As previously discussed, it may take many years for those experiencing infertility to accept this condition. Therefore, the experience may be prolonged and often end with the loss of control over fertility leading to a sense of helplessness and depression (Mortimer, 1994). Menning (1980) refers to this as a common failure to grieve. Failing to grieve suggests that

“such people may be helped by counselling in coming to accept their childless state as an alternative to seeking medical intervention or correct their infertility. The continual search for a treatment which may assist conception denies people the opportunity to accept and adjust to a future without children” (Mortimer, 1994. p.11-12).

Sandelowski (1988), considers the grief model to be a limited framework as “the emotional responses to infertility do not follow a sequential pattern” (p.159). Despite this, however, the model is still a useful paradigm from which to understand the psycho-social effects of infertility in connection to a collective loss. Mahlstedt (1985) held the view that infertile people also experience losses commonly held to be causal in the aetiology of depression. He refers collective losses to those of a relationship, health, self-esteem, competence, control, fantasy, security and the “loss of something or someone of great symbolic value” (p.340). The latter is in regard to the loss of a potential child; the loss of the potential family. This loss is not of a tangible nature and, especially when the infertility is in the ‘unknown’ factor, the mourning and resolution

may never be achieved. Dunkel-Schetter and Lobel (1991) note that the loss of control in people's lives encompasses not only daily activities, but also future events.

In summary, the grief paradigm goes some way to explaining the experience of infertility. However, as infertility is not a sudden, definitive or tangible event, the model fails to capture some defining characteristics of the experience.

CRISIS MODEL - SITUATIONAL CRISIS / LIFE CRISIS

Mortimer (1994) perceives that infertility as a situational crisis presumes it to be a short-lived experience and implies the concept of illness (Sandelowski, 1988) thus limiting its utility as a model. She illustrates with the following example: a person involved in an accident may sustain injuries, necessitating a short stay in hospital. The person's absence from work and home may require alternative arrangements to be made until the individual has recovered.

Menning (1980) comments that infertile people commonly experience a state of crisis during investigation or treatment. Regarded as such, the crisis can be perceived as an opportunity for establishing new coping patterns, for developing insight, and for personal growth and change (Mortimer, 1994). However, for many people, the possibility of multiple crises throughout medical intervention proposes a state of constant disequilibrium that may in turn lead to a threat of maladaptive functioning.

Alternatively, Menning (1980) focuses his discussion on the experience as a 'life crisis', a better description for infertility, for some, than a 'situational crisis'. He notes that couples rarely experience crisis at the same time, so when one partner is dysfunctional, s/he may believe that the other does not understand her/his position. Differences in coping styles may also be the cause of misunderstanding and resentment (Abbey et al., 1991). The resulting breakdown in communication may drive a wedge between the couple as they are less able to attend to each other's needs (Mortimer, 1994). Men often find it difficult to express their sadness and disappointment, which can lead to their partners' misinterpreting their silence for not caring (Mahlstedt, 1985).

An extreme consequence on the marriage may be divorce, while Durkheim (1951, cited in Mortimer, 1994) found that suicide amongst childless couples was twice as high as amongst couples with children. "In his discussion about counteragents against suicide, Durkheim (1951, cited in Mortimer, 1994) asserted that "the family is the essential factor in the immunity of married persons ... this immunity even increases with density of the family, that is with the increase in the number of its elements" (p.13). There is little relevant literature regarding this comment to establish whether it holds true for the present.

Infertility rarely just suddenly occurs thereby initiating a crisis. It is generally characterised by its long-term duration and gradual dawning upon the individual that there is a problem with fertility (Mortimer, 1994). As such, the situational crisis model does not adequately fit into the realm of infertility.

DEVELOPMENTAL CRISIS

Infertility is commonly viewed as a developmental crisis (Kraft, Palommo, Mitchell, Dean, Myers & Schmidt, 1980) particularly in terms of Erickson's developmental theory (1950). Failure to achieve generativity, a specific task of adulthood, may lead to what Erickson (1950) termed *self-absorption* and *stagnation*. Non-resolution of this task (i.e. generativity) is perceived to restrain progression through to the next stage of integrity, when people attempt to discover meaning in their lives (Berger, 1983). In regards to this context, the importance of generativity refers to adults undertaking meaningful and productive work and raising a family. Potts and Selman (1979) assert that view

"Parenthood provides a sense of personal achievement with children bringing meaning, purpose, and satisfaction. They provide a feeling of immortality, particularly with the arrival of grandchildren and, as parents age, the adult children can bring comfort and support" (cited in Mortimer, 1994. p.14)

Most societies place a high value on children within the group or community. Often those who are childless may be made to feel that they have somehow failed to fulfil their role in life.

This developmental model conceptualises infertility as the ‘failure to achieve the adulthood task of generativity’, especially if generativity is perceived to equate with procreation. However, for Mortimer (1994) “to involuntarily miss a major developmental milestone, a stage which stretches into retirement, signals the need for carefully planned reconstruction of future life plans that encompass the task of generativity” (p.14). She further qualifies this as some couples choose not to have children, yet are not developmentally delayed. It is possible to successfully resolve this developmental crisis, to be able to fulfil generativity, through meaning and fulfilment being achieved via other avenues.

CULTURAL PARADIGM

In comparison with the other theoretical models, Mortimer (1994) viewed the cultural paradigm as a more appropriate framework from which to approach infertility as it better takes into account contextual factors such as both the personal and socio-cultural experiences of the individual. Sandelowski (1988) states further that for those who fail to attain this role, it may be perceived as though permission to enter the dominant culture is denied and, instead, they are forced to become part of a “deviant subculture” (p.148). Matthews and Matthews (1986) propose the idea of involuntary childlessness involving a “major reconstruction of reality by both partners” and often by their families (p.643 cited in Mortimer, 1994, p.15).

Mortimer (1994) utilises the following examples as an illustration of cross-cultural differences in terms of the context in which people experience infertility.

“in North American society, Miall (1985) claims that childlessness is viewed akin to a physical disability, provoking stigmatisation by the rest of society. Jindal and Gupta’s (1989) account of the social problems of

infertile women in India highlights the tremendous social pressure to become parents. The loss of status and prestige among infertile couples is reflected in the disharmonious interactions between families and friends. Females tend to be victimised and in some cases brutalised, often resulting from ignorance of male infertility factors" (p.15).

Sandelowski (1988) states that women are under a constant barrage of reminders reinforcing a sense of being apart and not belonging. Such failure to conform to society's expectations may result in isolation and withdrawal. Women are constantly reminded of their childless state on Mother's Day, Christmas, when someone else becomes pregnant, at baby showers, and even during menstruation (Mortimer, 1994).

Shattuck and Schwarz (1991) point out that traditionally, women have been held accountable for a couple's infertility. Often the problem is quantified in terms of delayed child bearing, sexual promiscuity and the inappropriate use of contraceptives. "Inferences are thus drawn that infertility is self-imposed and results from poor decision making in the past" (Mortimer, 1994). Women are also the primary targets for medical intervention in treatment of infertility, resulting in a greater assumption of responsibility for both their own and their partners' fertility, leaving them at increased risk for psychological distress and physical damage (Shattuck & Schwarz, 1991).

The understanding of the experience of infertility from this paradigm places it within; "a context of being different, of failing to meet societal expectation, and of changing life goals and personal aspirations" (Mortimer, 1994, p.16). As such, these factors may contribute to an overwhelming feeling of stress and sadness.

MEDICAL MODEL

The medical community often views infertility in terms of a medical problem. Specifically, as a dysfunction which needs to be cured (Mortimer, 1994). Mortimer, (1994) views the medicalisation of infertility as overlooking the accompanying social factors of the experience while imposing a notion of sickness upon the person.

Nachtigall and associates (1992) proceed further and claim that the high value placed upon children by society is, in essence, the medicalisation of childlessness. This concept is expressed well by Sandelowski, Holdtich-Davis and Harris' (1990) statement that "infertility is a situation frequently only referred to from the absence of an event, conception or birth, rather than documented by the presence of disease" (p.198). Therefore, the medical practitioner's role is to do his or her utmost to bring about a pregnancy (Mortimer, 1994). Mahlstedt (1985) notes medical personnel are trained to minister to the physical side of the problem and are ill-equipped to deal with the psychological aspects associated with it. The more involved these medical investigations are, the greater the strain placed upon the couple, especially in regards to marriage and intimacy, (Berg & Wilson, 1991). Berg and Wilson's (1991) study discovered that a couple's marital and sexual functioning were stable and did not suffer from stress which manifested in depressive symptoms during the first year of medical investigations. Emotional strain was lower during the second year. However, by the third year, psychological stress had increased, while marital adjustment and sexual functioning had markedly decreased. In reflection upon this, therefore, it is important to consider the particular period infertile people are in when interpreting or making generalisations from studies of the psychological effects of infertility. It is also important to take into account that the distressing effects of infertility may be compounded also by the long-term, intrusive medical procedures involved (Mortimer, 1994).

The medical model is an inadequate paradigm for the investigation of infertility. Its assumption of a pathological approach does not lend itself to accounting for psychological or social issues attributing to the aetiology of the problem. As briefly discussed above, medicalisation of the problem can in itself lead to emotional symptomology. In turn, such distress may lead to further exacerbation of problems with attempts to conceive.

CRITIQUE

Due to the multi-dimensional aspects of infertility, the models outlined are inadequate in their portrayal of the experience. While they explore some facets that may characterise people's experiences they are unable to illustrate the complete picture. Most models do not address contextual factors adequately, if at all. Infertility has been examined in terms of a single event, rather than an ongoing process (Mortimer, 1994).

There is a predominantly scientific, rigid methodology in use to research infertility which fails to provide a holistic view as the effects of infertility may represent more to an individual than not having a child (Mortimer, 1994). Mortimer (1994) illustrates that if, for example, research shows that those experiencing infertility have higher depression levels than those who are not, what does this tell us? What exactly is the contributing factor that causes the depression? Is it the loss of a preconceived future; is it the effects of the prolonged stress or disappointment; is it the feeling of being different from the norm or perhaps a feeling of having failed? Discovering a way to answer these questions may enable health professionals to better comprehend the dynamics of the experience of infertility and thus better attend to the psychological needs of those wanting a child.

SUMMARY

This chapter reviewed the paradigms commonly utilised in the literature to define the experience of infertility. The grief model was fundamentally based on a set of grieving or mourning stages through which infertility was experienced as a loss. The situational crisis model presumes infertility to be a short-lived experience and implies the concept of illness. The developmental model conceptualises infertility as a failure to reach a preconceived idea of an adulthood task. This failure is seen to cause the infertile person to become developmentally delayed. A cultural paradigm approach to infertility takes into account contextual factors such as both the personal and socio-cultural experiences of the individual. Lastly, the medical model views infertility in terms of a dysfunction

that needs to be cured. However, the chronicity and complex nature of infertility mean that it (i.e. infertility) does not yield itself easily to such manipulation. Critiqued, these models may fit some experiences only to a degree, or in some instances not at all. It is proposed that a new, fresh approach to infertility research is required in order to accurately investigate the phenomenon.

CHAPTER THREE

Grounded Theory

The first part of this chapter presents the rationale for utilising a qualitative research approach. The reasons why the grounded theory methodology is appropriate to the present study is also discussed. The second section defines grounded theory methodology and outlines its origin and development. The coding and data analysis techniques of grounded theory will be summarised. Finally, the general criteria for what makes a 'good' grounded theory will be outlined.

RATIONALE FOR ADOPTING A QUALITATIVE APPROACH

There are broad underlying philosophical differences as well as surface methodological differences between qualitative and quantitative research methodologies (Ramsey, 1994). Ramsey (1994) states that, in spite of these differences, the epistemological stances of qualitative and quantitative approaches may be viewed as a "continuum of differing forms of the analytic practice of re-representation in science" (p.32). From this perspective, Ramsey (1994) contends further that a close examination of the suitability of the research method, both in relation to the research question being asked and the understanding of the epistemological stance underpinning the proposed method, is required by the researcher.

Qualitative analysis is a research tradition that is essentially reliant upon the technique of observing participants in their own environment, initiating interactions in their language and on their terms (Roskilly, 1996). Considered a socially located phenomenon, it involves naturalistic, ethnographic, and participatory, qualitative analyses. It offers analytic induction, content analysis, semiotics, elite interviewing, and the study of life histories (Kirk & Millar, 1986). Marshall and Rossman (1989) define qualitative research as an approach that

“values participants’ perspectives on their worlds and seeks to discover those perspectives, that views inquiry as an interactive process between the researcher and the participants, and that is primarily descriptive and relies on people’s words as the primary data” (p.11).

Qualitative research is distinctly separate from the quantitative approach as it emphasises the use of linguistic data rather than numeric data as units of analysis. The linguistic data reflects the participants’ thoughts, feelings and perceptions. Secondly, a qualitative observation focuses on the presence or absence of a particular feature under investigation. A quantitative analysis involves measuring the degree to which the feature is present. The information gained is then used as a tool for discovering psychological invariants.

A qualitative approach was chosen for the present study for several reasons. The major rationale concerned here is associated with the ability of the approach to explore meaning and to represent reality through the eyes of the participants (Bryman, 1988 cited in Ramsey, 1994). The qualitative approach documents and interprets the understanding people have about themselves and their world. Here, the participants can be consulted as knowledgeable experts. This seemed appropriate for the study of infertility experiences since this topic per se is essentially psycho-social. Considering language is the primary medium for communication in society, it is appropriate to analyse results in terms of language. Thus participants are able to express themselves linguistically, as opposed to numerical ratings on a scale (Roskilly, 1996). Such a style fosters a spontaneity and flexibility that allows immersion into the participants’ thoughts, feelings and perceptions that contribute to the understanding of the complex process of living with infertility.

Associated with this, not only is qualitative research seen to acknowledge the participant’s inner experience, but also inner experience itself becomes the analytic data (Roskilly, 1996). Conversely, with traditional research methods, participants’ behaviours are considered the basic data source. Qualitative methodology encompasses meaning, and acknowledges the purpose and significance people attach to actions or events (Stiles, 1990). Thus, the researcher’s task lies not only in acknowledgment of

those personal perceptions and philosophies, but also in empathising with the individual's perspectives (Roskilly, 1996).

A qualitative approach to data collection and analysis that emphasised an understanding rooted in context, rather than a significance of numbers, was deemed appropriate for the inquiry into accounts of the psycho-social effects of infertility.

RATIONALE FOR ADOPTING A GROUNDED THEORY METHODOLOGY

Specifically, the grounded theory approach was suitable for the study of experiences of infertility for a variety of reasons. Firstly, there is a decided lack of literature pertaining to the experience of infertility as perceived by both partners. Henwood and Pidgeon (1992) propose that there are occasions in psychology when existing theory is incomplete, inappropriate, or entirely absent. In such instances, they suggest that the grounded theory method be utilised as it does not rely on research that either confirms or discredits pre-set theory (Ramsey, 1994). The methodological drive of this approach is aimed at the development of theory, without commitment to specific kinds of data, prior research, or theoretical interest (Strauss, 1987 cited in Roskilly, 1996). The absence of theory in this area leaves room for the current research to explore a new domain and develop a fresh outlook on the experience of infertility.

Other attributes of grounded theory methodology are also relevant. The underlying procedure of grounded theory is that of "constant comparative method of data analysis" (Strauss & Corbin, 1990 cited in Roskilly, 1996. p.62). Each piece of data is consistently studied and compared for similarities and differences in meaning. With such a rich abundance of data, the participants expressed differing approaches and attitudes in inner perspectives, which were recognised and considered relevant and noteworthy to the study (Roskilly, 1996). The full complex diversity of each experience was explored, lending the theory itself to be context sensitive. This approach has great importance to the present study as the experience of infertility as a topic is seen as deeply personal. The private emotions connected to such experiences are highly

sensitive in nature. Thus, grounded theory methodology acknowledges the emotions caught up in the data and utilises them in order to develop the core theory (Glaser & Strauss, 1967).

Further pertaining to the researchers themselves, Roskilly (1996) notes that the grounded theory approach lends support to creativity (Corbin & Strauss, 1990) and ideation (Glaser, 1978). Methodological procedures of grounded theory force the researchers to relax their mental constraints and establish the free association that is required to generate stimulating advances in the development of theory. The creativity encouraged in the methodology pushes the researcher to discard preconceived assumptions surrounding the phenomenon, in order to encourage new discoveries.

DEFINITION OF GROUNDED THEORY

For the purposes of the current research, a grounded theory method of analysis was utilised. A grounded theory, in essence, is one that has been inductively derived from the study of a represented phenomenon. The theory is discovered, developed, substantiated and also illustrated through the use of direct quotations from the data. Thus, through the intertwined process of data collection and analysis, the theory is allowed to emerge (Strauss & Corbin, 1990)

In contrast with most other qualitative methodologies, it is not the focus of the grounded theorist to verify any preconceived hypotheses. Rather, the researcher begins primarily with a diverse area of study, permitting the data collected to generate a relevant theory from within. Thus, the theory is grounded inside the data, providing the term 'grounded theory' (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

Strauss and Corbin (1990) define the grounded theory approach as:

“a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon.”

(p.24)

Here, a constant comparative analysis underlies the procedure. Data are broken down, with each piece being compared with all others. A search for any similarities or differences in meaning is the focus. The hierarchy of the categories and concepts is also examined and contrasted in order to fully explore the complexity and diversity of the data (Strauss & Corbin, 1990). Furthermore, "there is a generative focus underlying the exploratory and descriptive purpose and propositions may be stated about the relationship between the concept and categories" (Chenitz & Swanson, 1986; Henwood & Pidgeon, 1992, cited in Ramsey, 1994). Derived solely from the data itself, these concepts and relationships constitute a theoretical formulation of the reality under investigation. The basis of the theory is grounded from within the immediate data themselves and not from the material of other sources or theories. Individual deductions or assumptions regarding the study are not involved, nor do they constitute any part of the theory unless evidence is rooted within the data (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

THE ORIGIN AND DEVELOPMENT OF GROUNDED THEORY

Developed in 1967, grounded theory is the collaborative work of Barney Glaser and Anselm Strauss. While both men originated from a sociologist discipline, each contributed differing philosophic and research backgrounds to their work together. From the University of Chicago, Strauss was strongly influenced by the strong history and tradition of qualitative research of the institution. Emergence in the field of study was considered important in order to fully comprehend the phenomenon under inquiry (Strauss & Corbin, 1990). As a student at Columbia University, Glaser was greatly influenced by the work of Paul Lazarsfeld, a man renown for the innovations of qualitative methods. He recognised the need for a cognitively planned, systematic set of procedures for coding and testing hypotheses generated during the research process (Strauss & Corbin, 1990). Together, the traditional research backgrounds of both men emphasised the production of research that would be useful for professional and lay people' alike (Glaser & Strauss, 1967).

In the 1930's, the generators of theory were critiqued for largely utilising "qualitative methodology non-systematically while relying primarily on personal logical assumptions loosely connected to their data" (Roskilly, 1996). Consequently, the resulting qualitative work was claimed to be either theoretical or too impressionistic (Glaser & Strauss, 1967). During this time, there emerged strong advances in quantitative research the methods of which appeared to prove theories with empirical facts which overshadowed qualitative methodology. Such developing systematic rules of quantitative analysis accommodated issues of reliability, validity, sampling, coding, frequency distribution and conceptual formulisation (Roskilly, 1996). Comparatively, qualitative research methods, lacking in such 'scientific' criteria, failed to achieve such credibility (Glaser & Strauss, 1967).

However, with grounded theory, proponents of qualitative methodology have now adopted a more quantitative approach to research methods (Glaser & Strauss, 1967). As Glaser (1992) states, the main goal of grounded theory "is the systematic generating of theory from systematic research" (p.6). Through detailing methods of collecting, recording and analysing data, and by noting exact procedures of interviewing, sampling and coding, qualitative methodology is able to adhere to those verifications so readily accepted as credible scientific research. However, the development of grounded theory has not been a smooth path.

Following a parting of accord by the co-creators of grounded theory, there has been an establishment of opposing views on the 'true' fundamental methodology of grounded theory. While Glaser (1992) purports a strict adherence to the original methodology of grounded theory, developed in 1967, Strauss (in collaboration with another researcher, Corbin) (1990) has produced further new work in contribution to the field. It is important to note that this researcher has chosen to utilise the latter's published work as a definition of grounded theory and its methodology. The essential base in the original development of grounded theory itself was firmly established in "improvements" and "different perspectives" towards research (Glaser & Strauss, 1967, p.vii-viii). Strauss and Corbin (1990) have taken this spirit and further developed the basics of grounded theory into published work which clearly outlined the methodology of this research in a way that was clear and comprehensive in its structure.

CODING AND DATA ANALYSIS

Data analysis in grounded theory comprises of three major types of coding. These are: open coding, axial coding; and selective coding. Here, it is important to emphasise that there are no firm boundaries between each code, with the different types not necessarily taking place in stages. Rather, one form of coding may move freely between others throughout the analysis.

Open Coding

The conceptualising of the data is the first step of analysis. Here, an observation, paragraph, sentence, or even word is disassembled. Constant comparative analysis then occurs with each incident being compared and contrasted with others. Questions of 'What is it?' and 'What does it represent?' are asked (Strauss & Corbin, 1990).

Incidents were compared and similar phenomena grouped together, then labelled with common names. The new labels chosen were deemed by the researcher as ones that logically represented the phenomena. These substantive codes, as they now have become, enabled the researcher to appropriately categorise as many phenomena as required. New and emerging categories were acknowledged and adjusted for.

Each transcript was analysed and coded individually. Once the open coding was completed and the data fragmented, its properties and dimensional locations were identified in preparation for restructuring into categories.

Axial Coding

Axial coding then occurs. This is a set of procedures whereby the similar properties of substantive codes were identified and reconnected. This is done by utilising a paradigm involving conditions that give rise to it, the context in which it is embedded, the action/interactional strategies by which it is managed, and the consequences of those strategies (Strauss & Corbin, 1990). Within the category, these features are termed 'subcategories' as they provide the category with its precision and are, indeed, dimensions of a greater category. A paradigm model is utilised in order to examine the

similarities and differences of these criteria. Once identified, they are linked together to provide an axial code.

Selective Coding

During the previous procedure, the basis of selective coding has been developed. Here, these axial codes are further integrated at a higher, more abstract level of analysis. The same paradigm of condition, context, strategies and consequences is further utilised in order to relate subsidiary categories into a larger category. This larger phenomenon is then labelled with a selective code. As these subcategories develop, the selective codes are arranged in an hierarchical fashion.

At this stage of coding, the core category is identified. The data are repeatedly reflected upon, with categories being systematically related to all others. Strauss and Corbin (1990) define the core category as being “the central phenomenon around which all the other categories are integrated” (p.116).

WHAT MAKES A GOOD GROUNDED THEORY?

In the practical application of grounded theory, the view of Glaser and Strauss (1967) is that the development of a theory requires four highly inter-related properties.

The first underlying prerequisite rests on the assumption that the theory closely fits the substantive area in which it will be applied. In essence, the theory must correspond closely to the data if it is to be used in daily situations. Deducing practical applications from formal theory rests on the theory supplying concepts and hypotheses that fit. Should a theory not fit well, often the consequences are a forcing or distortion of the data in order to suit the categories of the deduced applications. Relevant data that seemingly do not fit, or cannot be reshaped into, the pre-existing categories may be neglected. Rather, a theory that is true to the daily realities of a substantive area is one that has been carefully induced from the data. Only in doing so will it be applicable to dealing with these daily realities.

Secondly, it must be readily understandable to laymen concerned with this area. This engenders a readiness to make use of the theory as the rationale behind it is easily comprehended and applied.

Thirdly, a theory must be sufficiently general, being applicable to numerous and diverse situations within the substantive area, not just to a specific type of situation. A delicate balance is required where the categories are not so abstract as to lose their sensitising aspect, yet flexible enough to make the theory a general guide to multi-conditional, dynamic daily situations. The level of the concepts generally allows the theory to be flexible enough to be readily reformulated should it not work in application. It is important that the theory be general enough to be applicable to the picture as a whole.

Fourthly, it must allow the user partial control over the structure and process of daily situations through time. The theory's user must be able to understand and analyse on going situational realities, to produce and predict change in them, and to predict and control consequences both for the object of change and for other parts of the total situation that will be affected. As change occurs, the theory must be flexible in revising the tactics of application. Indeed, in revising the theory itself if necessary.

SUMMARY

This chapter began with a discussion of the rationale for choosing a qualitative research approach for the present study, followed by the rationale for adopting a grounded theory methodology. The ability of the approach to represent the experience of infertility through the participants themselves, initiating interactions in their language, and in their terms, to serve their interests as research participants, was among the reasons for opting to utilise a grounded theory approach in the present study. The main advantage of grounded theory is that it is context sensitive, and as such, acknowledges the inner perspectives of the participants themselves. The second section of this chapter discussed the specific methodological approach utilised in the present study, that of grounded theory. Grounded theory is considered a derivative of the represented

phenomenon itself. Here, information is used to establish a theory that is grounded within the collected experiences of the participants. Developed in 1967 by Glaser and Strauss, the emergence of its use is chronicled, accumulating in the eventual philosophical divide between the two co-creators. The specific grounded theory technique utilised in this research was outlined, together with a summary of the coding and data analysis methods applied. Open coding involves the conceptualisation of the data and coding substantive categories, axial coding entails the connection of the categories using specific paradigms, and selective coding sees integration into broader categories using the same paradigm. The emergent core category was identified during this process.

CHAPTER FOUR

Methodology

The following chapter will summarise the objectives and framework of the method used by the researcher to conduct the present study. The first section outlines the criteria for participant selection, recruitment methods, and sampling. Secondly, the ethical considerations of the study are considered. Lastly, the research measures for data collection and methods are explained. Here, the rationale for adopting a semi-structured interview schedule, and aspects of data collection including initial contact with participants, interviewing, transcribing, and follow-up are summarised.

OBJECTIVES

The primary purpose of this study was to present a grounded theory of the impact of infertility as experienced by couples. Through utilising a grounded theory methodology, the researcher was interested in identifying the similarities, differences and unique experiences encountered when looking at male and female partners. The emotions generated in the data were acknowledged through grounded theory, and utilised to develop a core theory in regard to the couple's psycho-social experiences of infertility.

The objectives of the present study were:

1. To establish a grounded theory to explore the psycho-social experience of infertility on couples.
2. To further investigate the experience of infertility from a male perspective.

THE PARTICIPANTS

The participants were 10 couples who were at different stages in the process of dealing with their infertility (e.g. those in the early stages of treatment, couples who have been successful, and those who have ended their pursuit of a child). No criteria were placed on the eligibility to enter the study (i.e. the stage of infertility, or medical intervention/treatment). The researcher merely asked that prospective participants have some history of a fertility problem, and that both partners elected to take part. All those who showed a willingness to share their narratives were welcome.

Participants were originally sought through an adoption agency operating in conjunction with the Manawatu Children's, Young Persons' and Their Families Agency (CYPFA). However, one couple elected to prospectively participate in the research.

Simultaneously, an article was published in the local paper, 'The Evening Standard', making note of the study and issuing an open invitation for couples to share their experiences of infertility. This had been organised as part of the 'Infertility Awareness' week promotion. Seven queries were returned, of which four did not proceed further in their inquiries due to either having no current partner, or their partner being vehemently opposed to sharing their experiences. The remaining three couples chose to follow through with their participation in the study into the next phase.

Following contact with the New Zealand Infertility Society and then in turn the Auckland Infertility Society, five more couples were obtained from within their established support groups. It was through a 'word of mouth' means that these couples became aware of the study. From here, the first six willing couples were selected. Although this means had generated many more responses, it was decided to limit the study to a maximum number of 10 participant couples. Due to the particular methodology utilised, information generated from this number was considered to be more than adequate. Indeed, any increased volume would have caused the study to become difficult to manage.

Each potential participating couple was sent an introductory letter explaining the research and introducing the researcher (Appendix A). These letters were accompanied by information sheets (Appendix B) which further clarified who the researcher was, the

nature of the research was about, and what participation entailed. Any interested person was then sent a consent form (Appendix C). These two forms were again reviewed in person before the interviews commenced.

Thus, from the 10 participating couples, four resided within the Manawatu region, while the other six lived in various suburbs of Auckland. The age range was between 27-48 years. Participants were in various stages of the infertility process. Four couples had long been involved in the system, (4 years, 5 years, 6 years, 7 years), and were still actively seeking medical intervention. For the remaining four couples, their involvement had resulted in having children, through either conception or fostering with the view to adoption. One couple decided to relinquish their hopes of having a child completely, while another's relationship ended. Here both partners were willing to participate, and had planned to pursue the desire for a child separately.

