# THE PSYCHOSOCIAL EFFECTS OF INFERTILITY

## A QUALITATIVE STUDY

by

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## ABSTRACT

The psychosocial consequences of being infertile or involuntarily childless are diverse and far-reaching, touching all areas of an individual's life. Seven interviews were carried out to examine individuals' and couples' experiences of trying to conceive. The transcripts were qualitatively analysed using a grounded theory approach. The range of feelings and experiences reported confirmed the findings of earlier research. For some participants, indirect effects included alcoholism, depression and a suicide attempt. For others, the experience strengthened their marriage and their resolve to lead a fulfilling life. The people who experienced less distress were those who had received strong support from family and friends, had a career commitment and alternative life goals. Most participants related negative experiences with the medical profession. Insensitive and inappropriate comments from people generally were also reported. Analysis produced a model which illustrates the experience of trying to conceive as a process, with all participants experiencing a degree of sorrow and then finally moving to acceptance, new goals and growth. The study highlights the importance for people trying to conceive of having appropriate support, an empathic medical practitioner, a commitment to a career, outside interests, a strong marital relationship and alternative goals for the future.

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I give special thanks to all the participants in