ETHICS OF THE STUDY

Due to its sensitive nature, ~~it was imperative that this research~~, it was imperative that this research was conducted within the ethical guidelines of both Massey University and the New Zealand Psychological Society. Approval was sought and granted from the University's Human Ethics Committee (Appendix D).

While it might appear that the potential existed for harm to participants in the narration of one's infertility experience, findings to the contrary have been established. Many researchers have found that in fact it is more conducive to the 'healing process' than harmful for sufferers to talk about their feelings and the circumstances surrounding them after a negative life experience (Pennebaker, Kiecolt-Glaser & Glaser, 1988; Oakley, McPherson & Roberts, 1984; Pizer & Palinski, 1981 cited in Mortimer, 1994). It was also anticipated that couples would have, to some extent, come to terms with their infertility as they were amenable to participating in the study. Within the context of the planned procedures for this study, all potential participants were in the position to make an informed choice as to whether or not they wished to participate and talk about their experiences. In light of the cited literature findings, such an opportunity to share their

stories with an informed and empathic researcher, and for the cause of furthering the knowledge to help others in a similar position, could present potential benefits to the participant. However, should participants wish to further discuss their experiences, or perhaps undertake some form of counselling, a referral sheet containing the names and contact phone numbers of qualified and appropriate agencies was made available from the project supervisor for all those who wished to make use of it.

Potential participants were fully informed, both orally and in writing of the objectives of the research and procedures involved in the study. As well as an information sheet outlining the rights of participants being provided, an informed consent form was also signed. The contents of both had been discussed with the participants prior to the study commencing. Following their reading of the information sheet participants were required to read and sign the consent form. This was necessary to officially confirm in writing that both the researcher and participant agreed to conduct the interview in accordance with the conditions outlined in the information sheet.

Complete confidentiality was assured. This pertained to the secure storage of the interview tapes, transcript manuals, or other materials. These were accessible to the researcher, the project supervisor and official transcriber only. Further confidentiality was ensured through the use of personal pseudonyms, rather than individual names, thus eliminating the chance that participants in this study might be identified. The rationale for this was explained, and the participants chose alternative names themselves prior to the interview's commencement.

METHOD OF DATA COLLECTION

Interview Format

A semi-structured interview format was utilised for the collection of data. Here, the researcher devised in advance a list or guide of specific areas on which to focus the interview. These questions were assembled through a combination of both previous research areas (Mortimer, 1994) and various issues that the researcher thought important to explore. Questions were of a simple, yet focussed, nature as it was essential that

participants were given the opportunity to speak on experiences they themselves deemed most important. The interview guide was prepared to ensure that areas of information elicited from individual participants were consistent across interviews. However, given the type of analytic procedure used (the grounded theory approach) the interview guide evolved as the research progressed. Questions became more defined and purposeful as patterns and important themes began to emerge (Appendix E).

During the interviews, the focus of discussion centred on the participant's experiences of infertility, from prior knowledge of the infertility through to the present time. The participants, in what resembled a 'time frame' structure, narrated the experiences encountered. This process was investigated in more detail. The opening questions aimed to generate rapport and ease the participants while establishing a base of information. The researcher raised specific issues, and the participants discussed their personal experiences relating to the infertility. The researcher inquired about the physiology of the infertility, experiences with the medical profession, the emotional consequences and resulting coping mechanisms utilised, and at what stage they were currently in their lives. Participants were also asked to consider what plans they intended to make for the future, and how the infertility had impacted on them.

Throughout the interviews the researcher utilised a variety of questions and probing techniques in order to encourage participants to dialogue in more depth about their experiences. Prompting through open-ended questions was most effective (for example, 'Can you tell me more about that?') as they allowed the participants complete freedom to respond in any appropriate way. Closed questioning, where appropriate, was necessary to elicit more specific information, either to clarify a point or produce a less variable response. Probes were made use of in order to follow up on an original question. To gather more information a mixture of pursuit ('What happened next?'), neutral ('Uh-huh', 'Hmmm'), and silent probes were utilised to explore an issue or experience further.

As at times there was an open, free flow of dialogue from the participants, it was necessary to note information so as not to interrupt their thought processes. Additional queries (or the guide itself) were rearranged and stored in a mental checklist that was revisited with the participants at an appropriate opportunity. The structure and format of

the interviews remained flexible throughout. At the end of each interview the researcher asked each participant if he or she had anything they wished to alter in regards to the interview.

Rationale For Adopting The Semi-Structured Interview Guide

Cannell and Kahn (1968) have defined the research interview as “a two person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information and focused by him on content specified by research objectives” (p. 530). Expanding on this, Cohen and Mannison (1980 as cited in Ramsey, 1996) point out that it serves three main purposes. Firstly, it may be utilised as the principal means of information gathering. Secondly, it may be used to test hypotheses or suggest new ones. Lastly, it may be used to follow up expected results, investigating deeper into the responses and the rationale behind them. As such there is no one set research interview since the purpose of the specific research investigation is seen as determining the style of the interview. The two main types of interviews, which in essence represent a continuum, are namely the structured and the unstructured. In the first instance, the interviewer assumes complete responsibility for imposing a chosen interview structure, determining the topics to be discussed and those to be avoided. The general pace and duration of the interview also are controlled. In contrast, the unstructured interviewers act out a less dominant non-expert role where the interviewee assumes a more powerful role in determining the direction and content of the interview. Within these two extremes there is an intricate relationship between reliability, validity and structure. “Highly structured interviews may be more reliable in that similar results may be obtained on different occasions, but less structured topic interviewing may be more valid in that the real problems of interviewees are more likely to emerge” (Millar, Cruik & Hargie, 1992, p. 103).

In regards to the current research, a comprehensive semi-structured interview guide was deemed the most appropriate to employ. This allowed for many advantages. While reducing the subjective biases introduced by interviewers (Millar et al., 1992), it aids the researcher to develop areas of inquiry (rather than a random list of questions, remember

information, recognise relevant and irrelevant answers, and determine which probing questions) to ask. In being semi-structured, it is not so specific and predetermined as to preclude the inclusion of other topics when deemed appropriate by either the interviewer or interviewee (Roskilly, 1996). This flexibility opens the interview to modification, depending on the interviewee's initiations and responses. Questions are initially addressed and then further explored and elaborated on through probes conducted in a manner that distinctly lacks strict formality, resembling that of a conversation. Oakley (1981) ascertained that the best way of uncovering people's experiences through interviewing is when there is a non-hierarchical relationship between the researcher and participants. Here, barriers and dominant roles are dispensed with during interactions. The resulting relationship allows for the development of a free and easy conversation style in the sharing of participant experiences. The broad questioning and informal tone of the interview prompt participants to narrate important events from their lives. Mishler (1986) suggests that "narratives are one of the natural cognitive and linguistic forms through which individuals attempt to order, organise and express meaning. Therefore, by encouraging free expression of individuals' narrative, data content becomes "rich with meaning" (p. 48, cited in Roskilly, 1996). This is indeed an important aspect of grounded theory.

THE PROCESS OF DATA COLLECTION

Initial Contact

As previously outlined, the initial contact was made with participants via the phone. The researcher took this opportunity to introduce herself and the topic of study. The interview process by which the data would be collected was also discussed. From here, any queries were addressed and the participants gauged as to whether they wished to become further involved in the research.

An introductory letter was sent to the participants' home. Attached to this was a copy of the information sheet and a copy of the consent form. All participants who received any initial information opted to take part in the research. All consent forms were

returned, signed, indicating that they wished to proceed. Upon the researcher's receiving these forms, the participants were contacted in order to arrange an interview date and time. The venue where the interviews would occur was also discussed. It was hoped that an environment conducive to a relaxed atmosphere where the participants would feel at ease with sharing their experiences would be chosen. For this reason, the decision was made by the participants as to where they felt most comfortable and wished to be interviewed. Of the 10 interviews, nine were conducted within the participants' homes, while one was held at a neighbour's house. In regard to the latter, this was due to the participants' residing with extended family. They perceived lack of privacy in their own home and preferred to meet at a friend's house.

The participants were contacted again the day prior to the interviews' scheduled time. Confirmation of the arrangement was sought. However, no changes were made.

The Interview Process

Upon arrival at the participants' homes, introductions were made and 10 to 15 minutes taken to establish rapport. Prior to the interviews, participants were supplied with a fresh information sheet to re-read, and consent form to sign. The researcher took this opportunity to reiterate the participants' rights, assure confidentiality and discuss the study in general. Participants were given the opportunity to raise any questions they wished clarified. Permission was then requested and granted by all participants to tape record the interviews. The purpose of this was to achieve an accurate account of the proceedings. This was explained to participants. A small unobtrusive audio tape was used to record all interviews. Once participants were comfortable and written informed consent regarding the study was obtained, the tape recorder was turned on and the interview commenced. The initial interview with both participant couples present ranged from 1 hour 15 minutes to 2 hours 45 minutes.

Directly following this first interview, a second interview was conducted with the male participant. The purpose of this was to provide him with an opportunity to clarify any points noted during the main interview, and to discuss concerns, if any, that he may not have chosen to voice in front of his partner. Of these subsequent interviews: two

declined stating that they had nothing further to add; two had their partners request to be present - to which they consented; and six agreed to participate. These interviews ranged from 15 minutes to 1 hour 20 minutes in duration.

At the conclusion of these interviews, each participant was thanked for their time and co-operation in taking part. The following stage was then reiterated, whereby the interviews would be transcribed verbatim and transcripts then posted for their perusal. This provided participants with an opportunity to read, edit and correct the record of the interview, ensuring the information accurately reflected their experiences as they perceived them.

Due to the sensitive nature of the topic, the welfare of participants was of utmost importance. It was acknowledged that some of the participants may have experienced distress upon completion of the interviews. Time was spent with each participant after the interviews concluded. Renzetti and Lee (1993) advocate the necessity of this in order to restore equilibrium to the relationship. Through fostering this type of 'debriefing', it was thought to help lessen any disturbing effects of participants' disclosures, especially when the topics discussed were largely sensitive and personal. A referral sheet was made available, outlining appropriate psychologists, counsellors and support agencies should further follow-up care be required. All participants declined the use of these systems however, preferring to access already established support.

Transcription

The interviews were transcribed by the researcher, verbatim. Any distinguishing details that may have led to the identification of the participant were omitted. Personal names were exchanged for the participant's chosen pseudonym. However, information pertaining to places or locations was not altered in any way. This was due to such information being of a contextual nature in the type, and quality, of medical intervention and support the participants received. Overall, all efforts were made to secure the confidentiality of participants through eliminating, or in some circumstances minimising, any details which may have led to their identification.

Following completion, the transcripts were posted, accompanied by a letter to the

respective participants (Appendix F). The letter thanked them for their participation and requested that the transcripts be reviewed. Participants were invited to edit, correct or amend the interviews, ensuring the information accurately reflected their experiences as they perceived them. A stamped, self-addressed envelope was enclosed in order to simplify return postage to the researcher. Eight couples replied, with all having made minor alterations to their transcripts.

Follow Up

Along with their transcribed interviews, a brief participant profile was sent to each of the couples. An accompanying letter requested that these should both be reviewed (Appendix F). Participants were invited to check the vignettes for accuracy and also express any thoughts regarding their experiences relating to the research. The profile sheet accommodated these reactions as well as an option of having a copy of the final report made available to them.

SUMMARY

The primary objective of the present study is to establish a grounded theory to explore the psycho-social experience of infertility from a couple's perspective. This chapter has summarised the method utilised by the researcher to conduct the investigation. The predominant criterion for involvement in the study were that participants had some history of fertility problems (either factor) and that both partners elected to share their experiences. The recruitment process itself was also outlined. Potential ethical considerations were presented and the means through which they were surmounted discussed. The rationale for, and structure of, the interviews that occurred were reviewed. The exact process of data collection has been summarised, detailing initial contact, the interview process, the process of transcription, and follow up.

PART TWO
FINDINGS

Overview of Findings

The results of the research are presented in chapters 5 to 12.

The findings section begins with a compilation of vignettes providing a brief outline of participant profiles. Background information is introduced, including the infertility circumstances of each participant interviewed.

Introducing the central core category, the grounded theory is presented next. The documented sequencing of the analysis is presented in reverse order to its chronological emergence in the data analysis. The objective of initially discussing the central category is to clarify and direct the reader through subsequent discussion of the grounded theory. The core category presentation is accompanied by an investigation of the core category's four pre-existing conditions.

These four identified selective codes are then discussed. Each pre-existing condition is respectively disassembled into axial codes and then substantive codes. The first of the selective codes is 'parenthood', addressing participants' 'rationale for wanting a child'. These included reasons such as 'biological drive', a 'continuation of heritage', 'generativity', 'genetic homogeneity', and 'self-fulfilment versus altruistic desires'. The questioning of participants' motives for 'parenthood' related to perceptions of the need for a child-raising experience. Subsequently, the impact of the infertility itself was drawn into question. 'Reactions to the medical process' are then discussed. Participants' infertility experiences were largely directed by 'investigation and intervention' procedures. Here, the 'infertility factor', 'provision of information', 'medical process', and 'attitudes and treatment from medical professionals' were all significant emergent themes. These concepts were themselves impacted on by 'contextual factors' such as 'financial status' and regional 'location' of the participants. Following is the 'making meaning of events' code. Each participant had his or her own specific perception and understanding of the social processes involved with infertility. This experience contributed through detailing 'cognitive' experiences such as a 'distorting of one's self-perception', 'emotional reactions and triggers', and a description of 'the grief cycle' and 'stress'. These impacted upon participants 'behaviours' in regards to their 'marital relationship', 'communication', 'social interactions', and types

of 'support systems' utilised. The fourth selective code is directed at 'lifestyle adjustments' which participants experienced in regards to the infertility. The 'ways of being' participants experienced here entailed an 'acceptance and resolution' process, 'personal growth', a perceived 'locus of control', and 'lifestyle planning'. These had been subsequently affected by the infertility. The common thread underpinning the grounded theory is the core category of 'adjusting to living with infertility'. This relates to the necessity for participants to adapt appropriately through the process of these four pre-existing conditions to successfully come to terms with the phenomenon of infertility.

The next chapter in this section integrates the above findings from the grounded theory with the core concept. Early, middle, and late stages of the experiences involved are outlined, illustrating the process of 'adjusting to living with infertility'.

The final chapter investigates themes of gender specific experiences emergent throughout the data.

CHAPTER FIVE

Personal Profiles**BRIDGET AND MARCUS (43 & 40)**

Intuitively, from an early age Bridget had always believed that she would not be able to have children naturally. Her feelings of not being “quite like the other girls” were realised when the onset of adolescence led to serious gynecological problems. Medical interventions and subsequent surgery identified her infertility.

Bridget shared this information with Marcus as the seriousness of their relationship became evident. Marcus was accepting of this and the couple made the decision to marry. Although aware that children conceived naturally were not possible, Bridget and Marcus still had a desire for a family. The couple briefly investigated the choice of assisted pregnancy, but after serious consideration decided that they did not wish to pursue this.

In a positive view, Marcus saw their infertility as a “liberation” for him from the “stereo-typed male role as a provider”. This enabled him to follow a career that he found as fulfilling “without having to worry about the pressures of supporting a wife and kids first”.

However, still unable to completely resign themselves to a child-free life, adoption was raised. This was not well received amongst family members. Marcus’ parents had firm beliefs in the importance of genetic links to children. While welcoming possible grandchildren, the family farm was sold as they did not consider it important to pass this heritage on to children “not of the same blood”. Bridget and Marcus attribute this to a “stereo-typical rural attitude” which the couple deem as a common reaction experienced to their infertility from the farming community. As such, Bridget and Marcus received limited support during this time.

However the couple’s plans for adoption were unsuccessful. After further investigation, they discovered their age had already exceeded the maximum age criterion. Emotions of disappointment were quickly put aside as Bridget’s physical

health deteriorated. She was now experiencing almost constant pain. A hysterectomy was performed, which Bridget describes as “the best thing she’s ever done”. Bridget’s only regret was that this course was not followed earlier as she feels much of her later life was “wasted due to the pain”.

The hysterectomy seemed to have acted as a cathartic release for the couple.

After 13 years of marriage, Bridget and Marcus have fulfilled their desire for children through fostering and channeling their emotions into their beloved pets. Both are now content with their lives, busy pursuing further education and new careers.

SHAREE AND KARL (30 & 35)

Sharee and Karl were just two years into their marriage when Sharee suffered the loss of her twin sister. This focus on the ideal of the family unit fostered a desire within the couple to have children. Sharee felt that a child at this time would be “proof of their love” for each other. However, as time progressed and many of their friends started families, the couple began to feel a greater pressure to conform also. When Karl’s sister also fell pregnant, the couple were placed under immense strain to have a child. Sharee became “obsessed” with trying to conceive.

Two years on from their initial decision, Sharee and Karl consulted their family GP for advice. A sperm count was ordered for Karl, but a normal result set off a barrage of investigations for Sharee. They revealed that Sharee suffered from endometriosis which had left her infertile. Despite treatment, Sharee and Karl were still unable to conceive during the following six years. In this time the couple were preparing themselves to accept the possibility of never conceiving. Alternatives were investigated and the couple had completed a course enabling them to foster a child. It was not until four months after stopping chemical intervention that Sharee fell pregnant. They are now the parents of a healthy baby boy.

During this process, Sharee and Karl found the intrusive medical procedures difficult to deal with because of what they perceived as “inept” and “callous” treatment from the medical professionals. This has left the couple with a negative view of their experience.

The medical process/experience placed undue stress on the couple’s marriage and left them feeling bitter and often arguing. Friends and family were a great source of comfort during this time, but Sharee and Karl found it most helpful to have a break away with just each other. This enabled them to be removed from the constant pressure of trying to conceive, and allowed them to focus on communicating between themselves.

Sharee and Karl have found parenthood an exciting and challenging career, one which they feel has been worth the “heartache” to achieve. With their son now an active toddler, they have plans to start trying to conceive a second child shortly. However, this time the couple feel in a more informed position regarding what to expect during procedures, and their rights as clients. “This time we’ll be in control”.

ALICE AND PETER (29 & 32)

After being in their relationship for eight years, Alice and Peter decided that it was the right time to try to conceive a family. Alice explained that her “maternal instincts were too strong to resist” any further. However, things did not go as smoothly as anticipated by the couple. After many unsuccessful attempts, tests revealed that Peter’s sperm count was low. This was attributed to complications caused by the diabetes he experiences. Peter was not surprised by this diagnosis as health concerns raised by the diabetes have affected much of his life to date. He attributes this infertility to “just another in a long line of health problems”. However, the couple did find this difficult to cope with due to a perceived lack of information received from the medical professionals. Indeed, they describe it as a “battle” to discover information regarding their prognosis. For Peter, it was “like they were trying to spare your feelings, ... giving you false hope”. For Alice this “false hope” led to trying times each month when menstruating. “I would work myself up every time, thinking that there was this little bit of a chance left with what they told us”.

An initial option of ICSI was disregarded by the couple due to it being more physically demanding - as well the high cost of the procedure (\$6-7,000 plus expenses) making it financially unfeasible for them. Donor insemination was attempted, and Alice and Peter waited 18 months prior to being given seven donor options to consider. For Alice and Peter, a match in physical characteristics was important so as to provide a “family resemblance” for their child. Due to his being the direct opposite of Peter in hair, eye, and skin colouring he was immediately rejected by the couple. At the time of our interview, Alice and Peter had attempted their first donor insemination procedure.

Throughout this time, Alice and Peter have been open about their experiences with others. Alice found the support of others comforting, while Peter was more reserved in his need for outside aid. Although not “ashamed” to discuss their infertility, Peter did not see the need to “tell everyone” either. The couple attribute these differences to differing “tolerance thresholds” between them. With an on going support group unavailable in their local area, the couple made use of counselling offered prior to donor insemination. For them, this aided in establishing small six monthly goals to achieve

rather than “looking at the big picture”. This restructuring was conducive to Alice’s and Peter’s refocussing their childless status within their lives. While Alice and Peter continue in their attempts to conceive, they have opened themselves to other opportunities in life, so as not to become “overwhelmed”. Both are content with their career pursuits at present and do not plan to re-evaluate their alternatives to having a child for some time.

Communication was received from Alice and Peter almost two years after our interview. They wished to share that they were now the proud parents of a healthy baby girl, conceived through donor insemination.

CARON AND JAMES (31 & 33)

One year into their marriage, Caron and James decided to try for a family. Living on a farm, both felt that having children was a “natural thing to do”. However, following six months of unsuccessful attempts, investigations revealed that Caron suffered from both ovarian cysts and endometriosis. An operation proceeded to remove both and the couple carried on with their pregnancy plans. After further conception attempts proved futile, a secondary infertility factor was discovered in that James' sperm count was sterile. With this, the couple decided to utilise donor insemination. Unfortunately, eight insemination cycles failed to lead to a pregnancy. Specialist consultation revealed that the endometriosis damage was more extensive than initially diagnosed. The couple then turned to IVF treatment. One attempt at this did result in a pregnancy, however after three days a miscarriage occurred. More intensive ICSI intervention was then sought. Two attempts at this, though, yielded only four viable eggs due to difficulties in managing Caron's hormone levels. Following this, the couple were advised that all options medically available to them had been exhausted. Unable to relinquish their desire for a child yet, Caron and James turned to homoeopathic medicine for help. Natural therapy, Chinese herbalism, and colour therapy all aided in improving their general health. However, it did not affect their fertility for the better. Seven years after their initial attempts, Caron and James are now pursuing adoption. Despite initial reservations, the couple feel that having exhausted all avenues, this is “the next best thing”.

In their experience, Caron and James felt that “absolutely everything that could go wrong, did go wrong”. During this time, the couple turned to each other for support. Initially friends were not informed of their situation due to a fear of “country gossiping” and an aversion to a perceived expectation of ‘are you pregnant yet?’ questioning. Intensely private people, both Caron and James declined to utilise outside support. They preferred to “talk it through” and “deal with it” in their own way. The couple describe it as “easier to get over if no one knows about it”.

Although they feel that their infertility is with them constantly, Caron and James take the view that “you have to make do with what you've got ... you just can't dwell on it

'cause you're not going to win". Having sold the family farm, the couple are still awaiting an adoption. However, this time there are no expectations of this happening immediately. Until then, Caron and James are focusing on the positive aspects of their lives and enjoying being child-free while they can.

RACHEL AND DAVID (39 & 43)

Rachel and David were childhood sweethearts who were in a relationship for 13 years prior to marrying. Originally from England, Rachel and David immigrated to New Zealand to start a new life together soon after they wed. They had delayed plans to have children at first, feeling that “it was not the right time to begin a family”. Homesickness and financial strain led the couple to thinking a child would merely “trap” them. However, after seven years of marriage Rachel and David had settled and now felt it a “natural progression” in their lives to start a family. Six months after stopping the contraceptive pill, Rachel had an intuitive feeling that things were “not normal”. Following a GP visit, investigation procedures occurred. However, no reasons as to why they had not yet become pregnant could be found. The couple were repeatedly told by medical personnel that they were going to have children. This hope carried Rachel and David through the IVF process, however unsuccessfully, for eight years. At the end of this time, they reached a mutual agreement to not only stop trying for a child, but to discontinue in their relationship as well. Without a common goal to unite them, Rachel and David found themselves moving in different directions. Throughout this time the couple had supported each other in their experiences. The decision to separate was a difficult one, attributed in part to the stress and pressures of their infertility. Having had a child from a previous relationship, David concedes that this may have affected how the couple coped with their infertility. The couple had no close family members here, and chose not to rely on friends due to a perceived “stigma” of infertility. However, they found support from the medical profession, counsellors and infertility support groups invaluable in aiding them through this loss. Both have made this experience a positive part of their lives. For David, the opportunity to have been involved in the process of “creating life”, seeing the embryos being made, has had a profound impact. To have been a part of this process has outweighed any negative aspects. Rachel, in turn, has had to make a lifestyle change, refocussing her life away from parenting and towards more independent career pursuits. She feels that this ordeal has made her a more insightful and stronger person with a better appreciation of life.

Rachel and David remain close friends.

JEANINE AND JOHN (32 & 32)

Jeanine and John were in a relationship together for five years before marrying. Two years following this, the couple felt that it was “the right time” to try for a child. This period had aided in bonding their partnership and the couple, especially Jeanine, saw this as an opportunity to extend their family. Family had always been important for both. John saw it as a means of continuing his heritage, while Jeanine felt children were an essential female experience. After six months of not conceiving, Jeanine insisted on investigations being performed. A history of infertility was evident in Jeanine’s immediate family, making her conscious that there may be concerns regarding herself. As feared, tests showed that Jeanine did not ovulate regularly. Originally there had been some confusion over the infertility factor as John had suffered a childhood injury which may have affected his ability to father children. For Jeanine, John’s unhealthy lifestyle of alcohol and cigarettes rankled, especially so during the more intensive phases of the treatment when Jeanine was conscious of her own physical well-being. After five years without any results, the couple have now opted to join the waiting list for IVF.

In order to cope through these times Jeanine and John regularly have breaks from actively attempting to conceive. They found holidays away aided them in taking control of their lives once again. This has brought them closer together and helped make their relationship stronger. Good communication with each other, as well as supportive family and friends, has enabled the couple to put in perspective their negative feelings about medical procedures.

Jeanine and John are continuing in their efforts to conceive.

MICHELLE AND ANDREW (29 & 27)

Michelle and Andrew decided to start a family after being married for two years. This was an important decision for Michelle, as at the time she had no firm career desires and had planned to channel her energies into raising a family. After a year of attempting to conceive the couple duly went and had the usual tests done. It was discovered that Michelle's fallopian tubes were damaged due to an undetected sexually transmitted disease, contracted from a previous long term relationship. Following corrective surgery, the couple tried for a child unsuccessfully for another two years. Further investigations revealed that Michelle had only a 1% chance of falling pregnant naturally. Michelle and Andrew decided to seek IVF treatment shortly after discovering this, and were fortunate enough to conceive in their first cycle. Five years after their initial attempts, Michelle and Andrew were pleased to share, during our interview, that they were seven weeks pregnant.

The couple state that their experience has helped improve their relationship, bringing them closer together. However, this was not always so, especially during the earlier stages of the process. The discovery of their infertility was difficult to cope with. Michelle's reaction to the diagnosis was to feel "incomplete" and "only part of a female". Indeed, in Michelle's self perception she was "robbing Andrew from ever having a child". This, in turn, impacted on Andrew's "natural instincts as a provider and protector", leaving him feeling "helpless". The couple initially turned to their church for guidance and support. However, they did not find their Pastor empathetic or understanding towards their situation. While Michelle has always talked openly about her feelings with others, Andrew is a more private person and prefers to share his concerns with his wife only. Despite this, Michelle has found it helpful to utilise outside support and regularly attends counselling sessions. As of yet, Andrew has declined all requests to go with her.

Follow up contact with Michelle and Andrew revealed that they are now the proud parents of a healthy baby girl.

SUSAN AND DON (35 & 38)

When Susan and Don married 11 years ago, the couple were already aware that there were no prospects of conceiving children naturally.

From an early age Don, was aware of his sterility. This was due to a disorder resulting from his mother's use of a then approved drug, diethylstilboesterol, which prevented premature miscarriages. In the 1950's and 60's, the side-effects of this drug were unknown, but subsequent follow-up has linked diethylstilboesterol with congenital defects in the resulting children. Following exploratory examinations, Don's inability to produce sperm was confirmed at the age of 16 years.

As their relationship progressed, Don shared this information with Susan. In love, Susan made the decision that a life with Don was more essential to her happiness. The future was discussed and, although never giving away hope of having children, the couple saw the benefits of a child free lifestyle. They placed their names on the waiting list for donor insemination soon after their marriage, then proceeded to carry on with their life together. This issue was not raised again until three years later when they were given the opportunity to attempt donor insemination. The couple succeeded within their first month of donor insemination. They now have two children by the same donor.

Both Susan and Don found the process less traumatic than they expected. Prior to beginning donor insemination, they had joined an infertility support group due to the concerns raised over the stress and pressure the treatment involves. This, together with each other's support, has been their primary means of coping with the situation. Early on, Susan and Don made a conscious decision not to inform friends of their infertility. Nor were family members told of the donor insemination attempts at the time. The couple saw no need in "making the private, public" as "things flowed quickly without prolonged drama". It has been only recently that they have shared their experience with others.

At present, Susan and Don are preparing themselves to help their children learn about and understand how they were conceived. For them, life is busy concentrating on being "good parents".

ELIZA AND HAMISH (45 & 48)

Eliza and Hamish have a strong marriage that has withstood 21 years of difficulties. After their first year of matrimony Eliza had been experiencing unpleasant side effects while on the contraceptive pill. She decided that she could no longer continue with this, so would stop contraception and try for a family. Having children was considered a “natural human reaction” for Eliza and Hamish. They had not given much in-depth thought to this, yet had always considered it the “next step” in their marriage plans.

Following difficulties conceiving, the couple proceeded with the usual step of visiting a GP, then a specialist. After two years with a gynaecologist, it was finally revealed that Hamish had a low sperm count. The only option available to them was donor insemination. At this time, IVF was in a developmental stage, and was not a possibility for the couple. However, several attempts at insemination were unsuccessful.

The couple were in their mid-20’s at that stage and thought that they had some time to go before conception became impossible. Yet, in remembering the procedures, Eliza and Hamish felt the process was very “long winded and drawn out”. During this time, their confidence and self esteem became eroded through being faced with continual disappointment.

Having reached a cut-off point, the couple felt that they had “put their lives on hold” for long enough. For 10 years they had focused themselves solely on becoming pregnant. Every avenue available had been exhausted. Eliza and Hamish decided to “firmly close the door behind them on the opportunity to conceive” and move on with their lives. The couple relocated and attempted to start afresh. Here, Eliza and Hamish undertook the fostering of teenagers for a time. However, unresolved emotions surrounding their infertility interfered and made this “substitute” an unacceptable option. Hamish found the grief of their loss too much to bear and suffered an emotional breakdown.

Until this point the couple’s main support network had been each other. This was difficult though, as Hamish was not able to openly communicate regarding the infertility. Often Eliza tried to protect him from inquisitive friends and family by not emphasising the situation. Counselling was sought as a means of helping the couple

accept their infertility, and to enable them to discuss it without trying to protect each other. With this, Eliza and Hamish decided to return to their home town, realising that the original move had merely been a way of avoiding the issues.

The couple are now actively involved in their local infertility society and are strong advocates of support groups. Hamish, especially feels a greater need to address male experiences as he has often felt men are unable to communicate their issues as effectively as their partners. He hopes the establishment of a male peer support group will aid this.

While Eliza had been eager to pursue the option of adoption, Hamish did not feel that this was an appropriate decision for him at present. He considered his desire for a child not so great as to "just take anything". The couple continued in their fostering work instead. However, when the opportunity arose for them to become permanent placements for a little girl, both felt they had now reached a stage in their lives where they could offer someone this commitment.

Although they feel that the infertility will always be present in their lives, they have now adjusted themselves to living with it.

At the time of this interview, Eliza and Hamish had just become the legal guardians of their little girl.

MONICA AND BRAD (35 & 49)

After being married for four years, Monica and Brad were ready to start a family. The couple never expected to have any difficulties conceiving, feeling that this would be a “natural progression” in their lives. However, after a year in which nothing happened, their GP was consulted. Routine investigations were performed, yet the results obtained were unable to specify an exact reason to explain their problem. Monica and Brad found this frustrating as they felt a categorised disorder would enable some type of treatment to occur.

During the first three years there did not seem to be a “panic” to conceive as both were led to believe that it would eventually happen.

During this time Monica and Brad supported each other. This experience strengthened their relationship as they had chosen not to rely on family and friends as a support network. They often found it difficult for those who had not experienced infertility to be empathetic. This led to Monica’s and Brad’s seeking group support from couples in similar situations. The couple view this as the catalyst to accepting their infertility and becoming more pro-active in the treatment process.

IVF treatment was utilised. However, two cycles were unsuccessful. In spite of this the couple have four frozen embryos remaining. At present, they are in discussion over the viability of continuing with IVF. One main factor in this debate concerns their age. Monica and Brad have questioned the “fairness” towards a child with their increasing age. No firm decision on this has been reached as yet due to both being unable to reach a consensus. As Brad explained, “the thought of completely closing the door on your future is a difficult decision to reach”.

Currently, Monica and Brad are still considering their future options.

Table 3: Core Category And Its Pre-Existing Conditions

Substantive Codes	Axial Codes	Selective Codes	The Core Category ADAPTING TO LIVING WITH INFERTILITY
Biological drive Continuation of heritage Generativity Altruism vs. self-fulfilment Genetic homogeneity (own and others beliefs)	Reasons for Wanting a Child	PREEXISTING ATTITUDES AND BELIEFS	
The infertility factor Provision of information The medical process Attitudes and treatment from medical professionals	Investigations and Interventions	REACTIONS TO THE MEDICAL PROCESS	
Finance Location	Contextual Factors		
Cognitive distortions to self-perception Emotions Emotional triggers Grief cycle Stress	Cognitive	MAKING MEANING OF EVENTS	
Marital relationship Communication Social interactions (friends / family) support	Behavioural		
Locus of control Acceptance and resolution Personal growth Lifestyle planning	Ways of Being	LIFESTYLE ADJUSTMENTS	

CHAPTER SIX

The Core Category and its Pre-existing Conditions

The core category and its four pre-existing conditions will be presented initially. This will be followed, in subsequent chapters, by an exploration of the data on the experience of infertility. The structuring of the analysis in this way encourages a comprehensive understanding of the emergent grounded theory through a clarity in presentation.

THE CORE CATEGORY

ADAPTING TO LIVING WITH INFERTILITY

The core category of **adapting to living with infertility** clearly underpinned the participants' data when discussing the psycho-social experiences of infertility. For participants to deal with, respond to, and overcome the effects associated with the phenomenon in a productive manner, an adaptation to living with infertility was required.

The core category of **'adapting to living with infertility'** was more intricately conceptualised by participants as being characterised by the existence of four conditions. Illustrating the main theme of infertility throughout these conditions formed the basis upon which the core category was built. An in-depth discussion of these pre-existing conditions, with specific references to their grounding in the data, is presented later in the chapter. The core category and its key conditions are presented in Table 3 (p.73).

The first of these conditions related to the participants' awareness of the desire to undertake a **parenthood** role. Specifically, the **reasons for wanting a child** were expressed. In essence, the lived experience of many of the participants centred on the self-fulfilment of roles or societal expectations that having children would achieve. Individual needs such as **biological drive, continuation of heritage, and personal generativity** could be attained through becoming parents. Beyond this, a different

reaction was verbalised by those participants who had experienced the infertility process for a longer time period. Here, the reality of a biological conception lessened with ongoing disappointments experienced with various treatment options. Couples now turned to alternative means to obtain a child, such as fostering or adoption. In confronting one's perception of parenthood with respect to **genetic homogeneity**, the issue of achieving parenthood for **self-fulfilment** or **altruistic** reasons were raised. The questioning of one's wish for children created a change in one's perception of parenthood and made clearer distinctions amongst the desired aspects of the parenting experience. Individuals who went through this process gained new insights into why they want to be parents. This gave rise to an awareness of the parenting goals held, and which ones were particularly important to them. A greater perception of choice options, resulting in increased feelings of self efficacy and control, followed. These feelings, in turn, led to new decisions regarding infertility - ranging from a renewed engagement in treatment to a return to pre-infertility activities. However, the process of examining one's values and goals associated with parenthood did not occur for everyone experiencing infertility. Some individuals succeeded in their treatment early on and did not experience repeated failures to conceive. For others, this re-evaluation led towards a discovery of new ways to achieve their goals. In some cases goals were reshaped, or desired goals which could not be achieved were abandoned. Here, it is possible for individuals to successfully disentangle the meaning of infertility and the desire for children from other goals in life. As such, this first condition was integral to the core concept of **adapting to living with infertility**.

The second pre-existing condition was subsumed under **reactions to the medical process**. This condition was influenced by the participants' perceptions of the **investigation and intervention** procedures experienced in pursuit of conception. Diagnosis of the **infertility factor** was the first experience with the medical process faced by the participants, and in itself, directed the specific treatment options available to the couple. All participants observed a lack of **provision of information** following this discovery. Although participants encountered a similar **medical process** and **attitudes and treatment from medical professionals**, their perceptions of this varied to a wide degree. Participants described both negative and positive experiences. The

factor contributing to this was the participants' personal discernment of the situation. The theme of intrusive intervention techniques was verbalised by all participants. However, some individuals broadened their focus from seeking an allopathic 'cure for infertility' to a search for homoeopathic alternatives for a complete physical healing. Individuals who retained feelings of control, and were able to have some influence over the process, adapted better than those who relinquished all personal power to the medical professional. Participants who actioned decisions regarding treatment options and were able to make informed decisions regarding procedures had improved experiences. **Contextual factors** impacted on this ability for participants to become empowered, as the **financial cost** of treatment procedures and the regional **location** of clinics and additional support systems limited the options available for some individuals. In **adapting to living with infertility**, experiences and individual perceptions of the medical process were central to the phenomena experienced.

Making meaning of events was the third pre-existing condition subsumed under the core category of **adapting to living with infertility**. This condition contributed via detailing **cognitive** and **behavioural** experiences encountered with infertility. Each participant had his or her own specific perception and understanding of the social processes involved with infertility. Participants' **cognitive** reactions were strong in five defined areas. Firstly, a **cognitive distortion of one's perception of self** altered in a negative direction following the diagnosis of infertility. This was regardless of the specific infertility factor involved, and affected mainly female participants. Participants now experienced a sense of lower self worth than that held prior to the diagnosis. Perceptions of not being "whole" or a "complete man/woman" were verbalised by many of the participants. Intense **emotional** responses pervaded all participants' experiences. Often these, too, were negative feelings, centred on "extreme obsession", "frustration", "self-pity" and "embarrassment" at the infertility. These feelings were subject to **emotional triggers** that could occur during any social interaction. Many participants experienced what they described as a **grief cycle** reaction. The infertility itself was likened to a death with its own mourning phase occurring. Here, the loss was not for any tangible object, but rather for an intangible ideal of the possible experiences, hopes, and aspirations a child would bring, but which were now seen to be unobtainable with

the infertility. Lastly, all of the participants reported finding the experience of infertility **stressful** in some aspect. This, in turn, impacted on their ability to appropriately place in perspective the role that infertility played in their lives. The second axial code relating to **cognition** concerned the **behavioural** coping strategies. Infertility impacted greatly on participants' **social interactions**, affecting the **communication** within the **marital relationship**¹ as well as the **support** structures utilised in coping with the infertility. While a large proportion of participants expressed similar cognitive occurrences with infertility, reactions differed throughout the process of **adapting to living with the infertility**

Finally, **lifestyle adjustments** was the fourth pre-existing condition contributing to the complete establishment of the core category. This consisted of the participants' descriptions of **ways of being**, that is, how participants perceived themselves to "be" in terms of their experiences with infertility. Data analysed indicated that **ways of being** interacted with the previous three codes as it illustrated a developmental process in the perception of infertility. As such it is an integral part of the process of **adapting to living with infertility**. Those participants who experienced an alteration in insight regarding the experience of infertility were able to progress to a stage of **acceptance** and **resolution**, leaving negative aspects of their experiences to embrace a more positive attitude towards the infertility. This, in turn, impacted on **lifestyle planning** and the **personal growth** of the participants. They were now able to pursue different avenues in life once closed off to them due to their narrowed focus. The overriding factor involved in this development relates to a perceived internal **locus of control** by the participants. The importance of this relates to control over daily activities, bodily functions and emotions, as well as control over the future, specifically the ability to predict or plan events, and meet life goals. Participants who experienced a shift from an external locus of control to a perceived internal locus of control were enabled to become empowered within certain aspects of their lives. Although they experienced the same events, the participants' perception of the experience had altered. They were now in a position to decide on certain aspects of their lives. This process of **lifestyle adjustment** does not

¹ As not all participants were legally married, this term is used loosely to represent the commitment couples had made to each other as partners.

occur for everyone experiencing infertility. Similarly to the first concept of **parenthood**, some individuals may succeed early on and not experience repeated exposure to failed attempts at conception. For others, a re-evaluation may occur towards finding other new ways to achieve their goal. At some point in infertility treatment a couple may seek specific treatment options. At other times they may restructure or abandon the desired goal that cannot be achieved.

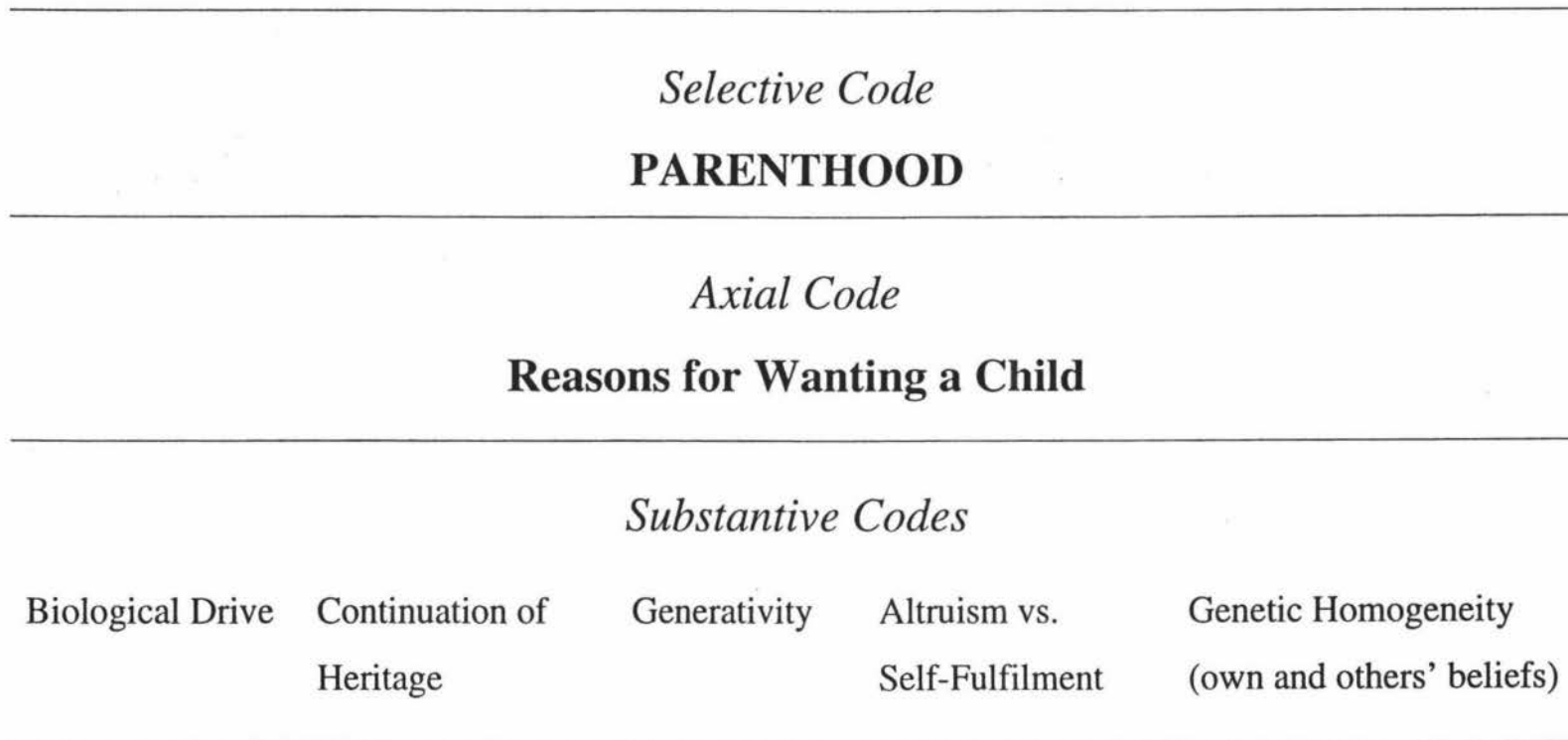
The presence of the core category **adapting to living with infertility** was an emergent concept participants expressed throughout their experiences of infertility. The infertility itself was a pervasive factor of participants' lives that required an acknowledgment of its presence as well as a recognition of its impact on desired goals. There is a clear division between participants within their reaction to infertility experiences. The process of infertility began with essentially fundamental natural instincts regarding the desire for a child. Here, participants established different perceptions of parenthood based on the premise it being a natural biological occurrence, an egocentric response (e.g. wanting a child to fulfil their own needs), or altruistic desire (eg wanting a child to give something to it) to bring meaning into their lives. These categories determined participants' concept of children in their lives, as well as determining the degree to which fulfilling the role of parenthood was considered all-encompassing. Participants who were able to evolve beyond an instinctual or egotistical response for the need to have a child to a more humanitarian generativity were better able to adjust and **adapt to living with infertility**. Here, the need for a child no longer became the central focus of their lives. Participants were able to alter their perception of what constituted enriching and rewarding achievements. Those couples who had progressed to this point, in turn, exhibited a positive perception of the treatment and experiences involved with infertility. Those who were unable to attain their desired goal of a child were able to move on in their lives and develop other aspirations through an **adaptation to living with infertility**. Participants' experiences of the phenomenon of infertility were observed to have a reduced negative impact on life, with an enhanced sense of empowerment, through their **adapting to living with infertility**.

SUMMARY

This chapter introduced the emergent core theory, together with the four pre-existing conditions that constitute its existence. The fundamental theme that ran throughout the data regarding participants' experiences with infertility were their attempts at adapting to living with infertility. To fully achieve this, specific conditions were required to be present. The first of these pre-existing conditions was that of parenthood. The process of adapting to living with infertility was affected by the degree to which participants focused upon parenthood. In questioning the parenting goals held, participants gained insight into why they continued to remain actively involved in the infertility process. Clarity here enabled the participants to separate out life goals and possible means of achieving them. As such, this condition was an essential category. The second identified pre-existing condition was that associated with perceptions of reactions to the medical process. Participants' experiences of infertility were largely dominated by the treatment procedures which they experienced. Negative reactions identified in the transcripts relating to the infertility factor and a lack of information provided by health professionals, impacted personal perceptions of the investigations endured. Interactions with medical professionals also were described in heavily unsatisfactory terms. Those couples who endeavoured to undergo varying aspects of treatment with a sense of empowerment perceived their experiences in a more positive light. Making meaning of events emerged as the third pre-existing condition. This related to the participants' perceptions and understanding of the psychological and social processes involved with infertility. Here, participants' cognitive processes and behavioural strategies used to deal with infertility impacted upon their experiences. Infertility was deemed to be an extremely emotional life event that both affected, and was affected by, the quality of their personal relationships with others. Finally, the fourth pre-existing condition involved lifestyle adjustments made by participants in reaction to infertility. Participants expressed a strong commitment to the process, with activities of daily living centring upon the infertility. Participants who were able to achieve the goal of adaptation to living with infertility displayed an ability to readjust lifestyle planning away from infertility milestones to a regular semblance of life. These participants no longer viewed

themselves as existing in relation to the need for a child in any sense. Acceptance, resolution, and control enabled participants to achieve personal growth. An ability to plan a lifestyle more suited to current circumstances was forthcoming in this process.

**Figure 1: First Pre-Existing Condition Of Parenthood Contributing To The
Core Category Of Adapting To Living With Infertility**



CHAPTER SEVEN

Parenthood

The first factor contributing to the core category of **adapting to living with infertility** was that of **parenthood**. Participants described specific reasons as to why they wished to become parents and the importance of this to their life experience. The rationale expressed by the participants for their desire to achieve parenthood was essentially categorised into three groupings. The first grouping centred around a natural biological drive related to heritage. The second involved an egocentric response in the sense that the desire to have children was motivated by the need to have children to satisfy certain needs for fulfilment in life that participants did not feel they could attain in other ways. The third grouping centred around altruistic desire. Here participants expressed a desire to have children in order to be able to 'give' in a variety of different ways to another human being. These categories influenced participants' conception of the role of children in their lives, as well as determining the degree to which fulfilling the role of parenthood was considered all encompassing.

A comprehensive presentation of the axial and substantive codes identified under the selective code of **parenthood** is illustrated in Figure 1 (p.81).

SELECTIVE CODE:

- **PRE-EXISTING ATTITUDES AND BELIEFS**

AXIAL CODE:**REASONS FOR WANTING A CHILD**

SUBSTANTIVE CODE:

Biological Drive

Continuation of Heritage

Generativity

Altruism versus Self Fulfilment

Genetic Homogeneity

Participants initially expressed their desire for children in the assumption that such a wish was “normal”. Parenthood was taken for granted as part of the natural order of life, and described as a **biological drive** or **function**.

Hamish revealed his assumption that parenthood was a intrinsic instinct:

“It’s in your genes. It’s your purpose in life, because, lets face it, that’s what animals and humans are supposed to do. We’re supposed to leave offspring behind to keep it going.” (Hamish)

Alice also observed a similar aspect:

“It’s part of life. Just a natural progression.” (Alice)

In addition to a biological drive, another related theme was the desire for a **continuation of heritage**. Here, participants further explained their strong need to carry on their family’s lineage.

One couple in particular focused their desire to experience parenthood in terms of their family tree and the legacy it leaves behind:

“You think of your family tree. It might start way up and works its way down. And then there’s ours, a whole family tree just blank underneath. We don’t have a family tree. It’s gone. Just a hole. You’ve got no heritage. You’ve got nothing underneath you to live on. It’s quite a big

deal because it's a part of you that lives on. There's no experiences, no continuum, no heritage to leave behind." (Andrew)

The importance of this was shared by Andrew's wife, Michelle:

"It's heritage. Being able to help bring up your son, or daughter, in what you believe in, and who you are. To leave a piece of your personality within them. Just a little piece. Maybe they'll take hold of something that you've got and hang on to it, and pass it on to their kids, on to their kids, and so on. So a little bit of you carries on through." (Michelle)

In contrast, some participants expressed the aspiration towards parenthood in terms of a developmental **generativity**, involving a progressing to the next stage in a relationship:

"We were just flatting with each other. That's what it felt like. There was no goal or direction in the relationship or in what we were doing. It was not satisfying. We wanted the next stage." (Karl)

"It was time to move to the next level. We couldn't carry on like this forever. There had to be more to our relationship." (Sharee)

or, within one's own personal growth:

"I always knew I was going to be a mother. I was now ready for it. I was meant to be a mother and I had finally reached the stage in my life where I was ready and it was supposed to happen." (Monica)

Parenthood was seen as a means to overcome a stagnated phase in life. Individuals or couples perceived having a child as a means to experience the next level in their developmental process.

Later in the interview, Monica added:

“We have another chance at treatment, but we have to re-evaluate why we’re doing this. Why do we really want to have a baby? Is it for our own reasons or for what life we could offer the baby?” (Monica)

The questioning of one’s wish for children creates a change in the perception of parenthood and makes a clearer distinction amongst different desired aspects of the parenting experience. Such prioritising amongst infertile individuals in turn leads to an altering in their rationale for having children from a desire for **self-fulfilment** towards a more **altruistic desire**.

In the interviews conducted for the present study, some participants had shifted their views of wanting children from having a need to satisfy one’s own perceived gains from the parenthood experience (for example, self-fulfilment of biological urges and achieving perceived social roles), to an altruistic wish to give to others. This was best illustrated in the following responses:

“If you’re going to be honest about it, you’re doing that because it makes you feel good. Because nothing in this life is totally give. There’s going to be take as well, coming back - or people wouldn’t do anything. ... But it would be great if some kid fell out of the sky tomorrow that needed a chance. I wouldn’t turn them away. There would be something that I could do for a child. Bring some good into their lives.” (Rachel)

Similarly:

“We thought that we must be able to do something, for somebody. Put some sort of stability somewhere along the line for somebody.” (Eliza)

Altruism shifted the focus of parenthood from what experiences having a child can bring to fulfil the needs of the parents, to a genuine desire to provide the child with experiences.

Eliza further expressed this need as an alteration in her perception of children and

their role in the family structure:

“It’s not about us any more but them. What can we do to improve their life rather than what they bring to us?” (Eliza)

One couple described their reassessment of parenthood following an evaluation in life, leading to choosing to pursue the option to adopt:

“I felt with adoption that we could definitely take that child and give it a decent life. A loving life.” (James)

“What I’ve learnt with adoption is that no one really owns a child. You’re just really looking after it until it gets older. No one owns a child. You try to help them as much as you can, but they are their own person, and you can’t own them.” (Caron)

In deciding to pursue alternative options to achieving parenthood, participants were faced with the dilemma of **genetic homogeneity**, that is, being biologically related to the child. The importance of this tie was influenced by both **one’s own individual beliefs and the beliefs of others** regarding the need for a genetic link with the child.

With one participant, the need for the child to be of ‘her own’ overrode all other desires she experienced:

*“If I couldn’t have my own child, then I didn’t want anybody else’s.”
(Rachel)*

Such feelings were also expressed by another participant. John described the importance of being physically related to a child:

“I would like some sort of genetic continuity with my own child. It’s important and I would expect to see some physical traits. If it was a

daughter, to think that there's still some part of my mother walking around would be nice. It's a continuity thing, a genealogical thing as much as the child rearing experience." (John)

In contrast, the presence of a genetic link was not important for many participants. However, the feeling expressed in agreement with this were more common with those participants who had experienced, or were still experiencing, the infertility process for some period of time. The need for a biological child diminished as the focus and desire became more directed towards having a child at all.

John added:

"Saying that, if I couldn't have a child that wasn't genetically mine then I would start looking for alternative ways of having a child." (John)

Like John, Hamish was able to come to terms with the inability of achieving a biological child:

"I think I accepted that fact that I was infertile and that we could still have a family by donor sperm. It could still be partially ours." (Hamish)

Andrew explains this rationale in his statement:

"When you bring up a child, what you believe in and how you think, you put your flavour of life on to them. And it doesn't have to be your genetic material. ... Basically, you are passing on who you are, the flavour of you." (Andrew)

For those participants who did not share this particular view, often the perception that biology equated to the concept of family, was influenced by others around them. Participants felt that the options available to them in having a child were in some way coloured by the personal convictions of others.

Susan spoke of her experience with medical professionals during donor insemination treatment:

“Our donor looked a bit like Don. Tall, brown hair, hazel eyes, tanned skin. I think even academically, even about the same level! They matched them as near as they could. We didn’t think about it. Naively we just wanted a chance for a child. It was them [sic]who said ‘We’ve selected this person for you’. We had to accept their choice. We never had the option. ... We gathered we could only have two. That’s the impression that we got. So we got the same donor for them both. In the end I didn’t want any different. I began to think ‘At least they’re the same blood’.” (Susan)

Caron and Bridget experienced similar opinions from family members:

“When we brought up adoption with James’ mother, she said, ‘If you’re going to adopt, make sure you get a little girl. It would be nice if you had a little girl, so then you can have a boy of your own to take over the farm’.” (Caron)

“The genes were very important for them [Marcus’ parents]. It’s not just the kids, but the genes. Marcus comes from an old dynastic family. It’s very important to them. ... There was this sort of expectation that as the oldest son, you would carry on the family name and the family business, the farm. ... After my hysterectomy, when his mum came to pick me up at the hospital, she said to my mum, ‘Oh, Marcus and Bridget will never get the farm now’. ... Within four months of that, the farm was leased out, or put up for tender.” (Bridget)

While these women were able to progress beyond their own views of parenthood as being solely seen in terms of a genetic link, they still experienced a resistance to

broadened values from medical professionals and family alike. Susan, Caron, and Bridget attempted to adapt to living with the infertility through developing alternative means of achieving their goals. However, they were forced to experience again their previous rationales for parenthood, such as biology, this time from those surrounding them.

SUMMARY

In this chapter, parenthood was the first pre-existing condition to be discussed. This was a central theme throughout the research as the desire to become a parent was the force behind all participants' experiences of infertility. The rationales for wanting a child were outlined and analysed. The reasons illustrated the degree to which participants pursued the goal of parenthood and established possible treatment options available to them. Many participants initially expressed their desire to become a parent in terms of a natural biological occurrence, while some expressed it in terms of an egocentric response. Here, both these categories were characterised by a wish to fulfil the participants' own personal needs and desires. Parenthood was a means to satisfy personal objectives. Conversely, few participants had developed their ideals to the point of perceiving the role of parenthood in terms of an altruistic need to give to others. The child itself became the focus of needing fulfilment. Here, what one could do for a child, rather than what experiences a child could bring for the adult, was the primary concern. Participants who reached this stage were able to re-evaluate their personal goals and means of achieving them, an essential way of adapting to living with infertility.

Figure 2: Second Pre-Existing Condition Of Reactions to The Medical Process Contributing To The Core Category Of Adapting To Living With Infertility

<i>Selective Code</i>					
REACTIONS TO THE MEDICAL PROCESS					
<i>Axial Code</i>				<i>Axial Code</i>	
Investigations and Interventions				Contextual Factors	
<i>Substantive Codes</i>				<i>Substantive Codes</i>	
The Infertility Factor	Provision of Information	The Medical Process	Attitudes and Treatment from the Medical Professionals	Finance	Location

Chapter Eight

Reactions to the Medical Process

The second factor contributing to the core category of **adapting to living with infertility** was that of **reactions to the medical process**. Participants' experiences with the medical process emerged as an important category as all expressed some opinion regarding the treatment they encountered during the treatment phase of infertility. This, in turn, impacted greatly upon the experience of infertility perceived by the participants. The following outlines the general themes evident in participants' interactions in the medical process.

A comprehensive presentation of the axial and substantive codes identified under the selective code of **reactions to the medical process** is illustrated in Figure 2 (p.90).

SELECTIVE CODE:

- **REACTIONS TO THE MEDICAL PROCESS**

AXIAL CODE:

INVESTIGATIONS AND INTERVENTIONS

SUBSTANTIVE CODES:

The Infertility Factor

Provision of Information

The Medical Process

Attitudes and Treatment from the Medical Professionals

The establishment of **the infertility factor** was the first experience with medical professionals encountered by the participants. Reactions to the diagnosis of factor responsibility varied to a wide degree within the participants. However, three distinct responses could be categorised. Firstly, an element of accountability was evident in those couples with a discernible infertility factor. Here, a sense of culpability was expressed by participants towards either themselves or their partners.

Such sentiments were verbalised by Sharee. She remembered her experience with the news of the diagnosis in such terms:

“Initially I felt it was more and more my fault. I kept thinking ‘It’s me, there’s something wrong with me.’ That can really eat away at you.”
(Sharee)

This reaction was often experienced regardless to whom the infertility factor was attributed to, as was the case with Alice. She recalled that despite male factor infertility being involved in their circumstance, she herself felt responsible for the couple’s inability to conceive. Alice explained:

“I felt like a failure. It was male infertility that affected us, yet it was me [sic] that felt the failure.” (Alice)

A similar pattern emerged with many female participants attempting to shield their infertile spouses from potential adverse social reaction to the condition. Here, in order to protect the men, the women assumed the males’ infertility as their own.

Eliza recollected Hamish’s inability to confront his infertility. She described her own response to this:

“Hamish couldn’t talk about his infertility. I ended up starting to protect him, passing it off when it came to other people.” (Eliza)

Susan, too, experienced a similar reaction:

"We've always kept quiet, didn't really want it known. It was really more from his side. I didn't want him to be hurt. Like you don't want people to say, 'Ah, he can't conceive', laughing at you." (Susan)

In contrast to this, for those participants whose infertility was categorised as being 'unknown' or 'both', responses to the infertility were, overall, blameless in regards to either party. Neither partner attributed their current situation to any specific rationale. Rather, it was viewed in terms of an equal experience that they shared together.

Caron explained:

"There's no conflict in the marriage about who's to blame. I used to feel threatened, that I was holding James back and that I should let him go. But I've realised that we're mixed up in this together now." (Caron)

For Brad, attempts to apportion responsibility were considered futile as the consequences remained an inability to conceive.

"There hasn't been any blame. No blame. ... It didn't matter who had the problem the outcome was the same. There wasn't a child." (Brad)

Couples who were aware of the presence of infertility prior to attempts at conception experienced a sense of increased control regarding the infertility process. In both circumstances, the other partner was informed of the infertility factor before decisions were made to progress in the relationship. This gave the fertile partner a sense of choice in electing to continue the relationship together, albeit the possibility of being a child-free one. The partner who was infertile had already had many years to come to terms with the diagnosis themselves. This promoted a sense of control amongst those participants.

"Bridget actually knew she couldn't have children before we met. I went into our relationship with my eyes open. ... I had to accept it because

she meant more to me.” (Marcus)

“We knew from the word go we weren’t going to have children, well, naturally. ... We’d talked about what was going to happen if we didn’t. It would have hurt, yes, but we would have gotten on with things. Accepted life, thought about a career or travel. ... But I’ve always just been comfortable with the two of us. ... We were just going to live happy ever after.” (Susan)

Adapting to living with infertility was affected by the participants’ perception of the initial infertility diagnosis itself. Participants who did not experience, or contribute to, a sense of blame or guilt regarding the infertility had an increased ability to perceive their situation, while not entirely positively, at least as not wholly negative. This was enhanced for those who were aware of the situation prior to actual attempts at conception.

Following the initial diagnosis, all participants expressed concerns relating to the lack of **provision of information** that they received. Details regarding infertility, in general or as it pertained to the couples themselves, or the specifics of the treatment procedures occurring, were not adequately disclosed to the participants.

Jeanine felt:

“It was most frustrating because he was not communicative at all. He would just write another bloody script without explaining anything to us.” (Jeanine)

All participants spoke in terms of the need to seek provisional information from their practitioners.

Peter described his experiences of searching for better information in terms of a “battle”:

“They don’t give you information or tell you what’s going on. It’s not

freely given, you're just expected to know. You have to go looking for it. That's a real battle getting information." (Peter)

Sharee explained the need to discover information regarding procedures prior to undertaking them as a means of preparing herself for the intrusiveness of the investigation involved. Unfortunately, she found interactions with the medical fraternity "frustrating" and "devastating" as much of the information about the treatment was either inadequately explained, or withheld until the last moment.

"It was a big secret what was going to be next. I wanted to know, 'cause I like to be one step ahead so you know what's around the corner, be ready for it. But they don't like to tell you. Sometimes it's like a bomb, like the post-coital tests. Whereas if you know beforehand you can mentally prepare yourself for things, but we weren't told anything." (Sharee)

Similar experiences happened to Alice. However, she and many other participants had now learned to become more assertive in their dealings with specialists in order to obtain the information they required.

"They haven't given me as much information as I needed, but I've learned to ask if I'm unsure, if I didn't know what's happening. ... It's the fear of the unknown. I've had to learn to just ask." (Alice)

The lack of freely accessible information for participants had a negative impact upon the experiences of the participants. An inadequate communication system left the couples in a position where they were uncertain of what to expect with their infertility. This in turn impacted on their perception of the treatment process.

Also considered an important factor in **adapting to living with infertility**, were the

dimensions of the various **investigations and interventions** undertaken by the participants, which ranged in degrees of time and intrusiveness required.

All but one couple considered the medical process a rigorous and drawn out procedure. The timeframe experienced by the participants spanned from one month, for a couple who had prior knowledge of the infertility fact and conceived following their first attempt at donor insemination, to over twenty years for another. Eliza described her infertility experience as “pretty long winded and depressing” and going on “for years and years and years.” While many of the participants in the study were still actively undergoing medical intervention, initial observations indicated that the increased length of time for which couples were involved with treatment procedures adversely affected their experience of infertility. Couples who repeatedly endured unsuccessful attempts at conception, and who were subsequently forced to experience the detrimental emotional aftermath of the failures, reported higher incidence of dissatisfaction both with the medical profession and in their personal lives.

Participants also described the interventions themselves as progressing along a similar vein. The intrusive nature of the techniques increased, following each unsuccessful attempt.

Jeanine explained:

“It’s a constant reassessment. Because as you go through each process, the first stage is when they are just hormonal tests and things, there’s nothing to worry about. It’s just investigations. And then once you’ve taken the tablets, you realise that nothing’s happening. Then you go on to the stage that you realise that you’re infertile. And then going to more intensive treatments and you have to look at your various options. I think you tend to go through stages, as they get more invasive and personal with your body.” (Jeanine)

The majority of participants also expressed unfavourable views of the medical processes involved.

Sharee reflected upon her experiences in terms of “an emotionally cold and draining

event". She explained:

"You had to perform sex at a certain time, take your temperature at a certain time, keep your specimens warm or cold, plan your day around interview and appointment times. It made you feel like a robot, just going through the motions." (Sharee)

Sharee elaborated:

"There were so many tests, I can't even remember the names for them all. Most of them involve having your legs up in the air, spread eagled, or something being inserted into an aperture too small for it. 'Delightful' stuff. ... It was really undignified. The first time I couldn't relax enough for them to put the speculum in. I was so embarrassed, I bawled my eyes out for hours afterwards." (Sharee)

John also related his experience in producing a specimen as "an unnatural act" in relation to something that is the most natural of occurrences:

"What got to me was you're walking out of the room with this jar of sperm and you think, 'Am I holding my son in my hand? Is this how he's going to start life? In a bloody plastic jar after his old man's just had a quick one off the wrist'. That's what it boils down to. You'll never think of him [sic] being conceived at the height of passion, but in a horrible grey painted bloody room at National Womens'. ... All the actual beauty and excitement's taken out of it." (John)

Contrary to these views, David was the only participant who verbalised a semblance of uniqueness regarding the infertility. For him, the ability to partake in the experience of visually observing conception was, as he described, "life altering".

“It was the most amazing thing that’s ever happened in my life. I got to be there, to see everything. Like the embryos, before they put them back in. I thought, ‘Now that’s brilliant. If that works, you’ll get a child through it, you will see it from that stage.’ Well, even from the sperm, ... swimming under the microscope. To see it from that stage right through till it was a baby. When I saw the embryos I remember saying ‘Even if nothing comes of this, it will have been great. Nobody else sees their children this small.’” (David)

Another trend emerged in regards to medical **investigations and interventions**. Following repeated unsuccessful attempts through Western medical techniques, participants displayed a propensity to seek out alternative homeopathic means to achieve a more holistic healing of the body.

One couple spoke of their decision to try this:

“I tried acupuncture, homoeopathic stuff. ... It was good but I wish that we had tried it first, before we went to the doctors. It makes sense to get your body into shape naturally. ... People always try medical things first and if they don’t work, they often go for the alternative.” (Jeanine)

“I’ve been seeing a naturopath in between the intensive treatments with the infertility specialists. ... I suppose you are always looking for clues. Always searching for answers. I’m rapidly coming to the conclusion that if you’re going to wait for western medicine to help, well then you’re going to be waiting a bloody long time. If there’s something else you can do in the mean time.” (John)

This characterised a shift with some participants from utilising medicine as a means to achieve merely a pregnancy, to achieving a complete physical healing.

James sought the assistance of many different alternative healers such as a homoeopath, a natural therapy, a Chinese herbalist as well as a ‘colour man’ who

worked with crystals. James' reaction was:

"It's fixed me up a treat. I felt like I was about 10 years old again. Forgetting the fertility side of it though, I felt much better." (James)

Johns' following elaboration summarised many participants' views regarding the medical process associated with infertility treatment:

"You turn your lives over to the doctors to a certain extent. There's a lack of control that you have over the process. They say they can only advise you, but in the end, when it comes down to it, they basically decide." (John)

Experiences with the medical personnel involved in the medical process also shaped participants' experiences of infertility.

Participants' experiences with the **attitudes and treatment from the medical professionals** emerged as an important category. Reports of negative encounters with general practitioners and gynaecologists were common. Participants' complaints referred to inappropriate, insensitive and patronising comments, a discounting of their ideas, not listening, and a general sense of unsupportiveness and understanding from those involved in their care. The subsequent extracts testify to the general dissatisfaction felt by most of the participants in this study.

The sentiment of being made to feel inconsequential was described by participants.

Jeanine experienced this as a lack of any acknowledgment of her as a person:

"The nurses hardly speak to you at all. I remember going for a scan, introducing myself, and they said 'Oh, you're the 'Soti' woman'. It was quite dehumanising to be labelled, to be known as the timed intercourse woman. In that instance, I was made to feel like a nothing." (Jeanine)

Another participant also experienced such treatment as being dehumanising. Peter explained that emotions of care and understanding had been stripped from the medical professional involved with his treatment. Here, treatment had progressed to an automated response, similar to that of a production line technique.

“Things are just so routine for them that they don’t care. The human element’s gone. It’s like a wheel in a machine type of thing.” (Peter)

Michelle also felt the same:

“The treatment, well I felt like a piece of meat. I was poked and prodded and looked at in the most dehumanising way. ... It left a really bad taste in my mouth.” (Michelle)

Moving from a production metaphor to a creator image, John related a similar aspect. Here specialists were likened to God. The responsibility, and sense of achievement in the conception of a child had shifted from the potential parents to the medical professional involved.

“It’s when doctors are at their most God-like. They were the ones making the baby, not you. Without their direct intervention, a child wouldn’t be born. And it shows.” (John)

This theme of professionals as the originators of conception showed strongly throughout the participants’ extracts.

Such a disregarding attitude extended to the environment the medical professionals worked in. For those who went to clinics at a hospital, they found it distressing to encounter pregnant women attending antenatal classes, as well as women seeking abortions, at the same time.

Sharee described her visit to a clinic:

“There was a real lack of sensitivity. It made you feel really worse when you went to an infertility clinic and had to wait in a room full of pregnant women. At the GP I had to sit next to a woman who was wanting her third abortion! ... Or having to listen to nurses talking about their kids.”
(Sharee)

When going through the process of infertility investigations, feelings of disappointment, anger, and frustration were common, leaving participants in a vulnerable position. When encountering adverse experiences with a doctor, they can become disempowered and unable to be assertive. Most participants who experienced dissatisfaction regarding the medical profession considered it impossible to change their doctor or specialist. A few couples, however, managed to undertake such an “upheaval in routine” to do so.

Karl and Sharee felt that the lack of empathy displayed by their current practitioner was so inadequate for their needs as to justify doing so:

“Basically he didn’t know what we were going through.” (Karl)

This led the couple to seek alternative medical care:

“That’s the impression we got from him and we didn’t like it so we decided to change doctors. The other specialist was the exact opposite. He made us feel comfortable first, talked for a few minutes, before doing what he had to do. It was so much more pleasant.” (Karl)

“Until I changed specialists. He was a lot more supportive towards what we were feeling. Much more sympathetic to our cause. ... We weren’t just a clinic statistic to him. He treated us as human beings.” (Sharee)

This improvement in treatment was also echoed by Michelle following her change of specialist:

“It was so neat. That I wasn’t just a lump of meat. It was great. To see the difference was amazing.” (Michelle)

A change of specialist resulted in a sense of improved treatment. Whether this was an actual improvement in the care provided, or merely a ‘placebo effect’ from the sense of control and empowerment attained from such a decision is uncertain.

While medical assistance was seen as a necessary ‘evil’ in the pursuit of conceiving a child, the invasiveness of the procedures involved and the extended time period required in the attempts added to the stress of infertility. Often this had a vicious circular aspect, as increased efforts for conception meant enduring more failed attempts, higher negative emotions experienced with each endeavour, and therefore an investment of more time undergoing medical procedures repeating the cycle. In **adapting to living with infertility**; participants who experienced an improved reaction to the diagnosis of infertility held greater knowledge regarding the infertility and experienced informed consent with treatment; spent less time in the medical system; and viewed healing as a holistic achievement rather than a narrowed focus of conception. They also retained some semblance of control over their experiences. While participants voiced some difficult interactions with the negative attitudes held by medical personnel, those who assumed control to seek alternative specialised intervention experienced greater satisfaction with their care.

AXIAL CODES:

CONTEXTUAL FACTORS

SUBSTANTIVE CODES:

Finance

Location

Participants’ reactions to the medical process were impacted upon by certain

contextual factors involved in the specific type of care made available to them. Essentially, participants' **financial status** and **regional location** limited treatment options available to them.

Alice outlined the difficulties experienced with the **finance** and the high monetary cost of certain technical treatment possibilities:

“The main reason we didn't go through with it, is that it costs so damn much. Around \$3,000 to \$5,000 a try. Some other treatments can go up to \$10,000! There are other expenses too. Travel cost to Auckland for the treatments, which means time off work, accommodation. I would have to stay for two weeks with hormone injections and such. I would have to be there for a while. The amount needed for that would be considerable. It costs so much. The amount needed for just a general examination is huge. The consultant fee is \$120, it's \$50 a scan, \$33 a blood test and I think last month I had five or six of them.” (Alice)

The financial strain this placed upon couples eliminated certain procedures for some couples. Many couple were unable to afford the cost of such technology.

Bridget experienced her infertility at a time when such treatments as IVF were considered daringly new and expensive options to undertake:

“I suppose IVF could have been a possibility, we just didn't have the money.” (Bridget)

Both Rachel and John expressed their opinions regarding the high financial cost associated with the medical interventions involved in infertility treatments:

“The more money that you've got the more treatment you can have, and that's the bottom line of it. If you're rich, they say money can't buy everything, but ultimately, it could give you a baby. It buys you a

chance.” (Rachel)

“If you can afford one, you can buy a baby. It shouldn't be down to bloody money. ... It's natural selection by bloody economics.” (John)

Finance provided participants with an increased number of attempts available to a couple for treatment, as well as specific types of modern, highly technical (and expensive) procedures possible. Some couples were unable to meet the cost of these interventions privately. There was a high reliance on the limited places available from the government-funded health sector. All participants noted that they placed their names on this waiting list. However, where possible, those who could afford to concurrently sought aid through private means in an attempt to decrease the waiting time, as well as increase their chances of a conception.

The regional **location** of the participants' homes also influenced the care available to them.

For Caron, living on a secluded rural farm posed its own set of problems to overcome. She described her experiences in obtaining the simplest of medical treatment:

“It's pretty hard living out here to go to treatments because you have a long way to go. And then the doctor in _____ who does my blood tests, when I was having them once every three days, well he closed down apart from two days a week. So I had to either go to _____ or _____ to get them done. Just for blood tests, which was an hours travelling every other day. And then two and a half to three hour's down to Wellington when I had to have a scan, and the trips to Auckland. I think it would be very easy if you lived in either Wellington or Auckland. It's just another added thing really.” (Caron)

Living in the smaller towns and city centres in New Zealand meant that the amenities regularly available in larger regions were not easily accessible for those participants. This extended to the systems of support in place for the couples. Distinct regional variances were observed between the two groups of participants from the Auckland and Manawatu areas.

Alice described the lack of a professional support structure available in the Manawatu region:

“There’s nothing in Palmerston North. Nothing.” (Alice)

This sentiment was echoed by those participants who resided in the more populated Auckland. Many had expressed anecdotal encounters with other infertile couples from around New Zealand who had made the required journey to a main centre for treatment.

David recalled:

“In Auckland, we met a couple from Christchurch. They had actually flown up from Christchurch for treatment!” (David)

Susan also remembered handling contact calls regarding the support group she was involved with:

“I feel for the people in other areas. Not in the main cities. They don’t have the fertility clinics like they do up here. We had some enquiries from New Plymouth and they had sent their enquiries to the Auckland Infertility Society for the support groups. I thought ‘Wow’! That’s a long way to come for a support group meeting.” (Susan)

Participants who were able to meet the contextual factors of **finance** and **location** were in an improved position to attain the core category of **adjusting to living with**

infertility. Being able to meet the increased expenditure required in undertaking modern medical treatments for infertility provided participants with the sense of having “tried their best” at attempts of conception prior to letting go and moving on. The number of endeavours a couple was able to undergo, as well as the type of procedure available, was connected to the financial situation the participants experienced. Location also determined the ease of accessibility to treatment and support systems for participants. Those who resided in the main regions of New Zealand were able to utilise specialised clinical facilities and benefit from the community aid groups which are established within the larger areas – which were not available to those residing in the smaller townships.

SUMMARY

The second factor contributing to the core concept, reactions to the medical process, was reviewed in this chapter. All participants’ experiences of infertility had been directed by the varying investigation and intervention procedures that occurred. Interactions with the medical process involved different factors that affected experiences. Participants who had experienced these factors in an empowered positive light were able to establish a foundation for adapting to living with infertility in the later stages of the process. Conversely, those whose interactions here were viewed as fraught with difficulties sustained damaging perceptions of their infertility.

Figure 3: Third Pre-Existing Condition Of Making Meaning Of Events Contributing To The Core Category Of Adapting To Living With Infertility

<i>Selective Code</i>			
MAKING MEANING OF EVENTS			
<i>Axial Code</i>		<i>Axial Code</i>	
Cognitive		Behavioural	
<i>Substantive Codes</i>		<i>Substantive Codes</i>	
Cognitive Distortions to Self Perception	Emotional Triggers	Marital Relationship	Communication
Stress	Grief Cycle	Support	Social Interactions (Friends / Family)
Emotions			

CHAPTER NINE

Making Meaning of Events

The third concept contributing to the core category of **adapting to living with infertility** was that of **making meaning of events**. All participants were linked by a commonality in regards to their attempts to interpret their experiences of infertility. **Cognitive** and **behavioural** distinctions were observed as participants attempted to discover their own specific perception and understanding of the social processes involved with infertility. The following excerpts illustrate the common thread between the participants.

A comprehensive presentation of the axial and substantive codes identified under the selective code of **making meaning of events** is illustrated in Figure 3 (p.107).

SELECTIVE CODE:

- **MAKING MEANING OF EVENTS**

AXIAL CODE:**COGNITIVE****SUBSTANTIVE CODES:****Cognitive Distortions to Self Perception****Emotions****Emotional Triggers****Grief Cycle****Stress**

Self-perception was observed as an important factor in regards to participants' reactions to the infertility. Here, there was a noted difference between participants' reactions to their diagnoses. Firstly, those who did not experience a crisis in self-perception exhibited better experiences with the infertility process.

Rachel rationalised this in terms of being able to place the experiences within a perspective, and as a result she did not suffer any identity concerns in her role as a woman.

"I've never felt that I'm not really a full woman because I haven't been able to have children. ... I've not felt defective. I don't know why. Perhaps I didn't really want children that badly, or that I had other things in my life?" (Rachel)

For other participants, a **cognitive distorting of one's self perception** altered in a negative way following the diagnosis of infertility. This was regardless of the specific infertility factor involved and was observed to affect mainly female participants. Participants now placed a sense of lower self worth upon themselves than they had held prior to the diagnosis.

Eliza compared her experience of infertility to a "disease" that drastically affected both her body image, and self-esteem. The medical process had a great impact in bringing about erosion, as Eliza described:

"Not only does it physically deteriorate you, but it erodes your self-esteem also. You see these successful people waiting in a room, and it's like a dole queue. ... It pulls you right down and you become an outcast. Your confidence in life is just used up." (Eliza)

In addition, Karl also expressed experiencing a loss of self-esteem. Like Eliza, for Karl these feelings were aroused in regards to his perception of the medical process undertaken. During treatment Karl noted an intense focus upon his partner Sharee. While Karl acknowledged the necessity of this given the nature of investigations for the

couple, he expressed the feeling that his involvement was “brushed aside”:

“I felt like a nobody. A nothing. Like extra baggage basically.” (Karl)

While the initial negative perception of not being “whole” or a “complete man/woman” was verbalised by many of the participants, as the infertility progressed, the self-perceptions altered with some participants.

Monica described the rationale for her change of cognition:

“I used to think that I was useless. I’m here as a woman, but I’m not fulfilling my body’s function. For a while, anyway. I’ve now got to know so many people in the same situation that I know I’m not some sort of freak.” (Monica)

While initially infertility was experienced as a catastrophic role failure, many participants reported that negative self-perceptions became overwhelming. Eventually the infertility came to permeate every aspect of their lives.

All participants acknowledged the intense emotional role the infertility played in their lives. Such **emotional responses** were pervasive throughout all participants’ experiences. Overwhelmingly, feelings expressed with regard to experiences throughout the infertility process were negative in nature. The following passages illustrate the wide variety of emotions verbalised by the participants.

*“It was an emotional roller coaster. It was up and down all the time.”
(David)*

*“It was so intense. You get hooked into the programme of trying to get a baby. ... You start to become obsessed with it. ... Totally obsessed.”
(Rachel)*

“I remember going into shock one day at home, in bed. I was cold and

shaky and clammy. I just remember being all alone. Feeling all alone. ... The pain got too much. I was thinking about all the things I had to face. It just got too much. The sadness was overwhelming.” (Michelle)

“When they told me my sister was pregnant, I just bawled and bawled. I cried out of self pity. I was very happy for them, but still sad for me. The envy and jealousy was [sic] there, but I got over it.” (Alice)

“Having to be in a room full of people while flat on your back with your legs in stirrups, up in the air, open. It was really embarrassing. The indignity of it, while they tried to carry on as if everything was normal.” (Caron)

“Everything was so complex and confusing. I was really scared because I didn’t understand what was going on. The way you deal with it is that you shut off your emotions, cry on the inside. It’s just blocked off. Outwardly, I would seem really bubbly and things like that, but, really, I would be just awful.” (Eliza)

“We were doing what the doctors were telling us. Following their instructions, but getting nowhere. Nothing was happening. That was the most frustrating thing.” (Monica)

“Every month when her period came, the brown stuff would hit the ring. The anger that it wasn’t going to be this time round, the tears. It was like grieving for a lost chance, another opportunity missed.” (Peter)

“I remember running. Running from the emotions, denying what was happening because it got too much.” (Hamish)

Participants often described having experienced feelings of being “out of control” of

their emotions. The infertility was met with reactions of “shock” and “denial”, as well as participants being “scared” and “confused” about the situation at hand. The medical process experienced also impacted greatly. Participants found the investigations and intervention procedures “complex” and “confusing”. The “indignity” involved with treatment and a “frustration” at unsuccessful attempts adversely effected the participants’ morale. Social interactions also evoked strong emotional responses. Often children became an “obsession” where participants found that they were more sensitive to the presence, of others’ children. Television commercials, children on the street, or friends and families’ pregnancies raised feelings of “isolation”, “jealousy”, “envy”, and “self-pity”. No participant spoke in terms of experiencing depression, however, an overall sense of “sadness” was pervasive throughout the process. One description of being on an “emotional roller coaster ride” succinctly summarised the emotional experiences of the participants.

The negative emotional responses experienced abated in some circumstances, however. Participants described a positive change in emotions as the infertility progressed towards the end.

David spoke of his acceptance of the situation over time:

“It’s gradual. The acceptance of things the way they are. Eventually, there’s nothing else you can do but accept it. You rationalise things to make it easier. Like ‘It’s okay to feel this way and there’s nothing you can do about it’.” (David)

For Rachel, the change in emotional responses also occurred in stages. She described:

“The further I go into it, the more different things became. My attitude [sic] at stages were different. On my third cycle at the clinic, I thought to myself ‘God, there’s some really screwed up women here.’ But looking back, I can see I was probably like that once. I suppose time and counselling helped with the emotional strain of it.” (Rachel)

The participants' feelings were subject to **emotional triggers** that could occur with any social interaction. Often responses did not occur within the context of the infertility environment, such as during medical procedures or with health professionals, but rather when the participants were in a social scene. Commonly, these triggers were associated with a reminder of the infertility, such as images of children around them.

For Sharee, this was a common trigger:

“Just something really stupid would set us off, like something on TV. We’d see a woman on TV giving birth or a baby.” (Sharee)

Eliza remembered similar experiences regarding a specific radio song:

“There’s a song on the radio, I don’t know why it affects me. Some days I can be driving along singing to the song and it doesn’t affect me at all. Others, I’m just a mess. Once I had to pull over on the road and have a good blubber!” (Eliza)

Andrew described these reactions in regards to “small stuff that happened”. Often, such emotional triggers occurred unexpectedly:

“Little things would ping me off. ... Just little things out of nowhere. You’d be happy, walking along, then you see the booties, and it would hit you in a big wave. Whomp! And then you know, ‘There ain’t going to be no kid’ or ‘There may never be no kid.’ A whole heap of emotions follow straight after that little home truth. It’s a reminder of what you don’t have.” (Andrew)

Eliza and Hamish attributed such sudden responses as being due to the feeling that the infertility was a constant presence in their life:

“It’s just because it’s there all the time. Anything can trigger it off, reminding you that it’s sometimes running your life, or when it’s not, it’s still there in the background.” (Eliza)

“We had a bad frost that killed quite a lot of trees, and from there I think everything was triggered again. ... Probably for some deep psychological reason. And then Eliza’s mum died, that was another severe trigger. Having those losses, especially after the grief of not having a child.” (Hamish)

A strong sense of the infertility “being there all the time” was a prevalent theme, with many participants reporting being preoccupied with it.

Many participants experienced what they described as a **grief cycle** reaction. The infertility itself was likened to a death with its own mourning phase occurring. Here, the loss was not for any tangible object, but rather for an intangible ideal of possible experiences, hopes, and aspirations a child would bring, but now unattainable with the infertility.

Eliza elaborated:

“I liken infertility as a ‘living death’. The death of your hopes and dreams, only we don’t have a person to mourn, memories or a ritual to go to, to say goodbye, let go, and yet we’ve lost so much more over the years. Anyone who has suffered a death of a child may begin to understand how infertile couples feel all the time.” (Eliza)

Grieving was a strong emergent theme. Both Michelle and Rachel also expressed their infertility experience in terms of an “emotional loss”:

“You go through all the different stages of grief. The hardest thing I found was coping with it, especially when people expect you to put a band-aid over it and carry on as normal. They don’t understand that,

okay, someone hasn't actually died, but our chances of a certain life, of having a baby had." (Michelle)

"There are real emotions of grief involved, definitely. There are a lot of emotions there that you need to come through on the other side of it. ... Support is an essential for this, and I was lucky to have a lot. But the sadness will never go away. I can't stop the grief. The fact that it didn't work." (Rachel)

David described the grief that he experienced as assisting him in acceptance of the situation. Being able to fully explore the emotions associated with grieving enabled David to "move on" with his life:

"Life goes on. You've got a choice. At the end of the day, you've got a choice. You have to go through the grief, and go through the shit. But at the end of the day, you have a choice. You either come out on the other side and you get on with your life and accept it for what it is, or you take the other path and get all bitter and twisted and let it ruin the rest of your life. It's healing I guess. It's the grieving, and being able to overcome the grief." (David)

Eliza's grieving was supported with professional help. Like David, Eliza expressed a need to fully experience the grieving process in coming to terms with the infertility:

"You have to complete this part of the course of life. I believe that. Counselling and stuff, to make sure you're really over this part of the grieving thing. ... You have to complete the whole circle. If you keep missing bits, you're going to be able to go back at some stage and that's what we've found out. We didn't have that and we have had to come back all the time later, to complete the part of the circle. So that you've got understanding and acceptance of the whole process." (Eliza)

The experience of grief was a common thread between the participants. The mourning for a loss occurred for an intangible ideal of possible experiences, hopes, and aspirations a child would bring. However, the experiences in grieving the infertility were no less real than they would have been if they had happened for an actual child.

Lastly, all of the participants reported finding the experience of infertility **stressful** in some aspect. This, in turn, impacted on their ability to appropriately order the role that infertility played in their lives. Jeanine stated:

"I felt that I dealt with it all quite well, but it wasn't until the treatment is actually over that you realise the stress that was on you. That was involved in the whole fertility process, really." (Jeanine)

Michelle described the stress she experienced and the rationale to which she attributed it:

"The stress was tremendous. My own expectations and desires. I was always going to be a mother. This was important. I felt a lot of pressure on me from my parents too. ... They expected grandchildren and all. There were outside pressures as well from friends and the doctors, the treatment process. A lot of stated and unstated expectations and levels to reach. But we coped with it. There may have been some tears and raised voices, but it was a release that was much needed." (Michelle)

Bridget elaborated on overcoming the stress she faced during the medically active period of her infertility experience:

"You learn a lot about how much you can handle. You find out you can handle a lot more stress than you thought. It helps getting support from the Infertility Society. A counsellor. Basically, it allowed us to talk about the situation as much as we felt we needed. It made things a lot more focused for us than we could have done for ourselves. You tend to get

caught up in the emotions, and that's easy to do because it is an emotional thing. But with guidance, there's a direction, a safe outlet, for those emotions." (Bridget)

AXIAL CODE:

BEHAVIOURAL

SUBSTANTIVE CODES:

Marital Relationship

Communication

Social Interactions (Friends / Family)

Support

The second axial code relating to **making meaning of events** concerned the **behavioural** coping strategies. While a large proportion of participants expressed experiencing similar cognitive occurrences with infertility, behavioural reactions differed throughout the process of **adapting to living with the infertility**.

Efforts to conceive appeared to affect participants' behaviours in a variety of ways. The main effect, however, related to participants' **marital relationship** with their partners, including sexual intimacy.

Some participants felt, in retrospect, that the experiences endured through the infertility had strengthened their relationship together. "Working through it together" and "pulling together to make it through" were commonly expressed themes emerging from the participants.

James noted:

"We got really close through it. We're more sensitive to each other now. You can't go through that and not be close. If you haven't got each other, you've got nothing. No kids, nothing. Just each other." (James)

While many participants echoed the above sentiment, relationships were not completely idyllic and not all expressed similar thoughts. Rachel and David were the only participating couple whose relationship did not survive those trying times. Rachel reflected:

“When I look back on it, it was probably a contributing factor to our ending things. ... It put a lot of pressure on us and made things different. It may have happened later on, but it wouldn't have happened at that time because it would have been a common goal, a bond. Without a child we had to refocus our lives. We both just ended up going in different directions.” (Rachel)

For Karl, Michelle and their respective partners, although their concerns did not end as drastically, the infertility process did have an adverse effect upon their personal relationships. An increase in tension and noticeable strain were common results.

“The sad thing for us, was that for about four or five years, our marriage was just in survival mode. We've lost a lot of our marriage, time that other people would take for granted, doing 'normal' things. During that time, we could have easily gone our separate ways.” (Michelle)

“It was the closest time of our marriage failing. ... It put an awful strain on it because we'd come home and take it out on each other because we weren't pregnant.” (Karl)

Peter developed his own personal theory rationalising these different responses:

“It's an either make or break sort of thing. Just the amount of pressure involved. I suppose each has their own way of dealing with it. With some it might bring them closer, but with others drive them apart. If they're not happy together, it might be that little bit extra needed to break them

up. I can really see that.” (Peter)

While infertility introduces tension into the relationship, the cause of much of this tension – the need for couples with different perspectives to work out a common course of action to deal with a common problem – may also, in the long term, make them feel closer together.

For most participants, sexual intimacy was a greatly affected aspect of their relationship. Previously, participants described intimacy as a spontaneous affirmation of their commitment to each other. With infertility, it now held a negative connotation. Couples were now more likely to schedule sexual intimacy in order to ensure that they would have intercourse at the most fertile periods. Sexual intimacy had been reduced by some to solely a “timed baby making exercise”. Consequently, the act often became strained and a chore.

Michelle described the effect of scheduled intimacy on the quality of her sexual relationship:

*“To me, sex used to be a waste of time. ... Why have sex if you can’t have children? It takes all the enjoyment and the spontaneity out of it.”
(Michelle)*

Karl described the effects the pressure had upon his view of infertility and intimacy:

“You’re actually physically put off each other. It takes all the romance out of everything. ... You’ve got to do it, even when you don’t really feel like it. Emotionally, it was a lot of pressure.” (Karl)

Alice also experienced a similar change in perspective:

“The pressure to perform was definitely there, not the fun loving aspect of it. It became more clinical. To be told you have to do it.” (Alice)

While these thoughts were foremost in the consciousness of the majority, a small number of participants spoke of making an effort not to view sexual intimacy in such terms. These participants noted being aware of the damaging effect a negative perception could have on their relationship. Often, humour was described as being used to lighten the seriousness of the situation. Participants reported that a detraction from an intense focus on conception assisted the relationship to pre-infertility normality.

“We’ve been quite conscious that we never treat it like that, even with the timed intercourse. ... We’ve always tried to say it’s day such and such of the cycle, it’s time to have sex. You have to inject some humour into things. Saying that though, you’re always aware of it, but you have to for things to be like before all this.” (John)

In the overall theme, the perceived need to schedule sexual intimacy in order to maximise the likelihood of conception contributed to a transformation of intercourse from an end in itself into merely the means of procreation.

The following emerging theme of **communication** was largely affected by the previous category. Participants commonly described a lack of open communication lines in regards to the infertility. The strong emotional reactions aroused by the infertility were observed to have blocked the ability for some couples to talk to each other.

Rachel noted:

“We had a pretty rough time. We had times when we weren’t communicating because of it. ... But I couldn’t say anything to him because I used to get upset, and I didn’t want to upset him. And he couldn’t say anything to me because he didn’t want to upset me.” (Rachel)

For Sharee and Karl, communication within their marriage deteriorated into “screaming matches”:

“We were at each other’s throats. Not talking, really talking, about the things that mattered. The relationship was quite close to breaking up.” (Sharee)

“It got to the point where we were basically storming out of the house and slamming doors and yelling at each other. Just not communicating because of the pressure.” (Karl)

Eliza expressed a need to protect Hamish from negative social reactions to his infertility factor. She elaborated:

“Hamish couldn’t talk about his infertility. It was only recently that he has been able to discuss it. Sometimes if I’d said something, he might sort of snap at me or say something and I’d back right off. I ended up starting to protect him because we didn’t discuss it and if family and friends asked, it was, “Oh, Hamish’s just got a low sperm count.” That sort of thing, just passed off. I’d done it without discussing it with him because I felt like I couldn’t discuss it with him.” (Eliza)

Conversely, Hamish reflected the futility of such behaviour in the past:

“It’s the importance of talking about it. It just keeps being swept under the table and ignored with the hope of it going away. But the opposite happens. Instead of going away, it just grows and grows to the extent that in which it affects your life, your relationships.” (Hamish)

Karl also expressed a need for communication in strengthening his relationship:

“It’s about talking to each other. Not holding any secrets. This is when doubts and fears, being alone, set in and cause the damage.” (Karl)

Retrospectively, couples expressed the importance of communication within their relationships. “Talking a lot” allowed for an acknowledgment of the experience, and created a bond in that they were facing a common problem with a common goal

Emerging strongly from participant narratives was the negative effect infertility had on couples’ **social interactions**. Participants described social interactions with friends, family, and colleagues as commonly being “tense” and “strained” for both parties. In the guise of ‘helpfulness’, peers often stated comments that were received by the couple as “inappropriate”, “insensitive”, or “hurtful” in nature.

Rachel shared:

“People are so insensitive. They don’t mean to be, they just don’t realise what they’re saying or doing and how much it hurts you. ... They have built up expectations of how things should be. You know, ‘Isn’t it about time for kids yet?’ ... ‘Oh, you haven’t got children, you must be selfish.’ They don’t know or understand.” (Rachel)

For Andrew, this general lack of sensitivity arose from his belief that it was impossible for others to comprehend infertility without having experienced it also. He viewed this as a lack of insight into the infertility phenomenon:

“People who don’t have the problem, or don’t believe they have a fertility problem, can not identify easily with the emotions of knowing that you can’t conceive, unless they are actually in it themselves. ... Generally people don’t have a clue. They say things that can either be hurtful, or stupid, even though they probably mean well.” (Andrew)

Not all comments made were in the guise of good intentions, however. John spoke of the difficult times he had experienced with colleagues who openly taunted the couple’s problem:

“It can be annoying people at work who think, ‘Well, what’s wrong with

you then? Aren't you doing it right?' Ha ha. ... Usually there's a lot of sneering because I can't function as a man, you know. I work in an engineering environment which is sort of mostly sexist, racist. It's filled with highly educated bigots. You have to play along with it to a certain extent. Obviously they cast doubts on your manhood and your ability to perform your function as a man." (John)

Another aspect of **social interaction** relates to participants' descriptions of social occurrences. Infertility had progressed from being specifically the couple's partnership with each other, to an overwhelming awareness of the presence of children in all social areas.

"It hits you when everywhere you go you see babies. Everywhere. Hundreds of them. They just come out of the woodwork. If you go shopping, you go to town, there's pushchairs, prams, babies, women with kids on breasts. Normally you wouldn't notice, but they are everywhere." (Michelle)

Bridget also spoke of a heightened perception of children. She attributed this to a "generational experience" for participation in which she did not meet the criteria:

"When I was in my mid thirties everybody else around had kids. It was the age group where that's just what you're supposed to be doing. What I would have been doing. But I had nothing in common with them. Talking about whether they'd teethed, toiletted or walked. Any of those things were important to a person at that stage." (Bridget)

Rachel elaborated:

"I guess your friends become people who are either similar or haven't had children, or their children are grown up. Obviously you don't relate

to people who have got young children. You may know lots of people but they may not become close because you can't relate to them." (Rachel)

As a result of this, social interactions for couples were viewed as difficult in regards to non-infertile friends and family.

"What happens with your friends is that you get known as Andrew and Michelle No Kids." (Andrew)

Consequently, participants noted a distinct divide between the social groups with whom they associated with. Often friends were categorised into those with or without children.

"You lose a lot of your fertile friends and have more contact with your infertile friends. But when you become pregnant, you understand what both are feeling. You think 'Where's my fertile friends?' And your infertile friends think you've just ditched them." (Michelle)

It is important to note that, while not all social interactions were perceived as negative, all participants expressed some anecdotal experience relating to difficulties within social relations. This specifically related to a distinction between fertile and non-fertile social groups. While attempting to provide support, fertile associates were perceived as unable to fully empathise with the infertility experience and often did not comprehend the effect their attempts at support had on participants. Participants described a close attraction to those with whom they perceived a commonality in lifestyle – infertile, or child-free peers. This was largely due an understanding of the experience that they shared. This impacted greatly on the following theme of support, specifically the type of support participants chose to access.

Support systems were an important aspect of participants' experiences with infertility. All participants disclosed a need for adequate and appropriate avenues of support. The means through which this support was achieved varied strongly throughout

participants' narratives.

Couples often described each other in the partnership as being the main system of support - as was the experience for Monica and Brad:

"We didn't ask for support. I suppose that you get different levels of people and different levels of needs. We have quite a good support system of our own. We don't feel that it's anyone else's problem. People don't understand and they think they do. You're better off not discussing it. ... It's easier to carry on and be yourself, only discuss it with a close few." (Monica)

"Unless somebody's affected by it, or has close family affected by it, it's one of those things where no one wants to know." (Brad)

Eliza and Rachel also expressed the importance of relying on their respective partners:

"We didn't have any support really. It was basically just the pair of us. The fact that he was there, there was no need for anyone else. I didn't want to close him out. We were in this together." (Eliza)

"We kept it to ourselves. ... We never told anyone. ... It's strange, like a sort of stigma. ... You don't want people to know you're going through that. You're struggling with your own emotions, you don't want to deal with others at that time too. Once you've come to terms with it yourself, it becomes a progression. Easier to discuss, later." (Rachel)

Consequently, many couples opted to seek support from infertile peer groups, such as infertility societies.

Andrew shared:

“What’s been really good for us, a real life-saver, is the Auckland Infertility Society. ... All the people in the committee have had fertility problems and you can say, ‘Oh, it’s been a horrible week or month. It’s been terrible.’ Straight away, they have their own personal experiences where they say, ‘Yeah, I went through this. Or, that happened.’ And you can support each other and have that comfort in knowing that there is someone who can understand.” (Andrew)

Hamish and Eliza were also great advocates for the importance of accessing peer support:

“There needs to be a lot more emphasis put on the support groups. The support groups and the counsellors. I think the only regret I have is we should have been encouraged to talk about it and to express our feelings more. Had someone we could have discussed it with first, before allowing us to go onto the next stage. A lot of people think that they can deal with it on their own but don’t realise the state they’re in. Or how things could be with proper support.” (Hamish)

“If we had the support we needed at a much earlier time, we would have been a lot further advanced than we are now.” (Eliza)

However, not all couples were provided with the opportunity to access such support. Often adequate societies were not established in some regions.

For Alice:

“There’s no support in Palmerston North. Nothing.” (Alice)

For others, the support groups they were part of were poorly organised and provided little assistance to them.

David explained his first experience:

“There was a group in Rotorua. We went and saw a lady there, but we ended up actually helping her more than us.” (David)

Susan shared a similar happening within her group:

“The discussion group we joined, ... well, a lot of it was negative. You had these three women who were very, very upset with what had transpired, and they were pretty dominant in the group. We were a bit shattered by what they were saying, beginning to think, ‘Gawd, is there ever any hope?’ It was a good opportunity for them, even if all we did was sit and listen.” (Susan)

Hamish also found support groups limited in the help they provided:

“I haven’t been able to get support or help from other males. I’m still pretty bitter about this, disappointed. Support groups that we have been members of, the males will just not share their feelings. They didn’t really want to talk about it. ... They had their ‘public’ masks on.” (Hamish)

Due to experiences like this, some couples proceeded with professional counselling as a means of obtaining support specific to their needs.

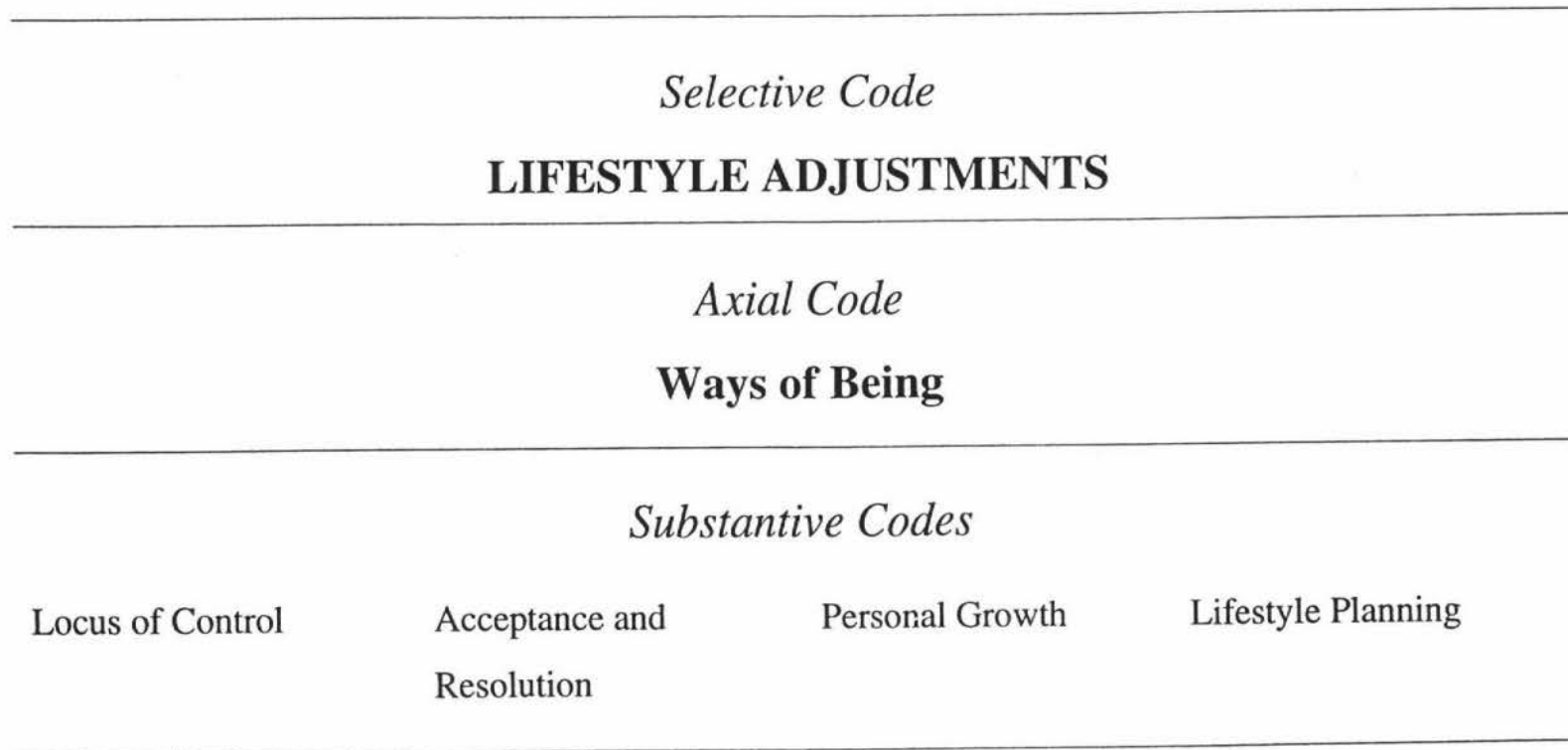
“Getting professional counselling, when you’re going through really traumatic stuff can really help you come out the other side and have a better grip on your life as a result. I’m lucky that I got the support from a good counsellor, but I think, too, that a lot more training needs to be done on infertility and its effects on marriage. That’s really important. We tried to get support from our church, but the Pastor had no training. They just weren’t trained there.” (Andrew)

It was noted to be important for participants to explore a variety of support options open to them, whether it be between the couple themselves, or from friends and family members. The choice of peer support was found to be helpful for some participants and not others. This was largely dependent on the other members of the support group at the time. Professional counselling provided another option for those who required more individual support.

SUMMARY

This chapter outlined the third concept that contributed to the core category. The selective code of making meaning of events pertained to participants' attempts to rationalise their infertility experience. This was further divided into cognitive and behavioural related codes. Participants' cognition was discussed firstly, specifically detailing self-perception and emotional experiences. Behavioural coping strategies were then examined. Infertility was found to have a large effect on participants' social interactions not only between partners, but relating to friends and family also. Acknowledgment of the emotional experience and access to appropriate support systems to cope with the process contributed to the core category of 'adapting to living with infertility'.

Figure 4: Fourth Pre-Existing Condition Of Lifestyle Adjustments Contributing To The Core Category Of Adapting To Living With Infertility



CHAPTER TEN

Lifestyle Adjustments

The fourth concept contributing to the core category of **adapting to living with infertility** was that of **lifestyle adjustments**. This selective code consisted of participants' descriptions of how they perceived themselves to "be" in regards to the infertility. The personal **ways of being** experienced by the participants were interrelated with their perception of the infertility, and resulted in the alteration of some lifestyle states. As with any process, the participants found their own unique sequence of visiting and re-visiting the stages, or feelings states, and the order presented here was the most common, taken from an integration of the data.

A comprehensive presentation of the axial and substantive codes identified under the selective code of **lifestyle adjustments** is illustrated in Figure 4 (p.129).

SELECTIVE CODE:

- **LIFESTYLE ADJUSTMENTS**

AXIAL CODE:**WAYS OF BEING****SUBSTANTIVE CODES:****Locus of Control****Acceptance and Resolution****Personal Growth****Lifestyle Planning**

The most prevalent reaction to infertility noted by participants was that of a **loss of control**. All participants described their experiences in similar terms of being unable to retain a sense of direction with the infertility. However, these experiences of being “out of control” varied with degrees of severity for participants. Some found the influencing effects of the infertility process overwhelming in their lives, while others were able to order the infertility experience in an effort to restore control.

For Bridget, it was the infertility itself that posed the feeling of disempowerment. Although she initially described herself as “not an overly maternal person”, and, admittedly, may have opted for a child-free existence herself, Bridget felt that the decision on whether to have children should have been hers. She explained this:

“It hurt, really hurt. I think that it was probably not having the choice. The decisions were taken away from us. I should have had some say in what was to happen with my life, but that was their way. It’s out of your control. It’s terrible because it somehow not only takes away your control, but ends up controlling you, controls your life.” (Bridget)

Other participants described the infertility process itself as the component that assumed control with daily living activities.

Rachel described this lack of control as “minimal” to begin with, yet as the process continued, feelings of “spiralling out of control” began to emerge for her:

“It wasn’t that important at first. ... It became more important as the process went on. ... It was the first thing in your life that you have no control over.” (Rachel)

This was commonly attributed to the effects of the medical process itself. Sharee expressed it thus:

“The hospital had all the power and control. You had to perform sex to a certain time, take your temperature at a certain time, keep your

specimens warm or cold, plan your day around interview and appointment times. ... They just ruled your lives.” (Sharee)

A similar occurrence was also experienced by Jeanine:

“The hardest thing is that you can’t plan your life, that you’ve lost control over it. You go for your injections and are having your blood tests and things. Everything just seems to revolve around it. You go to work late, take time off work, and go to the hospital every day. ... You have a lack of control over that process. You turn your lives over to the doctors to a certain extent. They’re the ones that maybe advise you, but that they basically decide. ... That’s the hardest stage, when you’re actually in that powerless situation.” (Jeanine)

Jeanine later elaborated on the means through which she was able to reclaim a sense of control over the process:

“Obviously some people aren’t interested in the tests, but I’m the sort of person who reads up about it and wants to know the exact numbers and want to log my own. I want to have some control of my own health. Just to know what’s going on.” (Jeanine)

Through becoming better informed with regard to the procedures involved, Jeanine was able to prepare herself for the experiences at hand. She was able to reassume control regarding the medical aspect of the infertility through removing experiences of shock and the fear of the unknown common with intrusive procedures. Through enhancing her personal knowledge of expected events, Jeanine was able to regain an authority over what was happening with her body. Susan and Ian were able to retain a semblance of control with their experiences through lowering their expectations of the outcome. They were one out of two couples participating who were fully aware of the presence of an infertility factor prior to attempts at conception. With this, Susan and

Don had previously acknowledged the possibility of a child-free life together, however decided to “take a chance anyway”. The couple stated:

“I was pretty much prepared to let fate take its course. I considered it a major bonus if we were able to have children because I knew from the start that I couldn’t. But I never focused on the negative side of it. It was always the positive. It helped that I wasn’t making big plans. I just let that roll through and address that problem as it came up, rather than having this sort of plan along side, trying to conform to it.” (Don)

““When we got married and I didn’t know what was going to happen, we talked about ‘Oh well. If we don’t have kids, we’ll go around the world, we’ll do this and that.’ You know, we were just happy anyway. I don’t feel that it ever really controlled our lives to a big effect, but we had to wait for them to say ‘Yes, you can go on the waiting list now. You can have kids now.’ But we weren’t hung up about it, we were prepared for it. ... But even after I’d had the first one, they said ‘You have to wait a year now.’ In other words they were dictating yet again. ... I was quite comfortable with them dictating to me because we’d never really thought it out. ... We knew we didn’t have a choice with some things so accepted it and instead focused on the things that were in our power.” (Susan)

Other participants commonly described attempts at recovering control in their lives through removing themselves from the situation associated with the infertility. Here, holidays were seen as a means to “take time off from the infertility”. During these periods, attempts at conception were secondary. Instead the purpose was viewed as a return to pre-infertility activities as reward for a difficult cycle, or rest and preparation for intervention yet to come.

Karl explained:

“It was just a time when we needed a rest. We had a gutsful of all these tests. We were sick of being treated like a number and didn’t really need all the hassles that we were getting. So we decided that we’d take some time off, just for us, and if we got pregnant in the interim, great, but if not, we’ll pick it back up later on. So we decided that we should enjoy ourselves for a little while, like it was before. We went off on holiday.”
(Karl)

Holidays also had another effect. They enabled participants to disassemble the infertility experience from one long ongoing process into discernible periods of time. In setting achievable objectives to reach, there was a perception of making the experience more manageable for the participants.

Alice elaborated:

“I used to think, ‘I just think that I can’t go through that again’. That’s when it’s time for a break. Another holiday. ... We look at it in small six monthly goals instead of looking at the whole thing. A counsellor advised that. It’s easier that way. Things just didn’t run on and on. There was an end in sight.” (Alice)

However, not all participants held such views. While the respite from active intervention was embraced, the effects of the infertility factor were still present upon resumption of regular life.

James illustrated this:

“But when you come back it’s still there. It’s still there with you in Fiji. It’s there all the time and you can’t run from it. You can go to Fiji and have a good time, but when you come back the problem will still just be there. Life goes on.” (James)

This perception led some participants to re-evaluate the issue of infertility in their

lives, and the control it held over them. Here, it was felt that the infertility had become an overriding and negating influence upon their lives. In re-assuming a sense of total control, few participants (mainly those who had experienced infertility for an extended amount of time, or who had few alternative options available to them), felt it necessary to relinquish the hopes of having a child in order to return to a “normal living”.

One such couple, Eliza and Hamish, explained their choice not to pursue an intervention technique offered following their acceptance of the infertility and a decision not to further the medical process:

“I think that it had controlled our lives long enough at that stage, and it was time to move on. It was torture I guess to some extent as we were waiting and waiting and waiting, year after year after year and nothing happened.” (Hamish)

“The infertility was controlling me. The emotion was really controlling me. ... It took a lot of counselling to work through the emotions and understand what was going on. The infertility was controlling me, but now I’m controlling the infertility. ... It was a choice that we had made at that time, to stop. I just couldn’t face going down those avenues again. So that was the choice we had made at the time.” (Eliza)

For Eliza and Hamish, a sense of control was reached through the recognition that 20 years of struggling with infertility was at an end. This recognition enabled the couple to **adapt to living with infertility**, rather than continue with a resistance to the position it had in their lives. However, this was not an experience voiced by all participants. As stated, those who were relatively new to the medical process and had not yet exhausted all intervention options available to them did not feel it was appropriate to “let go”, as one person described it, just yet.

“I’m not ready to give up yet. It’s not something that we’ve discussed.

There are so many other options for us to try, still giving things a go."

(Alice)

Such occurrences led to the emergence of a theme for **acceptance and resolution** to the infertility process. Here, acceptance is in reference to the recognition of a possibility of not ever experiencing life with a child. Resolution arrived both in terms of a clarification of the situation at hand and possibly resulting with the conclusion of active involvement in the infertility process.

This had occurred also for one other participant, David. He and his partner were offered another chance at intervention following their decision to discontinue with active treatment:

"All of a sudden, it came up again, the chance. It was a decision 'Are we going to do it? Aren't we?' type of thing. It was really 'Are we going to drag all the skeletons out of the cupboard again' though. When we thought it wasn't possible any more, any further treatment, we'd already started on a healing process. Getting our lives back to doing something else." (David)

Again, those who had fully experienced all possible alternatives were more accepting of the decision to forgo further attempts.

"I've just had enough. If we never have children, I feel as though I'll never have regrets because we've done all that we can." (Caron)

Monica described the deciding factor for her progression as being an ability to elucidate the situation in which she found herself, and evaluate its impact upon her life:

"Probably the catalyst to accepting the problem is talking about it. Beyond just us also. It helps to clarify and refocus the situation and your

lives, especially when you're caught up in the midst of it." (Monica)

With acceptance and resolution for Brad came the ability to see beyond the immediate of here and now with the infertility, and progress to a life beyond that:

"We can see there is a life without children now. I think that, as you get older, whether you like it or not, your body and your mind does [sic] change a bit. You can see things beyond the now." (Brad)

Marcus summarised his view of this simply as 'c' est la vie':

"Suppose one thing that went along towards accepting it, was 'that's life'. There are certain things that you have to accept, that you can't have or won't come your way, even though you try and make them come your way." (Marcus)

With an acceptance and resolution of the infertility, participants were enabled to consider the possibility of life without children. This, consequently, began the development of the next theme.

Personal growth was observed to have occurred subsequent to the participants' acceptance and resolution of the infertility. Those who had achieved this stage elaborated on feeling a sense of individual evolution as to how they viewed themselves. This was illustrated through Michelle's statement regarding her self-perception during the initial early diagnosis, in comparison to the later stages of treatment:

"I lost my identity. I mean, okay, a lot of women's identities nowadays are with careers and things like that. But if you haven't got a career, you have nothing. A career wasn't going to be the main thing in my life. It was to be a family. But I've realised, through time, that I am somebody and that my identity isn't to reproduce. But it's taken a while to come to this." (Michelle)

Rachel also described a development in her perception of life experiences. The infertility now meant that she would no longer fulfil long held aspirations of motherhood as a prospective career. With this came the realisation of the need to progress in her philosophy towards the direction she was to follow:

“I had to refocus. ... I knew that I wasn't going to be finishing work, or whatever. I had to refocus my life because I'd been focused on being a mother and all those kinds of things. Gradually you accept that it's not going to be like that. So you have to change. ... I started doing study because I didn't want to stay in the job I was doing for the next 20 years.” (Rachel)

While both women viewed an alteration of their value in terms of self-identity, Marcus described the infertility as enriching towards his life experience:

“Going through it all, and coming out at the end of everything, the process changes you. I mean, how could it not? Having such experiences, how it affects your relationships, and changing your whole plan and dreams in life will change you. For some people it might make them worse, kind of bitter and resentful on what they've missed, but for me, I have missed out too, but I've found other things that I wouldn't have had otherwise. You have to be more open to what life has to offer, look at it differently, not stuck in the 'me' of it all. I'm a stronger person for going through it. A different person than [sic] what I would have been otherwise, but I feel a better person.” (Marcus)

Personal growth allowed these participants to alter their perception of the infertility phenomenon. Often a consequence of this transformation was an alteration in the conviction participants held towards the purpose of certain life experiences. Such shifts often resulted in necessary lifestyle adjustments being made by the participants.

Lifestyle planning was a concept that occurred where participants were required to

adjust their circumstances in reference to the infertility. All participants displayed certain aspects of strategic rearrangement of activities. Commonly, this began with participants organising life events in the anticipation of a child's arrival.

As Rachel expressed:

"You start reviewing your life and you start to think 'Well, we'll go to Australia this year for a holiday because we might not be able to go next year because we might have a baby.' You start gearing your thinking towards it. It affects everything, your whole thinking, everything you do." (Rachel)

Other participants noted effects of infertility with regard to the intervention procedures involved, an alteration in career perspectives, or the possible absence of a child within their life. These experiences led many participants to describe a sense of suspending their regular lives in deference to the regimes required by the pursuit of a child.

Eliza stated:

"You just put your life on hold. That's what I felt like for ten years. I sort of put my life on hold." (Eliza)

Participants also observed a limitation in the ability to plan future activities at all. Jeanine and John reflected:

"There's a lack future planning. You're left in limbo. You hang while you wait. There is literally nothing you can do other than try not to let it get to each other, and try not to let it get to you." (John)

"The hardest thing is you can't plan your future because you don't know when you're coming up for IVF. You don't know when you're going to have kids. Plans ... have nothing to stand on. Your whole life's on hold."

(Jeanine)

However, not all participants' experiences here were expressed with the awareness of life as being postponed.

For Caron, the negative effects of infertility decreased as she became able to perceive positive aspects to her experiences:

"There are a lot of pluses. We can live great lives still, so as long as you take that attitude. Okay, we're missing out on kids, but we can still do everything else. Even more. We can go away for the weekend and not worry, not have to get a baby sitter or anything. It's just that you can't dwell on it because you're not going to win." (Caron)

Lifestyle planning for Marcus also took on a new meaning. With the infertility, Marcus was able to pursue a lifestyle he believed to be out of his reach during the societal era of the time. Then, it was customary for men to be perceived in the role of provider for his family. This usually meant being employed in a position that offered stability for the family, often a job that was not the preferred choice of the man. Marcus elaborated:

"Consequently it's a good thing for me in a way. Mainly because I didn't have to be stuck into the stereotyped role model. ... I feel like I don't have any shackles. ... It's been a liberation for me. I'm not being stuck into the sole provider role or being the basic bread winner. I've been able to have a career that I find interesting, not because I have to work. Not just for the money and not because it's what's expected of you." (Marcus)

Lifestyle adjustments were a possibility for Marcus and his partner Bridget, as the subsequent absence of children to support permitted both the ability to enter the work force with preferred careers.

The infertility was observed to affect the way participants were able to experience life. For some, this meant an adjournment in routine activities while the pursuit for a child became a primary concern. Here, an inability to arrange future events was noted due to the uncertain nature of the infertility, and the intervention techniques involved. Others described achieving a realisation of the infertility as a liberation, where the constraints and limitations that are associated with children were absent. For these few participants, which had previously been the infertility could be viewed in an affirming light. New opportunities were now available to them, previously restricted by societal beliefs held in regard to child rearing. Lifestyles were altered as a means of “making the best of a bad situation”, as described by one participant, or utilising opportunities provided to their fullest extent.

SUMMARY

This chapter discussed the fourth pre-existing condition relating to the core category. Participants underwent specific lifestyle adjustment strategies, made in regards to the infertility experience. Such planning of activity was originally made in reference to initial attempts at conception. Gradually, participants began to re-order their lifestyle as a means of reasserting control over the infertility. Ultimately those who achieved an adaptation to living with infertility were able to do so through achieving a perception of themselves as empowered. The four specific categories involved here were not sequential in the manner in which they were experienced. Rather, participants visited and re-visited stages or states of feeling throughout the development of the process of adjusting their lifestyle.

CHAPTER ELEVEN

Integration

This chapter will integrate some of the common themes that were observed to be associated with the different stages of the process of **adapting to living with infertility**. The data have already been presented in relation to specific patterns that emerged, therefore the following integration will be relatively brief. The early, middle, and later stages described in this chapter denote the manner in which the adaptation overlapped as the process developed.

EARLY STAGES

The earlier stages of the process occurred around the time participants first encountered difficulties with conception, followed by the initial diagnosis confirming an infertility problem. Participants expressed their rationale for attaining the **parenthood** experience. This centred on the self-fulfilment of roles or societal expectations that having children would achieve. Individual needs such as biological drive, continuation of heritage, and personal generativity could be achieved through becoming parents. In seeking assistance to conceive, diagnosis of the infertility factor was the first experience with the medical process and various investigations and interventions faced by the participants. In **reaction to the medical process**, the infertility factor itself directed the specific treatment options available to couple. All participants observed a lack of provision of information following the discovery that they were infertile. **Making meaning of events** through cognitive reactions followed. However, meaning making was commonly linked with negative responses at this stage. There was a cognitive distorting of one's self-perception, which altered in an adverse manner following the diagnosis of infertility. Participants now placed a lower self worth upon themselves than that held prior to the diagnosis. Perceptions of not being "whole" or a "complete man/woman" were verbalised by many of the participants. Intense emotional responses

pervaded all participants' experiences. Often these, too, were negative feelings, centred on "extreme obsession", "frustration", "self-pity" and "embarrassment" at the infertility. Behavioural reactions at this time tended to be suppressed as couples primarily sought support from the other partner. Disclosure of the infertility was suppressed in the belief that a conception would follow shortly. Participants' **lifestyle adjustments** during this phase concentrated upon alterations to regular daily routines in the attempt to conceive. This narrowed focus was described by participants as "controlling", where the infertility became "all encompassing" in their lives. This left many feeling scared and frightened as they were disempowered with respect to decisions as to what direction the course of normal events would take.

MIDDLE STAGES

During the second phase of the infertility process, in regards to the desire for **parenthood**, a different reaction was verbalised by those participants who had experienced the infertility process, especially the medical aspects of it, for a longer time period. Here, the reality of a biological conception lessened with ongoing disappointments in the various treatment options on offer. Couples now turned to alternative means to obtain a child, such as fostering or adoption. There appeared to be an overriding need for a child in itself. Biological links were no longer the main priority in attaining the goal of parenthood. Confronting one's perception of parenthood in terms of genetic homogeneity, the issue of parenthood for self-fulfilment or altruistic reasons emerged. As stated, this was largely influenced by the participants' length of time dealing with infertility within the medical model, specifically by the success rate of the treatments initiated. **Reactions to the medical processes** involved in infertility treatment were important factors in participants' **adapting to living with infertility**. Although participants encountered similar medical interventions, their perceptions here varied to a wide degree. Participants described both negative and positive experiences. The factor contributing to this was the participants' personal interpretation of the situation. The theme of intrusive intervention techniques was verbalised by all

participants. However, participants who were able to achieve a perception of control in the direction of this process reported improved experiences during medical involvement. The primary means of attaining this control was through the use of adequate information and informed consent to procedures. Participants who felt able to question medical professionals regarding the need for, or techniques involved with, specific interventions reported a higher sense of control over the medical process. Some participants achieved this after opting to change specialists subsequent to unsatisfactory care. Each participant developed his or her own specific perception and understanding of the social processes involved with infertility in attempts to **make meaning of events**. All of the participants reported finding the experience of infertility stressful in some aspect. This in turn impacted on their ability to gauge the role that infertility played in their lives. Infertility impacted greatly on participants' social interactions, affecting the communication within the marital relationship as well with as the support structures utilised in coping with the infertility.

LATER STAGES

The participants who were able to evolve from an instinctual or egotistical response for the need to have a child to a more humanitarian generativity during the middle stages of the infertility experience were, in the later stages, better able to **adapt to living with infertility**. This questioning of one's wish for children created a change in one's perception of **parenthood**. This defined the distinctions amongst the desired aspects of the parenting experience. Individuals who went through this process gained new insights into why they wanted to be parents, giving rise to an awareness of parenting goals held, specifically, which ones were of importance. Resulting from these increased feelings of self-efficacy and control, a greater perception of choice options arose. Participants were able to alter their perception of enriching and rewarding achievements. These feelings, in turn, led to new decisions regarding infertility, most commonly, a re-evaluation led towards new ways of achieving their goals. In some cases goals were reshaped, or desired goals which could not be achieved were abandoned. Here, it is

possible for individuals to successfully disentangle the meaning of infertility and the desire for children from other goals in life. Other reactions also involved a renewed engagement in treatment. Those couples who still chose to pursue the **medical process** exhibited an enhanced perception of positive treatment and general experiences involved in dealing with the infertility. Control over the process was observed at this stage, and commonly medical intervention exhibited a pronounced shift from 'a cure for infertility' to a search for complete physical healing. This was primarily directed through the use of alternative natural therapies in contrast to a dominant allopathic centred style. In the process of **making meaning of events** that followed, many participants described experiencing a grief cycle reaction where the infertility itself was likened to a death with its own mourning phase occurring. The loss was not for any tangible object, but rather an intangible ideal of possible experiences, hopes, and aspirations a child would bring, but now unattainable with the infertility. While such a reaction was evident throughout the process, and had been described by participants in the former two stages of infertility, those participants who encountered an alteration in insight regarding their experience were able to progress to a stage of acceptance and resolution. The negative aspects of their experiences were able to be discarded to embrace a more positive attitude towards the infertility. Such **lifestyle adjustments** permitted participants to pursue different areas in life once closed off to them due to their all consuming experience with the infertility. This development relates to a perceived locus of control experienced by the participants during these later stages of infertility. This relates to both a perception of self control towards daily activities, the body's functioning and emotional state of mind, as well as the perceived control in regards to the planning and prediction of future events, and personal goals and aspirations. Participants who experienced this shift from an external locus of control, whereby power was perceived to be wielded by the infertility, to an internal locus of control, enabled a sense of empowerment with respect to certain aspects of the participants' lives. Although the same experiences occurred, the participants' experienced an altered perception of it.

While these stages outlined the process involved in order for participants to achieve the core category of **adjusting to living with infertility**, the concept itself does not occur in a linear, nor sequential pattern. Participants were able to reach aspects of the

different stages at various times, especially while in an alternate stage itself. For instance, one couple was observed to have attained the third stage where control over the infertility was a defining experience early on. This was due, they noted, through their infertility factor being acknowledged prior to their marriage (a result of a childhood injury diagnosed in the male's youth). Here, before any decisions were made by the pair to attempt to conceive a child through an alternative technique, the couple had accepted the possibility of a child-free life together. This removed the majority of the negative aspects of infertility from the couple (ie. the shock of an unexpected diagnosis, prolonged and intrusive investigation into the problem, uncertainty in their lives regarding future planning). In the absence of such factors, the couple experienced the infertility with little adverse reactions upon their regular daily routine. Some couples are able to perceive certain aspects of a later stage while still primarily experiencing an early reaction to the infertility, while, unfortunately, others may never progress beyond their currently held perception of the phenomenon. However, it was observed that participants who were able to complete this process over time, or who had attained certain significant abstractions, were better able to negotiate the infertility experience and adjust to the impact it had on their lives.

SUMMARY

This chapter described the overall integration involved in the process of adapting to living with infertility. This specific category was contingent upon the presence of four pre-existing conditions, that of rationales for parenthood, the investigation and intervention techniques experienced, attempts at making meaning of events, and lifestyle adjustments required by participants. Each of these codes were outlined with regard to the three stage evolutionary process experienced in participants' attempts to reach the core category of adapting to living with infertility.

CHAPTER TWELVE

Gender Specific Experience

Gender specific experiences relating to infertility were observed from participants' interview extracts. These differences affected aspects relating to participants' attitude towards the infertility, lifestyle adjustments required as a result of the infertility, the medical process itself, effects upon the couples relationship, and support systems utilised by participants. The following chapter will explore these experiences.

During the interview process, a second interview was conducted with the male participants. The purpose of this was to provide men with an opportunity to clarify any points noted during the main interview, and to discuss concerns, if any, that he may not have chosen to voice in front of this partner. Of these subsequent interviews: two declined stating that they had nothing further to add; two had their partners request to be present to which they consented; and six agreed to participate. Despite all endeavours made by the researcher to ensure participants were comfortable with the interview process, attempts to elicit in depth accounts of the lived experience of the infertility process from the men were not forthcoming. While some male participants did openly share detailed descriptions of their experiences with the infertility process, others found this process decidedly uncomfortable. As a result, the interviews were unable to draw out as much information as originally anticipated at the outset of this research. This impacted on the quantity of detailed extracts available to support the emergent themes within this chapter.

Participant's **attitudes** towards the infertility differed greatly between male and female partners. Female participants noted that preconceived gender roles regarding their position in society had been irreparably altered. Here, women were seen as fulfilling a primary parental role throughout their lives. The inability to achieve this led to reactions of disillusionment and dismay from the women.

Caron's extract characterised the sentiment expressed by many female participants:

"I was devastated. My dreams of motherhood were shattered." (Caron)

In contrast, male participants were more accepting of the diagnosis. An indifferent attitude was displayed by most men.

James described the infertility in farming terms, jargon that he was familiar and comfortable with:

“For me it was really just one of those things. A fact of life. Especially when you’re farming. Basically you tend to see it in the stock that you have some are infertile. 20% of the male stock is infertile. So for me, it was, you know, I’m one of those. It was no big deal, just one of those things.” (James)

Brad expressed a similar ‘cest la vie’ attitude:

*“If that’s the way it’s going to be, then that’s the way it’s going to be”
(Brad)*

While not all male participants were blasé in their expression, the men were able to accept and adjust to the infertility sooner than their female counterparts.

“You just have to move on with things. Deal with what life throw at you. My infertility was just another one in a long line of many other problems. No biggie, really. It’s not a burden, deal with it.” (Peter)

Female participants experienced infertility as a potential threat to their gender role within society. Their male counterparts, however, did not perceive fertility issues in a similar vein. Consequently, male participants were found to be more accepting of a possible child free existence than their partners. These differences could be explained in the women’s perception of their place within society and the necessary changes required when such ideals can no longer be met. This is elaborated upon below.

The importance of preconceived gender roles re-emerged in regards to **lifestyle adjustments** necessitated by the couples’ infertility. Women participants again referred

to societal expectations of their behaviour. This ideal had been reinforced with constant questions regarding the couple's status of parenthood.

Caron described such questioning as something which occurred as part of "polite social small talk", invariably always aimed towards the woman:

"It's the woman that's expected to have the baby. To be baby-orientated. It's me who [sic] people ask 'Are you pregnant yet? Have you got kids yet?' Not James. That's not something men get asked, something that they have to deal with like women." (Caron)

Men were not constantly reminded of the couple's infertility status as concerns over children were mainly directed to their partners. Societal expectations associated women with fertility and fulfilling a nurturer role. Indeed, many women expressed that they had intended to assume 'motherhood' as their primary life choice. Professional careers were not considered by the majority of the female participants, who had described working in the vein of "killing time till I got pregnant". Such expectations were drastically changed with the infertility. however.

Rachel discussed the necessary lifestyle adjustments required of her. She also elaborated as to why the infertility did not have the same effect for her partner, David:

"All of a sudden, you have to view your life differently. But not for David. If we'd had children, what would have happened to him? He would have still carried on going to work, carried on with his job. He would have still carried on with his sport. Really, his life would have remained the same, it wouldn't have changed as dramatically as mine. I was the one who was going to have time off work, have a baby, all that. Not him." (Rachel)

Men's lives appeared to alter little in regards to both infertility and child rearing. Expectations were raised that men would assume a gender role of "provider" necessitating a working career, as such their lifestyle had been affected little. Society's

associating fertility with the female body lent weight to many women's experiences of being the focus of concerns regarding the infertility. A majority of female participants also held the belief that they, in turn, would fulfil the role of "nurturer" within the relationship. As such, the role of "motherhood" had been a primary concern in the women's lives. This changed following the infertility, and an unaccustomed lifestyle adjustment was required in shifting to outside careers.

Given the nature of infertility and child bearing, distinct differences were observed between the genders in regards to **medical investigations** and **intervention** techniques. Firstly, all participants acknowledged the obvious treatment focus towards the women. However, this was also present in cases relating to male factor infertility.

Both Rachel and Alice elaborated:

"From a female's point of view, I thought that because it was a woman going through it mainly, they probably took more care, more physical care of the women. I don't think it was like that for the guys though."
(Rachel)

"I felt sorry for Peter. I thought he got left out. They geared themselves up for the woman, because it's only the woman that they can work with. They sort of left the husbands. ... Everything was focused on me."
(Alice)

While medical examinations on the men were limited:

"I only had the one test, and that was it." (Brad)

There was some contention between the genders as to the effect such procedures had on male partners.

Rachel expressed an obvious belief that, due to physiology, the medical aspect experienced by men was less intrusive than what was required for women:

“A guy doesn’t have to wait for it to happen to his body every month. Not only the periods, but the whole lot of tests and things, too. He doesn’t have that.” (Rachel)

Andrew verbalised a concern that male treatment procedures, while admittedly not as intrusive as those for women, still exacted a heavy emotional toll upon the man:

“The actual sperm count was so traumatic. It was really tough for me. It took me two days to recover. ... It puts so much pressure on you, as a bloke, because you’re supposed to deliver the goods.” (Andrew)

He noted that such psychological effects are commonly overlooked in deference to the more intense female experience. Andrew further explained:

“Women have it a lot worse. They lose all their dignity with a guy peering up their vagina. I’m sure that the trauma of what a woman goes through is a lot worse as far as dignity and stress and all of that goes [as compared to the male experience]. I suppose that it [male investigation techniques] really doesn’t compare with what the females go through though.” (Andrew)

While acknowledging the greater impact infertility placed on the female body, some men expressed a degree of psychological distress similar to their partners when undergoing medical investigation and intervention. Although not as invasive, men reported experiencing high levels of emotional angst with regards to treatment techniques. Not all women in the study were appreciative of this however, with references being made by some female participants to the limited role men assumed during the medical procedure.

Gender differences were present with regard to the roles participants assumed within their **relationships**. Comments made by participants here largely related to male perceptions of the role men have as “protectors” towards their partners.

Andrew and John illustrated this with the following extracts:

“Guys just want to fix it when you can’t. They’re real protective. We have a protection thing over the wife. It’s bred into you. You want to protect them from all the nasties that are out there in the world. It’s about being her man. As a bloke, I was feeling really helpless. I wanted to help Michelle or put it right, but it’s not something you can do. You can’t put a bandaid on it. ... As a bloke, you want to be the protector, provider, you know, it’s a natural thing. But you just feel helpless instead.” (Andrew)

“I can’t stand the idea of people jabbing and poking things into my wife. I hate it. I want to protect her from all that stuff, the hurt and pain, but in this I can’t.” (John)

As seen earlier, women displayed concerns regarding gender roles when discussing attitudes to infertility. While men’s gender expectations were not aroused at the time, male participants did present role issues with respect to their relationships. Here, men perceived it as their responsibility to assume a “protector” role and shield their partners from physical and emotional distress.

Within marital relationships, **intimacy** and **sexual relations** for couples emerged as a gender specific experience also. Women in the study expressed a marked decrease in libido with the infertility. This was often explained with regard to their perception of intimacy. Comments similar to “why bother any more” were often made.

For Michelle:

“To me, sex used to be a waste of time. ... Why have sex if you can’t have children? (Michelle)

Intimacy and sexual relations had been associated solely with an act of reproduction. With infertility, sexual intercourse was viewed as a redundant activity.

Conversely, however, no lowering in libido for men was shared. Males themselves observed, and remarked, upon the lack of desire from their partners.

John elaborated on what he attributed to be the rationale for this:

“Because they can't have kids, it's looked upon as if it's not worth the effort. They lose their attractive eye in that pleasure, they lose their attractiveness. Because of how women are geared, from a man's point of view, she doesn't feel capable of having sex. She may not be at that point in time because she's not emotionally up to it. Sex is a very emotional thing for women.” (John)

In response to the infertility, many women expressed a gender identity crisis regarding their femininity and self-perception as a “true woman”. Consequently, a decrease in libido was experienced by some. The equation of sexual intimacy with physical reproduction contributed to this concern. While such feelings were not shared by male participants, many were aware of their partners' feelings regarding this, and attempted to be empathetic to their needs.

Patterns also developed when investigating **systems of support** accessed by couples. A distinct difference in coping strategies utilised by participants was observed in the type of support that was sought. It emerged that female participants expressed a need to talk through emotions and experiences of the moment. However, such attempts at communication were not always well received by partners.

Alice elaborated:

“I get a bit teary eyed and Peter's had enough of that, which I can understand. I mean men aren't like us and don't understand some times. I've got a good group of girlfriends that'll support me and they cope with my crying.” (Alice)

Jeanine, too, expressed a need to share her feelings. As was the case for Alice, an alternative support person had to be accessed when little response was received from her

husband:

"I've always sort of felt more of a need to find somebody in a similar situation to talk through with. ... I don't know whether women need to talk more, or talk through the emotions more?" (Jeanine)

With respect to the differences noted here, many male participants stated that they did not feel a need to verbalise inner emotions.

"I think it's a natural progression for me, as a bloke, to clam up. I just walk out and have a beer or watch telly with the boys." (Andrew)

The following statement characterised many responses given by male participants:

"I never told anyone. I kept a lot of things inside. I won't go and talk to people. I've always tried to hold on to them and deal with them myself, to try and find my own solution." (David)

In agreement with this, James elaborated on the rationale for his actions:

"My needs are different. ... I tend not to spend too much time thinking about it. If it gets to me, I've got work I can throw myself into. I can tuck back into it and not have to deal with it, lose myself in that. There are other things that help like getting out and about. Hobbies. She's there for me and I try to be there when she needs me, but I don't see the need of dragging others into it." (James)

Finding an active physical outlet, or distraction, was utilised by many men in this study as a means of coping with the situation in which they found themselves. Combined with supportive partners in turn, the men expressed having adequate support systems in place for their needs. Male partners did attempt to be supportive towards the

needs of their wives, however this was not perceived as such by the women. As a consequence, female participants turned more towards alternative emotional support, such as that provided by friends and family. Here, professional counselling and support groups became a part of the couples' lives also. However, the reluctance shown by men to discuss their emotions was extended to include an expressed dislike of outside support.

Andrew spoke of his initial experience:

“Michelle tried to get me to go to some counselling. It was all arranged, but I didn't go. I don't think that I was quite ready for that before, I was really emotionally dug in about it. But I feel like some professional counselling now. I don't think that it would have helped before when I wasn't ready for it though. I wouldn't have opened up because it wasn't right at that stage for me.” (Andrew)

Male reactions with regard to support systems were best illustrated in Hamish's comment:

“What normally happens there is that the women are quite good at sharing, but the males are just talking rugby and cars. It was just normal chit-chat. The men had their normal masks on. They didn't want to share their feelings, that sort of thing. It was just too dangerous. Men don't do that sort of thing, express their feeling to any one apart from their wives. ... I was extremely envious that I haven't got that sort of support from my fellow males. I think it's very good for the females that they can do that.” (Hamish)

In sum, support systems accessed differed greatly between genders. Male participants characteristically preferred to rely on distraction techniques, along with primary support from their partners. Women participants however, found a distinct lack of communication in the relationship, making it necessary for them to seek support from

other sources. All participants expressed the importance of utilising appropriate support systems in coping with the infertility process.

SUMMARY

Gender specific experiences have been observed with respect to certain aspects of the infertility process. The most significant of these experiences were associated with participants' perceptions of gender roles. Female participants experienced a gender identity crisis where their self-perception as a "true woman" had been questioned. Doubts concerning their physical femininity were experienced due to the infertility. The women also had to come to terms with the possibility that they would not fulfil a "nurturing" parental role, an ideal many had aspired to since childhood. Instead, new developments for professional careers needed to be considered. Little change was required in this aspect for male participants. The absence or presence of children within the male's life did not affect the presumption of his assuming the role of "provider". Many men noted, however, experiencing a desire for a "protector" role in shielding their partners from painful infertility experiences. Distinct differences were observed also with respect to support systems accessed during the infertility process. While all participants expressed the importance of utilising appropriate support systems, male participants characteristically preferred to rely on primary support from their partners. Women participants, however, found it necessary to seek support from other sources. Of note, participants expressed being aware of many of these gender differences, and attempted to be empathetic to each other's needs.

PART THREE

**DISCUSSION AND
EVALUATION**

Overview of Discussion

The third section, covered in chapters 13 and 14, discusses and summarises the findings of the research together with its present limitation.

Chapter 13 reviews the findings of the grounded theory in relation to previous literature on the experience of infertility.

In chapter 14, the limitations of the present study are considered, and topics for future research into the area of infertility are suggested. The findings are then examined in relation to clinical implications for those working with infertile individuals.

CHAPTER THIRTEEN

Discussion

This chapter discusses the present findings in relation to previous literature regarding the psycho-social experiences of infertility for couples. Firstly, several lines of research supporting participants' descriptions of the process experienced with adapting to living with infertility are explored. In the second section, gender specific experiences encountered by the couples are discussed in relation to pertinent literature.

With regard to previous research, however, before beginning this section it is important to emphasise that, despite an extensive literature search performed by the researcher, the studies and articles utilised here appear somewhat dated. However, the literature cited within the present study is that which is most pertinent to the specific areas of discussion under review. The need for further research into these areas relating to infertility experiences will be discussed in chapter 14.

ADAPTING TO LIVING WITH INFERTILITY

The present study, concerning the psycho-social experiences of infertility amongst couples, resulted in the establishment of a grounded theory. This grounded theory directly concerned the process participants experienced in relation to coming to terms with their infertility. The theory rested upon the notion that infertility was a pervasive and ongoing occurrence that remained with individuals throughout their lives. For participants to deal with, respond to, and overcome the effects associated with the phenomenon in a productive manner, an adaptation to living with infertility was required. Thus, the core category which linked participants' perceptions of their experiences emerged. Menning (1980) and Hughes (1982) both suggest that resolution of the infertility problem may be as much influenced by the adaptive capacity of the individual as by the outcome of the treatment itself. Interpreted from interview extracts, the core category emerged prominently throughout participants' reflections on their

infertility experience. It is important to note here that the participants were not directly questioned about any specific adaptation in their lives, but that the term **adapting to living with infertility** was a primary perception generated independently by the participants. From the collective data as a whole, the core category emerged as the strongest theme pertaining to the infertility experience.

A paramount understanding of the need to experience an adaptation to living with infertility was contingent upon four pre-existing conditions. The first of these related to an awareness of the parenthood experience: specifically, the desire for children expressed by participants. Even though many couples today may spend a great deal of time thinking about the decision of when to have children, and even whether to have children, this cognitive process does not prepare individuals to face the possibility of not being able to have children. Most people assume that they will be able to conceive. Often the infertility is met with reactions of shock and/or disbelief (Clarke, Henry, & Taylor, 1991). Clarke et al. (1991) state that, for many infertile people, the goal of having children is extremely important and intricately enmeshed with a higher level of goals for fulfilment and happiness in life. As a result, threats to one's fertility are perceived as devastating. Individuals' assumptions regarding their ability to conceive, along with cultural definitions tying fertility to adulthood and sexuality, can deeply affect one's sense of value of, and goals in, life. Mandler (1982), and Vallacher and Wegner (1987) (cited in Clarke et al., 1991) claim that people are not generally conscious of all levels of their goal hierarchies. That is, at any given moment one may not be aware of the reasons for engaging in certain activities. Both suggest further that the goal of having children may often be an "inherited goal" (p.159), that society has passed onto individuals with the assumption that procreation is a natural part of adulthood. "Societal and cultural norms require that a person engage in behaviours which show his/her normalcy and responsibility. Bearing and raising children constitute such behaviours" (p.159). Consequently, in-depth reasons for having children are rarely questioned.

However, throughout the course of the present study, participants were given an opportunity to consciously consider and express their rationales for wanting children. Under this pre-existing condition of parenthood, several distinctive categories emerged.

In essence, the rationale experienced by many of the participants centered on the self-fulfilment of roles or societal expectations that having children would achieve. Individual needs could be attained through becoming parents. As has been mentioned, several participants were unable to clearly define their reasons for pursuing this experience. Described by participants in terms of a merely “biological drive” or “continuation of heritage”, Clarke and associates’ (1991) theory relating to “inherited goals” (p.159) and societal assumptions that procreation is a natural part of adulthood, was evident within the present study’s specific group of participants. Having children was described as a natural biological function that was an inherent expectation in their lives. Other participants identified themselves more closely with a differing view for desiring children, particularly with regards to personal or relationship development. Theories of human development, notably Erikson’s (1950) theories regarding individuals, and Duvall’s (1977) theories about families, emphasise parenting in terms of life stages and appropriate developmental tasks.

Duvall identified two major phases in the family life cycle: **the expanding family and the contracting family**. She also observed eight tasks essential for survival of the family unit - including reproduction and the recruitment and release of family members (Anderson, 1989). Duvall noted that couples regard themselves as potential parents long before children actually arrive. Infertility is seen as placing emphasis on the attainment of these phases and the accomplishment of the major tasks of parenting.

For Erikson, adulthood was characterised by two major phases of **intimacy versus isolation**, and **generativity versus stagnation** as establishing and guiding the next generation. Erikson defined **intimacy as the readiness to commit oneself to others and to situations, including children and parenthood**. Anderson (1989) noted that the primary motivations for generativity are **productivity** and **creativity**. ‘Generativity’ may be perceived by many as reproduction and readying the next generation for life. In addition to this, both intimacy and generativity may be diminished by infertility. Here, failure to achieve generativity results in **stagnation** and **self-absorption**. Erikson further suggested that failure to achieve the developmental tasks of adulthood might impede progression to the next developmental stage, that of **ego integrity versus**

despair, which may have serious implications in terms of the adult life cycle. A selection of participants spoke of parenting in terms of attaining these stages.

Beyond this, a different reaction was verbalised by those participants who had experienced the infertility process for a longer time period. Ongoing disappointments in the various treatment options led couples to alternative means to obtain a child, such as fostering or adoption. The reality of a biological conception lessened as participants' perceptions were challenged, i.e. the necessity of achieving parenthood by conceiving and bearing children who preserve the 'genetic homogeneity' of one's ongoing biological family. Parenthood for 'self-fulfilment' or 'altruistic reasons' emerged as an issue for some participants. Clarke and associates (1991) noted that individuals who experience infertility for a period of time may begin to examine in depth why they want to have children. They report further that, while this may occur at various points within the infertility process, the questioning of the reasons for parenthood is motivated by four specific factors. These are: a threat to not achieving parenthood, costs of continuing treatment, the social stigma of infertility, and the adoption process as an option (Clarke, et al., 1991). "The distress of the infertility experience may lead individuals to become more aware of how they think of parenthood, and of themselves as parents-to-be. ... This questioning process may help individuals rethink their identity, ideal self, and the meaning that parenthood holds for them" (p.163). It is further argued that the questioning and examination process establishes a re-conceptualisation of the concepts involved with infertility such as the ideal self, goals for the future, and the meaning of parenthood itself (Clarke et al., 1991). Through an examination of rationales for parenthood, individuals may attain a realisation that certain aspects of the experience are still available to them. Alternatively, it may be decided that the parenthood experience is not a necessary aspect of their marital and personal satisfaction. Here, it is possible for individuals to successfully disentangle the meaning of infertility and the desire for children from other goals in life. As such, this first condition was integral to the core concept of adapting to living with infertility. Questioning of one's goals contributes towards the core category of adapting to living with infertility.

The second identified condition contributing to the core category of adapting to living

with infertility emerged surrounding perceived experiences with the medical process. Participants' perceptions of health care professionals and the procedures experienced in pursuit of conception became part of the process of defining the experience of infertility. Participants described both negative and positive experiences. However, there was an overriding theme verbalised by all participants. This concerned the intrusiveness of intervention techniques utilised. Through their research, Beaurepaire, Jones, Thiering, Saunders, and Tennant (1994) observed that the particular stage of infertility treatment was shown to have a strong impact on the couples' perception of the infertility experience. Emotional strain and stress levels were reported as moderately elevated during the first year of initial diagnosis and early phase of treatment. Distress returned to normal levels during the second year, but again showed a marked increase during year three and beyond. This follows a pattern corresponding to the degree of intrusive intervention, which is part of the ongoing medical process. Abbey and Halman (1995) report that women attribute an increased responsibility to their doctors rather than to their partners over time. They note that this, in turn, is related to poorer adjustment to infertility. Because women receive many more tests and treatments than men do, physicians' responses may be more salient to the women. This finding is supported by Tennen and Affleck's (1990) argument that holding others responsible for negative events is maladaptive. Participants in the present study who retained feelings of control, and who were able to have some influence over the process, adapted better than those who relinquished all personal power to the medical professional, thus losing control of the infertility itself. Participants who actioned decisions regarding treatment options and offered informed consent to procedures had more positive experiences with respect to the medical investigation.

The third condition contributing to the larger core category pertained to participants' attempts to interpret events in a meaningful fashion. This specifically involved making meaning of the cognitive and behavioural experiences encountered during the process of dealing with their infertility. Each participant had his or her own specific perceptions and understandings of the social processes involved with their infertility. Abbey and Halman (1995) demonstrate that unanticipated negative life events, such as infertility, essentially challenge people's fundamental beliefs about life's being orderly,

predictable, and fair. Thompson and Janigian (1988, cited in Abbey & Halman, 1995) argue further that negative experiences represent a means of re-establishing a sense of control and purpose. The importance of this is increased when the negative event appears to be outside the individual's own control. A sense of secondary control can be created through finding meaning in the event as it provides a significant explanation for what has happened, and what is about to occur.

The present study categorised participants' attempts at discerning meaning from their infertility experiences into two distinct areas, namely, cognitive and behavioural attributions. The second axial code consisted of the behavioural coping strategies. Findings regarding social support provided a fundamental link between all substantive codes in this section. Throughout the present study, it was observed that infertility impacted greatly on participants' social interactions, affecting the communication within the marital relationship as well as the support structures utilised in coping with the infertility. Abbey and colleagues (1991) note the importance of three different positive aspects of social relationships: esteem, affirmation, and material support. Esteem or emotional support is typically viewed as central to coping with the various cognitive aspects of infertility. In the initial axial code of cognition, participants' cognitive reactions were strong in several areas, the most notable of which related to one's self perception following diagnosis. Participants now attributed a lowered sense of self worth to themselves than was held prior to the diagnosis of infertility. Perceptions of not being "whole" or a "complete man/woman" were verbalised by many of the participants. The importance of gender roles within the infertility literature has been well researched and documented. Intense emotional responses related to grief and stress pervaded all participants' experiences. Abbey and associates (1991) state that negative life events involve a sense of failure and threaten individuals' self-esteem and "sense of mastery" (p.63). The knowledge that one is loved and valued can mitigate this loss. Information or affirmation support involves providing individuals with information that helps them evaluate their situation or themselves. Here, thoughts and feelings are affirmed as normal - given the circumstances. Material or instrumental support involves concrete aid. It is necessary to note here that the existence of social support does not ensure that it will actually be provided. Researchers observe a distinction regarding

perceived support. “Words or actions are not socially supportive unless the target individual perceives them as such” (Abbey et al., 1991, p. 63). Specific infertility literature emphasises a negative cost to relationships. As observed with the participants in the present study, infertility can be, and often is, kept secret. Many couples are unwilling to discuss the issue with others – either for fear of embarrassment or due to the private nature of infertility. This secrecy can lead to painful comments from others such as “when are you going to have children?” Even when friends and family members are aware of the infertility, they may still unwittingly make insensitive comments or provide unhelpful advice. Participants’ descriptions of avoiding social events where children may be present is supported by Menning (1980). Menning (1980) observed that infertile couples often missed christenings, baby showers, and other events which focus on young children because of the pain they experience with these vivid reminders of their childless status. Abbey and colleagues (1991) report a vicious cycle relating to such behaviour.

“Friends and family sometimes avoid inviting infertile couples to these events because they feel awkward about exposing them to their children. Significant others unintentionally say and do things which upset the individual in need of support, who in turn withdraws. This response causes potential supporters to feel unappreciated and unwanted, so they too, withdraw. Thus the infertile individual becomes even more isolated” (p.67).

Abbey et al. (1991) maintain that these are reasons why infertile couples tend to rely upon each other for esteem, affirmation, and support. McEwan, Costello, and Taylor (1987, cited in Abbey et al., 1991) found that perceiving one’s husband as a confidant was related to enhanced emotional and social adjustment for infertile women. Abbey and colleagues comment that confiding in someone other than a spouse did not achieve the same result, because, perhaps as previously suggested, there are problems with privacy. Conversely, Mahlstedt (1985) notes that while relying on each other for support can make an infertile couple’s relationship stronger, it also places an enormous burden upon it. “Because each member is in crisis, they may become less able to fulfil

each others' needs" (p.337). Participants often described using self-help or support groups as a means to resolving the problem of inadequate support from friends, family members, or their partners. Through sharing their experiences and concerns with others who have had similar experiences, both members were able to receive the desired support in their situation. Unfortunately, an overwhelming theme throughout this study was a noted absence of such support groups usually available to participants residing outside main centres.

Finally, lifestyle adjustments comprised the fourth pre-existing condition contributing to the core category (adapting to living with infertility). These consisted of the participants' descriptions of ways of being, that is, how participants perceived themselves to "be" in terms of their experiences with infertility. Those participants who experienced an alteration in insight regarding the experience of infertility were able to progress to a stage of acceptance and resolution, leaving negative aspects of their experiences to embrace a more positive attitude towards the infertility. This, in turn, impacted on lifestyle planning and the personal growth of the participants. They were now able to pursue different goals in life once closed off to them due to their narrowed focus. The overriding factor observed in this development relates to a perceived increase in internal locus of control by participants. The infertility experience is essentially defined by a loss of control over one's reproductive ability. Widespread literature evidence has identified the feeling of loss of control as common among involuntarily childless individuals. Campbell, Dunkel-Schetter, and Peplau (1991) noted that infertile people, as assessed on an internal-external locus of control scale, were more likely to perceive themselves as controlled by external forces. This research suggested further that experiences with the loss of control inherent in infertility may have altered the perceptions of these individuals concerning the amount of control they have in their lives in general.

Treatments for infertility typically involve a significant loss of control. Diagnostic procedures and treatments for infertility are generally invasive and complicated techniques. Discussions of the details of couples' intimate relationships, along with discussions over the frequency and timing of intercourse, are common. Such procedures can threaten the couples' sense of control over their relationship and privacy. The stress

of treatment can be compounded if physicians do not inform, or involve the couple in decision making. As expressed by participants in this study these are just a few of the ways in which the medical process may substantially erode the infertile couple's sense of personal control. In retrieving a sense of control, Tennan, Affleck, and Mendola (1991) state that within infertility, aspects of control experienced can be further elucidated. **Primary control** relates to the experience of personal influence over an aversive situation. They note that there is little of such control with regard to infertility. However, prevalent in the experience is a sense of **secondary control**. This pertains to attempts to redefine the situation so as to reduce its threat. These appraisals include: **interpretive control**, which is accepting of the situation by giving it meaning and purpose; **cognitive control**, which involves thinking about a situation in a different way, such as construing benefits or gains; **predictive control**, which is an attempt to predict events so as to avoid disappointments; **vicarious control**, which involves **ascribing control** to an authoritative other; and retrospective control, in which the threat is seen as having been avoidable, thus protecting one's confidence that similar future experiences can be averted (Tennan, Affleck, & Mendola, 1991). Secondary control appears to enhance adjustment, and all participants in the present study attempt to utilise varying aspects of this control to empower their lives.

Much research documents the benefits of perceived control on responses to stressful situations (see Campbell et. al., 1991, for reviews). These field studies have shown that greater control can reduce the levels of negative reactions to stress experienced by individuals. One particular research study reported surprisingly similar experiences of infertility to those experiences expressed by participants in the present study. In their investigation, Campbell and associates (1991) examined participants' perceptions of control using the Pearlin Mastery Scale. The scale, used to measure general control beliefs, consists of seven items, each rated on a 7-point scale from "agree" to "disagree". When they asked their participants to provide examples of the ways in which they exercise control, the answers obtained illustrate a similarity to those expressed in the present study. Parallel to those experiences of the participants in the present study with regard to holistic care of the body, the subjects of Campbell et al.'s study reported engaging in health behaviours such as abstaining from cigarettes, drugs and alcohol,

attempting to maintain healthy diets and exercise regimens. Reducing stress and maintaining a positive attitude were also observed as means of re-assuming control by participants. Control over the medical process also was effected through the preferred choice of physicians, and types of treatment chosen. They reported also seeking information about the treatment, and adhering to the treatment regimen. The issue of controlling negative feelings by behaviours elicited a variety of similar responses between the two studies. These included seeking information and social support, and focusing on the perceived goal. With respect to controlling negative emotions through attitude, most respondents indicated that they tried to keep the matter in perspective, or to change the way they thought about the situation.

The presence of the core category, adapting to living with infertility, was an emerging concept participants expressed throughout their experiences of infertility. The infertility itself was a pervasive factor in participants' lives that required an acknowledgment of its presence as well as a recognition of its impact on desired goals. Participants who were able to achieve the core 'adaptation to living with infertility' displayed an ability to readjust lifestyle planning away from infertility milestones to a regular semblance of life. These participants no longer viewed themselves as existing in relation to the need for a child in any sense. Acceptance, resolution, and control enabled participants to achieve personal growth. An ability to plan a lifestyle more suited to current circumstances was forthcoming in this process.

GENDER SPECIFIC EXPERIENCES

The findings from this study suggest that, although women and men experience some aspects of infertility similarly, they are differentially affected by the experience in some areas of life. Women were much more vulnerable to the infertility experience as expressed in their accounts of lowered self-esteem, higher emotional turmoil, and greater problems in areas of personal life and with the health care system, in comparison to their partners. The greater effect of infertility on women's perceptions of themselves may reflect the relatively greater importance of parenthood for female participants.

Supported by Leiblum's (1997) citation of many research examples, this study found that women essentially experienced infertility as role failure and a threat to their feminine identity. While parenting is noted as a central component of society's expectations for both sexes, motherhood is traditionally perceived as the central role for women. Many female participants maintained that they could not imagine a life without children. Elaborating, Leiblum (1997) stated "to the extent that women define themselves in terms of their role as wives and mothers, inability to conceive threatens feelings of self-efficacy and feminine self-esteem" (p.100). Conversely, men described defining themselves in terms of occupational success. Infertility was experienced as an unfortunate circumstance that one could deal with and eventually overcome. Some authors suggest that the main concern for husbands with infertility is coping with their unhappy partners and a stressful home life, rather than with an assault on their self-esteem (Leiblum, 1997). There is evidence that couples place significantly different interpretation on the meaning of events. Abbey et al. (1991) reported that women regarded infertility as the major problem in their lives, whereas men regarded it as having the same priority as a number of other major stressors in their lives. Again, this can be linked back to the assumption of gender role within the couples and their importance in defining the self. As parenthood played a more central role for women, the potential loss of this option may be more disruptive to their lives, hence the intense focus on the phenomenon. Several women revealed that they originally intended their primary career to be motherhood, but had changed occupational plans upon experiencing infertility. Infertility required some women to reorganise their role structure, whereas men's experiences did not necessitate such an overwhelming lifestyle change.

Moreover, it is women who must endure the majority of evaluation and intervention procedures for overcoming infertility. As such, women's difficulties with the health care system exceed those of their partners. Draye, Woods, and Mitchell. (1988) observed that this occurrence was unsurprising, as women tended to initiate care for infertility, regardless of which infertility factor was present in the couple. Women in the study were more likely to assume responsibility for the infertility, regardless of the actual factor. This may be attributed to the woman's commitment to achieving the desired outcome of a child. Given the nature of infertility, there was a natural intense

focus of treatment orientated towards the female body, with women experiencing perhaps most stressful contacts with health professionals. With reference to this, some male participants also expressed concerns regarding their procedures. While the males' part in the medical process was severely limited, investigation techniques were experienced by males as equally distressing to those of their female counterparts. Men expressed concerns that this was commonly overlooked in deference to the female's role in the infertility process. Beaurepaire and associates (1994) report that while the greater physical involvement in treatment does expose the female to greater treatment stress, husbands' distress should also not be dismissed. A number of IVF treatments have been reported as particularly stressful for men. For example, note within this study the interview extract regarding producing sperm samples "on demand".

Men and women generally coped differently with the stress of the infertility. Men were more likely to use denial, and to distract themselves with increased activity at work and in hobbies. They were also more likely to rely solely upon their partners for any necessary support during this time. Men's quicker acceptance of the failure of treatment led some partners to feel that their husbands were not sympathetic enough. Women tended to ruminate about the problem and become deeply distressed about the situation. Abbey and colleagues (1991) illustrate that many authors lend weight to the findings of this study that women experience more negative affect than the men. Emotions such as depression, anxiety, guilt, frustration, and isolation were noted as being expressed more in the female experience. Unlike their partners, many women found the support offered by the men insufficient, thus making it necessary for them to seek out other avenues of support from friend and family.

Research by Stanton and colleagues (1992) illustrated that adjustment to living with infertility was best predicted by different variables for men than for women. Confrontive coping best predicted distress for men, whereas low perceived control over infertility and coping through accepting responsibility were unique predictors of distress for women. She further contended that well-being in adjustment was best predicted by low perceived threat from infertility for males and coping through positive reappraisals for females. Strong conformity to social role expectations may lead one to select particular coping mechanisms which, in turn, may produce distress. However, the

relationship between gender role conformity and distress in infertility is a question for further study.

CONCLUSION

The findings of the present study have been discussed and summarised. The objectives of the study have been met, and after assessing specific criteria, the methodology appears to represent sound research.

It was found that individuals experiencing infertility problems strove to deal with, respond to, and overcome the effects associated with infertility in a productive manner. As described in relation to the participants in this study, there is support in the infertility literature for the process of **adapting to living with infertility**. Infertility was perceived as a process subject to change over time. The present study has generated a description of the process of adjusting to life with infertility that is clearly relevant to the area. There was a surprising consistency in the changes over time that were expressed by the participants. The predominance of expressed rationales for attaining the **parenthood** experience, and coping with the medical process with various **investigations and interventions** faced by the participants were noted in the early to middle stages of the infertility process. Later stages of the experience were defined by attempts at **making meaning of events**. This pursuit culminated in **lifestyle adjustments** being made by participants in order to adapt to the infertility.

The present study also supported and extended some of the findings in the literature pertaining to gender specific experiences with infertility. Although women and men respectively experienced some aspects of infertility as being similar, both are affected by the experience in some areas of life. In comparison to their partners, women were observed to be much more vulnerable to the infertility experience with respect to accounts of lowered self-esteem, higher emotional turmoil, and greater problems in areas of their personal life and with the health care system. The greater effect of infertility on women's perception of themselves may reflect the relatively greater importance of parenthood for female participants, as well as the predominant focus of infertility

procedures on the female body.

CHAPTER FOURTEEN

Evaluation of the Research

The first section of this chapter describes some limitations of the present study, followed by recommendations for future research. Lastly, implications and salient issues arising from the current research are discussed with reference to clinicians and those working with infertile individuals.

LIMITATIONS OF THE STUDY

It is necessary to acknowledge the limitations in the use of a qualitative approach within the present study. The reliance on language can be seen as a double-edged sword. On one hand, it provides the means necessary in order to collect data that is rich in context for analysis, yet it also produces potential disadvantages as a tool for understanding. Spoken language – even though used for everyday communication - can be complex enough in its subtle undertones and inflections without the complications added by non-verbal body signals.

Expression of the experiences themselves can become an issue. In specific reference to the topic of infertility, it is important to note that, in discussing a sensitive area such as infertility, it may be difficult to access a participant's thoughts and feelings. Further, participants may not be able to articulate accurately the meaning of their infertility. General literature on gender comparisons in infertility suggests that women may be more expressive than men with regard to their experiences (Abbey et. al., 1991; Mahlstedt, 1985). In redressing this, the present study utilised a second separate interview with the male partner. This was in aid of providing an environment where he might feel more comfortable about expressing himself without concerns for his partner and her feelings.

To represent the perspective of the participants it is necessary to be aware of the potential for misunderstanding when using language (Ramsey, 1994). In addressing

this, it is essential to negotiate meaning throughout the research interview. Meanings are constantly checked out with the participants themselves. Reactivity to being studied occurs in qualitative research as it does in quantitative research, although this has not always been recognised (Bryman, 1988 cited in Ramsey, 1994).

The present study was further limited in certain areas. Of specific relevance here is the fact that the limited availability of participants may have impacted upon the findings.

Access to the sample population was limited by the availability of couples experiencing infertility who were willing to participate. As a consequence, the study focussed on the experiences of a small number of participants. Any emerging theory was subject to the viewpoint of just 10 couples. An increase in this number would have made the workload involved in the interviews unmanageable for the researcher.

However, grounded theory methodology has been developed as a way of obtaining from small samples of participants in-depth information from which more generalised studies with larger numbers and statistical power can be developed.

Further to this dilemma, the participants themselves were open to sample bias. Recruiting couples from infertility support groups and newspaper advertisements may have produced a skewed group of participants. These individuals were already well involved in the infertility process, having tried to conceive for at least a year, visited their family physician, and sought investigation and intervention treatment. Participants' willingness to share their experiences in a research study may bias the findings in that these couples may have somewhat already accepted the role infertility has within their lives. Indeed, when questioned as to their rationale for undertaking this study, some participants expressed a desire to inform and help others with experiences, as they themselves had reached a stage of 'understanding' regarding the threat infertility has upon their lives.

A qualitative approach was utilised primarily in order to provide participants with the opportunity to express their individual viewpoints. However, the limited time period involved for the interviews (occurring on the same day for male interviews) provided only what has been described as a 'snapshot' approach to participants' perceptions of their experiences with infertility at that point in time. Therefore, the specific time of these interviews was representative of their immediate perceptions, experiences and

lifestyle considerations. Descriptions were reliant upon memory, with emphasis on instances freshest in the memory affecting participants' perceptions of the phenomena at hand.

The researcher's gender, age, social status and background also influenced the grounded theory itself. The researcher, aged 22 (at the time the interviews occurred), is a European, and a University graduate from a middle socio-economic background. These factors may have affected the ease with which participants felt able to share their experiences. As previously discussed (refer to chapter 12 Gender Specific Experiences) some participants (primarily male) were noticeably ill at ease during certain stages of the interviews involved. Despite all endeavours made by the researcher to ensure participants were comfortable with the interview process, attempts to elicit in depth accounts of the lived experience of the infertility process from some men were not successful. While some male participants did openly share detailed descriptions of their experiences with the infertility process, others were less willing. As a result, the interviews were unable to draw out as much information as had been anticipated at the outset of this research. This impacted on the quantity of detailed extracts available to support the emerging themes.

The contextual factors listed with respect to the researcher would have also impacted upon her interpretation of the data, and the emergence of the grounded theory itself.

IMPLICATIONS FOR FURTHER RESEARCH

The present study opened avenues for further exploration into the field of infertility research, in relation to both the present study specifically, and the area in general.

The first of these implications upon research methodology relates to a more elaborate qualitative investigation into the contexts surrounding the adaptation to living with infertility experienced by couples. It would be possible for research to incorporate a larger sample size, thus extending the generability of the research.

Also, in an attempt to address concerns raised regarding the ease with which participants feel they are able to express themselves, participants could be matched to a

researcher whom they deemed an appropriate person with whom to share intimate details of their experiences (e.g. male participants to male researchers). This would promote an atmosphere conducive to eliciting in-depth accounts of what is a personal, and often difficult, subject to discuss.

Should the interview process itself be of concern, then information obtained within the present study may be utilised to generate a questionnaire exploring the issues raised by grounded theory and its generability to a larger population sample.

The population sample itself holds a variety of possible avenues for further research. Variations within the sample population hold specific relevance to two areas. Firstly, that of the immediate differences between specific participants experiencing different stages of the infertility process. Results obtained between different groups can be compared in relation to the present study as a means of investigating the presence of an actual process, within the phenomenon. Secondly, cross-cultural investigations on the larger scale would be relevant in exploring the importance of participant ethnicity upon the adaptation to living with infertility. Do factors such as the cultural importance of parenthood, even the definition of parenthood itself, affect an individual's reaction to the infertility as well as to their partner? Questions arise also regarding specific population areas. Urban versus rural perceptions of infertility (e.g. the farming quote elicited in the present study accepting infertility as part of nature, as well as the need for children to inherit the family farm). As a comparison between views held by populations who are adherents to strict birth control regimes (e.g. China) contrasting those populations with those who have liberal opinions on population growth (e.g. New Zealand) are research lines that pose decidedly interesting relevance to one's experience of infertility.

Reflecting upon the infertility area in general, the issue of adjustment to infertility in general can be considered on three distinct levels: the person who is diagnosed infertile, the partner of this person, or the couple who cannot conceive together. Each of these levels merits acknowledgment and attention within the research, as such factors may impact heavily upon the findings obtained.

Currently, it is unclear whether there are differences between individuals diagnosed as infertile and their presumed fertile partners. While these distinctions have not been acknowledged in the majority of the research conducted, there are plausible rationales

for expecting such differences. For example, although both parties are vulnerable to distress, holding oneself responsible for the couple's inability to have biological children could be guilt inducing, whereas perceiving one's infertile partner as responsible may engender anger. There may also be gender differences in male and female reactions to diagnostic responsibility. Initial evidence already suggests that female partners, regardless of the infertility factor involved, assume a responsibility for the couple's well-being, although such claims require further study. Current research makes very little distinction between the infertility factor involved in their participants' circumstances. Investigations into reactions between fertile and infertile partners themselves are nonexistent, a gap which future research could address.

With respect to gender issues, as noted, not all past studies on infertility have attempted to examine male and female experiences with infertility for gender effects. A further problem is that women's experiences have been studied much more than have those of their male partners. While preliminary research into male responses is relatively small in comparison to that into those of their female counterparts, results show that infertile men are equally distressed by their experiences. In reviewing the statistics on infertility, male and female contributing factors now appear to be comparable. Earlier research suggested that female factor infertility was more common. Given this new trend, it is important to increase the number of studies available on men - both with respect to the infertility factor, and with regard to their reactions as a fertile partner within an infertile couple. It is also imperative to report findings of gender differences when men and women are studied together. Compounding this lack of information, most studies do not take into account gender differences and the amount of time devoted to diagnosis and treatment within the experience. It has already been reported within the research that women initially seek treatment for infertility more than men, as well as carrying more responsibility for the treatment procedures involved. It is logical to suggest that gender differences would be expected due to the level of input invested into the infertility. This factor may underlie differences in distress for the couple. Another large area relating to the gender differences within infertility experiences relates to the gender specific value or importance of parenting in relation to coping. As discussed earlier in the present study, individuals placed varying degrees of

importance on parenting as a life goal or aspect of identity. It is necessary in developing an understanding of infertility reactions, specifically gender differences with these reactions, to investigate such claims further. Individuals who valued parenting highly were found to be more distressed if they were infertile than those who did not. The extent to which traditional gender roles dictate women should value parenting were found to indicate a socialised difference in the importance of becoming a parent. Untangling differences in gender roles, traditionalism and the strength of desire to become a parent, from gender differences in levels of distress, will go a long way towards clarifying distinctions in coping styles between men and women.

However, infertility is defining as an experience as it confronts not only the individual, but also the couple as a unit. Regardless of the cause, members of the couple experience the inability to conceive jointly, together make decisions regarding treatment avenues, seeking alternative options for achieving their goals if required, or choosing not to have children. Thus, research on life events that affect couples as a unit is relevant to studying adjustment to infertility (Dunkel-Schetter & Stanton, 1991). Within this, work on marital distress is pertinent to infertility. As infertility poses threats to a couple's joint goals and plans, disruption of marital functioning causing significant marital distress may be expected. Studies of couples' reactions to infertility are complicated by the fact that assessment tools and measures for studying couples in general have not been fully developed (Fincham & Bradbury, 1990, cited in Dunkel-Schetter & Stanton, 1991). It is important to note that within this research area, there is the necessity for research designs which address specific areas between the couple. The established literature does not clearly define events when researching into distressing situations experienced by the couple. Results obtained are, therefore, unable to accurately measure the level of distress that occurred - as each partner may be discussing individual and separate events.

Infertility represents a goal blockage for couples as a whole, together with the individuals involved. Each partner responds to it with their own personal perceptions, predispositions, experiences, and support resources. In turn, the reaction of each individual affects the functioning of the couple as they face decisions regarding their lives together. To gain greater understanding of adjustment to infertility, researchers

must examine the interrelationship of the couple as a unit as well as each individual's role within it.

IMPLICATIONS FOR TREATMENT AND COUNSELLING

The present research has ramifications for how physicians, counsellors, friends, and relatives might best respond to infertile couples.

The present study highlighted some practical implications resulting from the findings. Of major importance, it draws attention to problem areas in the delivery of infertility services. All couples interviewed for this study emphasised their desire for information regarding the treatment procedures involved in their cases, along with realistic statistics on the chances of their being successful in achieving a pregnancy. Within the treatment context, the sense of control experienced by the couples could be optimised by allowing them to make as many choices as possible regarding the scheduling of appointments and tests. The findings revealed the importance of couples' establishing a sense of primary and secondary control as essential to the psychological well-being of the couples. Difficulties were observed also with respect to the focus of infertility being primarily upon the female partner. While in most cases, given the nature of the phenomenon at hand, such a direction is required, it was noted to cause undue distress between couples. A lack of attention to emotional issues and non-medical aspects of infertility by physicians was reported by the participants, and was also considered to be a major issue. Some of these problems could be addressed by an integrated approach to infertility treatment. This idea is suggested in a two-fold manner. Firstly, treatment of men and women should be harmonised together. The couple, and not the individual, should be seen as the focus for treatment. This 'combining' should occur also with respect to blending medical aspects of infertility with the non-medical. Counselling should be included as a routine part of all infertility treatment, rather than being regarded as necessary for only the more technically advanced areas of assisted reproduction.

While the present research supports the concept of infertility being perceived as a process that unfolds within distinct stages, there are some risks associated with this

theory within the clinical arena. Conceptualisation of stages, especially those pertaining to adjustment to living with infertility, may in itself create expectations regarding appropriate behaviour. Although there may be perceived emotional advantages associated with finding benefits in infertility, it is important that support systems do not point out these behaviours or stages as being of potential benefit to individuals. While the infertile person may eventually achieve such perceptions on their own merit, when these ideals are offered as support gestures, they are often viewed as being unhelpful and inconsiderate to the individual's needs (Tennen & Afflect, 1990). Timing is important.

There may also be a need for clinicians to alter their techniques during interview sessions. Tennen, Afflect and Mendola (1991) observed that the traditional interview structure's use of open-ended questions did not fully capture individuals' beliefs regarding their experiences. They suggest that simply asking about causal beliefs did not produce the same findings as asking about specific causes. As such, the advantages of utilising open-ended questions in a clinical interview may be countered by the disadvantages surrounding the potential loss of important information. However, inquiring about perceived benefits of an experience may have diagnostic and prognostic value. A finding which emerged from the present study is that those individuals who believed that their infertility strengthened their relationship were observed to experience less emotional distress. These admissions were commonly observed to have been made by participants who had already reached, or were some way into the process of achieving an adaptation to living with infertility. In the clinical setting, such admission of the benefits of the infertility experienced by individuals still in the midst of the process would not usually emerge without the use of specific probes. Tennen and associates (1991) suggest that in asking about such benefits, "the clinician may be providing needed permission to examine the positive aspects of the infertility experience" (p.127). However, there appears to be a fine line between assisting versus leading individuals into areas which they are not ready to explore as yet. Health care professionals should not be too quick to bring meaning to an experience in the hope of attaining adjustment, especially when such meaning can lead the person down an avenue that may produce a premature closure to the process of adapting to the infertility.

In closing, in all infertility treatment, the couples' welfare, not a medical cure, should

be the primary goal. Counsellors need to discuss all options, not just medical treatment, with each couple. They must also be aware of, and help couples prepare for, the strain they may experience as a result of the potentially different reactions of each partner to infertility.

SUMMARY

Primary limitations of the present study were discussed. These concerns centered on issues raised by a limited population sample of only 10 couples. However, the grounded methodology has been developed in a way that addresses this concern. It was noted that sample bias and memory effects may have impacted upon the findings obtained in the present study. Of equal consideration to the validity of the study was the researcher herself. It was observed that not all participants were comfortable in sharing their experiences during the interview stage. This appeared to affect largely the male population. Not all male participants wished to discuss certain aspects of their experiences, especially those of an intimate nature, despite attempts by the researcher to elicit further in-depth information. This may be attributed to a natural reluctance in males to disclose personal feelings in general to anyone else apart from their partners, or preference not to share such experiences with a young female researcher. Implications for future research in this area also have been presented. There is a distinct need for future research to consider the effects of infertility upon the couple as a whole. Between partners, different aspects of their experiences (especially pertaining to gender roles) may be present that impact largely on both individual coping styles, as well as upon each other, and their joint decisions. In discussing ramifications of the research for those working with infertile couples, there was a noted need for an integration of service delivery. Couples require adequate information regarding the medical and non-medical options available to them, as well as appropriate support during this time to help them to achieve stages in dealing with the infertility with which they feel comfortable. It is the responsibility of all health professionals involved in their care to ensure that couples are equipped to deal with their experiences as well as what the outcome of these may bring.

References

- Abbey, A., Andrews, F. M., & Halman, L. J. (1991). Gender's role in responses to infertility. *Psychology of Women Quarterly, 15*: 295-316.
- Abbey, A., & Halman, L. J. (1995). The role of perceived control, attributions, and meaning in members' of infertile couples well-being. *Journal of Social and Clinical Psychology, 14*: 271-296.
- Anderson, K. A. (1989). Infertility: The silent crisis. *Canada's Mental Health, 3*: 9-12.
- Batterman, R. (1985). A comprehensive approach to treating infertility. *Health and Social Work, 10*: 46-54.
- Beaurepaire, J., Jones, M., Thiering, P., Saunders, D., & Tennant, C. (1994). Psychosocial adjustment to infertility and its treatment: Male and female responses at different stages of IVF/ET treatment. *Journal of Psychometric Research, 38*: 229-240.
- Benson, R. C. (1993). *Handbook of Obstetrics and Gynaecology*. California: Lange Medical Publishers.
- Berger, D. M. (1980). Couples' reactions to male infertility and donor insemination. *American Journal of Psychiatry, 137*: 1047-1049.
- Berger, K. S. (1983). *The developing person through the life span*. New York: Worth Publishers.
- Berg, B. J., & Wilson, J. F. (1990). Psychiatric morbidity in the infertile population: A re-conceptualisation. *Fertility and Sterility, 53*: 654-661.
- Berg, B. J., & Wilson, J. F. (1991). Psychological functioning across stages of treatment for infertility. *Journal of Behavioral Medicine, 14*: 11-26.
- Berg, B. J., Wilson, J. F., & Weingartner, P. J. (1991). Psychological sequelae of infertility treatment: the role of gender and sex-role identification. *Social Science and Medicine, 33*(9): 1071-1080.
- Bernard, J. (1972). *The Future of Marriage*. New York: World.
- Bernstein, J., Potts, N., & Mattox, J. (1985). Assessment of psychological dysfunction associated with infertility. *Journal of Obstetric, Gynaecological and Neonatal Nursing, 14*: 635-665.

- Boekemeier, J. L., & Monroe, P. A. (1983). Continued reliance on one respondent in family decision-making studies: A content analysis. *Journal of Marriage and the Family, 45*: 645-652.
- Brander, P. (1991). Infertility - a review of the literature on prevalence, causes, treatments, and prevention. *Discussion Paper 17*. Wellington: Department of Health.
- Bresnick, E., & Taylor, M. L. (1979). The role of counselling in infertility. *Fertility and Sterility, 32*: 154-156.
- Campbell, S. M., Dunkel-Schetter, C., & Peplau, L. A. (1991). Perceived control and adjustment to infertility among women undergoing in vitro fertilization. In C. Dunkel-Schetter & M. Lobel (Eds.), *Infertility: Perspectives from stress and coping research* (p.133-156). New York: Plenum Press.
- Cannell, C. F., & Kahn, R. L. (1968). *The dynamics of interviewing: Theory, techniques and cases*. New York: John Wiley & Sons, Inc.
- Clarke, L. F., Henry, S. M., & Talyor, D. M. (1991). Cognitive examination of motivation for childbearing as a factor for adjustment in infertility. In C. Dunkel-Schetter & M. Lobel (Eds.), *Infertility: Perspectives from stress and coping research* (p.157-183). New York: Plenum Press.
- Collins, A., Freeman, E. W., Boxer, A. S., & Tureck, R. (1992). Perceptions of infertility and treatment stress in females as compared with males entering in vitro fertilization treatment. *Fertility and Sterility, 57*: 350-356.
- Cooper, S. L., & Glazer, E. S. (1994). *Beyond infertility*. New York: Lexington Books.
- Daniels, K. R. (1989). Psychological factors for couples awaiting in vitro fertilisation. *Social Work in Health Care, 14*(2): 81-98.
- Daniluk, J. C. (1988). Infertility: Interpersonal and interpersonal impact. *Fertility and Sterility, 49*: 982-990.
- Daniluk, J. C. (1991). Strategies for counselling infertile couples. *Journal of Counseling & Development, 69*: 317-320.
- Draye, M. A., Woods, N. F., & Mitchell, E. (1988). Coping with infertility in couples: Gender differences. *Health Care for Women International, 19*: 163-175.
- Dunkel-Schetter, C., & Lobel, M. (Eds.). (1991). *Infertility: Perspectives from stress and coping research*. New York: Plenum Press.

- Elmer-Dewitt, P. (1991). Making babies. *Time International*, 39: 40-47.
- Erickson, E. H. (1950). *Childhood and Society*. New York: WW Norton & Co.
- Freeman, E. W., Boxer, A. S., Rickels, K., Tureck, R., & Mastrolanni, L. (1985). Psychological evaluation and support in a program of in vitro fertilization and embryo transfer. *Fertility and Sterility*, 43: 48-53.
- Gillette, W., Peek, J., & Lilford, R. (1995). Costs and effectiveness of infertility services in New Zealand: A decision analysis. Wellington: National Advisory Committee on Core Health and Disability Support Services.
- Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, California: Sociology Press.
- Glaser, B. G. (1992). *Basics of grounded theory analysis*. Mill Valley, California: Sociology Press.
- Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Gordon, A. (1982). Childless - and not by choice! *New Zealand Women's Weekly*, April 26.
- Graham, F. M. (1983). *Infertility: Therapeutic notes 192*. Wellington: Department of Health.
- Greil, A. L. (1991). *Not yet pregnant: Infertile couples in contemporary America*. London: Rutgers University Press.
- Griel, A. L., Leitko, T. A., & Porter, K. L. (1988). Infertility: His and hers. *Gender & Society*, 2: 172-199.
- Gunnell, D. J., & Ewings, P. (1994). Infertility prevalence, needs assessment and purchasing. *Journal of Public Health Medicine*, 16: 29-35.
- Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorising. *British Journal of Psychology*, 83: 97-111.
- Hughes, P. (1982) Psychological well-being as a outcome variable in the treatment of infertility by clomiphine. *British Journal of Medical Psychology*, 55: 375-377.
- Kast, V. (1988). *A time to mourn*. Switzerland: Daimon Verlag.
- Kirk, J., & Millar, M. (1986). *Reliability and validity in qualitative research*. Beverly Hills: Sage.

- Kraft, A., Palambo, J., Mitchell, D., Dean, C., Myers, S., & Schmidt, A. (1980). The psychological dimensions of infertility. *American Journal of Orthopsychiatry*, 50: 618-628.
- Kubler-Ross, E. (1969). *On death and dying*. New York: Macmillan Publishing Co.
- Lalos, A., Lalos, O., Jacobson, L., & von Schoultz, B. (1985). Depression, guilt and isolation among infertile women and their partners. *Journal of Psychosomatic Obstetrics and Gynaecology*, 5: 197-206.
- Leiblum, S. R. (1997). *Infertility: Psychological issues and Counselling strategies*. New York: John Wiley & Sons.
- Link, P. W., & Darling, C. A. (1986). Couples undergoing treatment for infertility: Dimensions of life satisfaction. *Journal of Sex & Marital Therapy*, 12: 46-59.
- Lilford, R. J., & Dalton, M. E. (1987). Effectiveness of treatment for infertility. *British Medical Journal*, 295, 6591: 155-156.
- MacNab, R. T. (1986). Infertility and men: A study of change and adaptive choices in the lives of involuntarily childless men. *Dissertation Abstracts International*, 47: 774a.
- McGrade, J. J., & Tolor, A. (1981). The reaction to infertility and the infertility investigation: A comparison of the responses of men and women. *Infertility*, 4: 7-27.
- Mahlstedt, P. P. (1985). The psychological component of infertility. *Fertility and Sterility*, 43: 335-346.
- Marshall, C., & Rossman, G. B. (1989). *Designing qualitative research*. Newbury Park: Sage.
- Mason, M. C. (1993). *Male infertility - men talking*. London: Routledge.
- Mathews, R., & Mathews, A. (1986). Infertility and involuntary childlessness: The transition to non-parenthood. *Journal of Marriage and the Family*, 48: 641-649.
- Mazor, M. D. (1984). Emotional Reactions to Infertility. In M. Mazor & H. Simmons. (Eds.), *Infertility: Medical, Emotional, and Social Consideration*. New York: Human Science Press.
- Menning, B. E. (1980). The emotional needs of infertile couples. *Fertility and Sterility*, 34: 313-319.

- Meyers, M., Diamond, R., Kezur, D., Scharf, C., Winchel, M., & Douglas, A. (1995). An infertility primer for family therapists: I. Medical, social, and psychological dimensions. Special Section: Infertility. *Family Process*, 34: 219-229.
- Miall, C. E. (1985). Perceptions of informal sanctioning and the stigma of involuntary childlessness. *Deviant Behavior*, 6: 383-403.
- Millar, R., Cruk, V., & Hargie, O. (1992). *Professional Interviewing*. London: Routledge.
- Mortimer, R. (1994). *The psychological effects of infertility: A qualitative study: A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Psychology at Massey University*. Palmerston: University.
- Mosher, W. D., & Pratt, W. F. (1987). Fecundity, infertility, and reproductive health in the United States, 1982. In *Vital and Health Statistics: Data from the National Survey of Family Growth, Series 23(14)*. Hyattsville: US Department of Health and Human Services.
- Nachtigall, R. D., Becker, G., & Wozny, M. (1992). The effects of gender-specific diagnosis on men's and women's response to infertility. *Fertility and Sterility*, 57: 113-121.
- Nicol, J. (1988). *Infertility: Causes and incidences in New Zealand*. Wellington: Department of Health.
- Nixon, N. (1985). *New birth technologies - an issue paper on AID, IVF and surrogate motherhood*. Wellington: Law Reform Division, Department of Justice.
- Oakley, A. (1981). *Becoming a mother*. Oxford: Martin Robertson & Co. Ltd.
- Oke, K., & Wood, J. (1987). The Role of the Social Worker and Nurse Practitioner in Infertility Care. In R. J. Pepperell, B. Hudson & C. Wood (Eds.), *The Infertile Couple*. New York: Churchill Livingstone.
- Pantesco, V. (1986). Nonorganic infertility: Some research and treatment problems. *Psychological Reports*, 58: 731-737.
- Paul, C., & Skegg, D. C. (1988). Contraceptive practice in New Zealand. *New Zealand Medical Journal*, 101: 809-813.
- Potts, M., & Selman, P. (1979). *Society and fertility*. London: MacDonald & Evans Ltd.

- Ramsey, K. E. (1994). *The spontaneous coping strategies of children who live with chronic pain: A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Psychology at Massey University*. Palmerston North: Massey University.
- Reading, A. E. (1991). Psychological intervention and infertility. In C. Dunkel-Schetter & M. Lobel (Eds.), *Infertility: Perspectives from stress and coping research* (p.183-196). New York: Plenum Press.
- Renezetti, C. M., & Lee, R. M. (1993). *Researching sensitive topics*. London: Sage.
- Roskilly, B. A. (1996). *How transsexuals cope with discrimination: A grounded theory: A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Psychology at Massey University*. Palmerston North: University.
- Russo, N. (1976). The motherhood mandate. *Journal of Social Issues*, 32: 143-153.
- Sandelowski, M. (1987). The color grey: Ambiguity and infertility. *IMAGE: Journal of Nursing Scholarship*, 19: 70-74.
- Sandelowski, M. (1988). Without child: The world of infertile women. *Health Care for Women International*, 9: 147-161.
- Sandelowski, M., Holdtich-Davis, D., & Harris, B. G. (1990). Living the life: Explanations of infertility. *Society of Health & Illness*, 12: 195-215.
- Seibel, M. M. (Ed.). (1993). *Infertility: A comprehensive text*. East Norwalk: Appleton & Lange.
- Seibel, M. M., & Taymor, M. L. (1982). Emotional aspects of infertility. *Fertility and Sterility*, 37: 137-145.
- Shattuck, J. C., & Schwartz, K. K. (1991). Walking the line between feminism and infertility: Implications for nursing, medicine, and patient care. *Health Care for Women International*, 12: 331-339.
- Stanton, A. L., Tennen, H., Affleck, G., & Mendola, R. (1992). Coping and adjustment to infertility. *Journal of Social and Clinical Psychology*, 11: 1-13.
- Stiles, W. B. (1990). *Narrative in psychological research*. (Visiting Fellowship Series No.1). Massey University: Psychology Department.
- Stoudemire, A., & Fogel, B. S. (1993). *Medical-psychiatric practice: Volume 2*. Washington D.C.: American Psychiatric Press, Inc.

- Strauss, A.L. (1987). *Qualitative analysis for social scientists*. Cambridge: University Press.
- Strauss, A.L., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, California: Sage.
- Taylor, P. J. (1990). When enough is enough. *Fertility and Sterility*, 54: 772-774.
- Tennen, H., & Affleck, G. (1990). Blaming others for threatening events. *Psychological Bulletin*, 108: 209-232.
- Tennen, H., Affleck, G., & Mendola, R. (1991). Causal explanations for infertility: Their relation to control appraisals and psychological adjustment. In C. Dunkel-Schetter & M. Lobel (Eds.), *Infertility: Perspectives from stress and coping research* (p.109-132). New York: Plenum Press.
- Valentine, D. P. (1989). Psychological impact of infertility: Identifying issues and needs. *Social Work in Health Care*, 11: 61-69.
- Zoldbrod, A. P. (1993). *Men, women, and infertility: Intervention and treatment strategies*. New York: Lexington Books.

Appendix A

INTRODUCTORY LETTER INFERTILITY: MALE AND FEMALE PERSPECTIVES

(Researcher's name)
(Researcher's address)
(Researcher's phone number)

(Date)

(Participants' names)
(Participants' address)

Dear *(name)* and *(name)*,

Thank you for your initial interest in the research studying the psycho-social effects of infertility, as mentioned by/in *(person, organisation, newspaper)*. Briefly, this study aims to talk to couples directly concerning issues of trying to conceive. Any information provided by you on your experiences will be extremely valuable, as it will add to our current understanding of infertility.

Please find enclosed a copy of the information sheet detailing the exact purpose of this study and what it involves. Also attached is a consent form. It is important to clarify here that all participation in this research is conducted on a purely voluntary basis, and any information obtained remains strictly confidential.

I will contact you further by phone in a few days time to inquire if you are interested in participating. If you have any questions or concerns, I will be pleased to address them at this time.

Your support is greatly appreciated, and I look forward to speaking to you soon.

Yours Sincerely,

Linh Hawke

Appendix B

INFORMATION SHEET INFERTILITY: MALE AND FEMALE PERSPECTIVES

Background Information:

My name is Linh Hawke and I am completing an M.A. in Psychology. My Thesis topic is studying the psychosocial effects of infertility on couples, with particular reference to men's experiences. I am working under the supervision of Cheryl Woolley, a senior lecturer from Massey University's School of Psychology.

I am seeking volunteers who would like to participate in my study. If you agree to participate, the following explains some relevant details about the study.

What is the Study About?:

In recent years, a wide body of literature and data has been amassed dealing with fertility issues. However, the vast majority of this information has largely focused on the experience solely from the woman's point of view. Unfortunately, from here, indirect observations only have been made concerning the men's experiences. To counter balance this, the objective of this research is to talk directly to men as well as their partners concerning issues arising during the process of trying to conceive.

What will You Have to Do and How Much Time is Involved?:

If you are willing, I will contact you in one week to see if you are interested in participating in this study. If 'yes', the attached consent form is to be signed and I will arrange a time to speak with you as a couple. An interview requiring 30 - 45 minutes of your time will be organised. This interview will consist of questions that will explore your experiences during your fertility investigations, the time following on from this, and where you are at now. After this, I would like to arrange a shorter time (15-20 minutes) to follow up some issues that may be unique to the male experience. If you agree, the interview will be audio-taped, but you will have the right to ask for the tape to be turned off at any time during the interview. All transcribing of these tapes will be done personally by me alone. No one else will have access to these tapes and they will be coded and stored in a safe place. They will be destroyed on the completion of the study. Once the research is finished, the study will be written in a manner which will be completely anonymous. This means that it will not be possible to identify individuals.

What Can You Expect from Me?:

If you take part in the study, you have the right to:

- * refuse to answer any particular question, and to withdraw from the study at any time;

- * ask any further questions about the study that occur to you during your participation;
- * agree/disagree to the interview being audio taped.
- * request that the taping be stopped at any time during the interview.
- * provide information on the understanding that it is completely confidential to the researcher. All information is collected anonymously, and it will not be possible to identify you in any reports that are prepared from the study;
- * be given access to a summary of the findings from that study when it is concluded.

You are very welcome to phone me at (*phone number*), or Cheryl at [REDACTED] ext. (*number*), if you require more information or wish to discuss this further.

Thank you for your interest, and I look forward to speaking to you soon.

Linh Hawke

Appendix C

INFORMED CONSENT INFERTILITY: MALE AND FEMALE PERSPECTIVES

PROJECT TITLE: Infertility: Male and Female Perspectives

PRINCIPAL INVESTIGATOR: Linh Hawke (B.A.)
Psychology Department
Massey University
Ph: *(phone number)*

SUPERVISOR: Cheryl Woolley (M.A., DipClinPsych.)
Senior Lecturer
School of Psychology
Massey University
Ph: 356-9099 Ext: *(number)*

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any time.

I also understand that I have the right to withdraw from the study at any time, and that I have the right to decline to answer any particular questions in the study.

I agree to provide information to the researcher.

I agree / do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I wish to participate in this study under the conditions set out on the Information Sheet.

Signed: _____

Date: _____

Signed: _____

Date: _____

STATEMENT BY INVESTIGATOR:

I have discussed with (*name*) and (*name*) the objectives of, and procedures involved in, this study.

Signed: _____

Date: _____

Appendix D

ETHICS APPROVAL LETTER INFERTILITY: MALE AND FEMALE PERSPECTIVES



MASSEY
UNIVERSITY

A L B A N Y

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF SOCIAL POLICY & SOCIAL WORK

1996

1/20/96,
1/20/96,
1/20/96 North.

Thank you,
Thank you for your amendments to the information sheet and consent form as requested following
discussion. The amendments mean that the project meets the University's ethical requirements as
required for research on human subjects is concerned and you should now proceed with the project. Best

Sincerely,

E. O'Brien
Chairperson, Human Ethics Committee.

Cheryl- ing

Appendix E

INTERVIEW GUIDE INFERTILITY: MALE AND FEMALE PERSPECTIVES

Areas For Discussion Are:

Designed from a combination of previous research, and what has been generally agreed upon as shown to be of importance, areas that are to be discussed here include;

Biography/Background Information

- * Pseudonym
- * Age
- * Career
- * Length of time trying to conceive

Motives

- * Whose idea was it to start trying for a family
- * Reasons for wanting a child
- * Number of children initially desired
- * Expectations (of having children before and after the fact)
- * Importance of parenthood

Diagnosis

- * Receiving the news (how)?
- * Reactions to the news of their infertility
- * Follow on effects on their lives
- * 'Identity crisis'? (Virility, Femininity)

Information Available

Experiences with the Medical Process

- * Dealing with medical tests and examinations
- * Stress of investigations
- * Coping with treatment (gender differences)
- * Menstruation
- * Quality of the medical service provided
- * Thoughts concerning the health care professional involved

Coping and Support Strategies (Mechanisms Utilised Between Genders)

- * Self-help
- * Partners and family
- * Support groups and agencies
- * Friends, family, work, etc.

Control over Infertility and Their Lives (Choices of Wanting, or Can't Have)

Beliefs and Attitudes

Relationships

- * Effects of trying to conceive on their relationship
- * Intimacy with the partner
- * Friends, family, work, etc.
- * Other pregnancies around you

Alternatives to ('Natural') Pregnancy (Thoughts and Feelings on)

- * Donor insemination, IVF, GIFT, etc.
- * Adoption
- * Remaining childless

No Longer Trying to Conceive

- * Was this decision ever made, if so, at what point
- * Reasons
- * Was there a re-evaluation with respect to a sense of purpose and meaning in their lives
- * Did they experience growth or had they become disillusioned or disappointed
- * What was their experience

Perceived Gender Differences Between Partners

Reflections, Goals and Further Aspirations

Comments Regarding the Interview (Anything that should be changed or added?)

This is a very flexible guide only. The importance here is to investigate areas and concerns which the participants themselves express as being of relevance to the experience of infertility.

Appendix F

TRANSCRIPT/FOLLOW-UP LETTER INFERTILITY: MALE AND FEMALE PERSPECTIVES

(Researcher's name)
(Researcher's address)
(Researcher's phone number)

(Date)

(Participants names)
(Participants address)

Dear *(name)* and *(name)*,

Thank you both for participating in an interview on *(date)*. As you know, information gathered at that time will be used in research examining the psycho-social effects of infertility on couples. The opinions and concerns you raised during our conversation were extremely enlightening, and will be of great help in my study. I appreciated your candour in discussing with me the intimate and painful details of your experience.

Firstly, please find enclosed a transcript of the interview for you to review. I would ask that you read through it, correcting errors, and noting any areas which you would like omitted. Also, feel free to add anything that may have been overlooked. This is purely to ensure that your experiences are captured accurately.

I have also enclosed a copy of your personal profile, detailing background information regarding your experiences with infertility. As you can see, I have substituted pseudonyms for your names so as to protect your identity. Again, I ask that you read this carefully, correcting anything that you feel necessary.

Enclosed a freepost envelope for you to return the transcript and profile. There is no urgency for this, so please take as much time as you require. I will contact you further by phone once I have received the required alterations. This is to discuss with you both the changes that you would like made.

I enjoyed meeting you both and found that I was able to learn a lot from listening to your experiences. Once more, thank you for your participation, and I look forward to speaking to you again soon.

Yours sincerely,

Linh Hawke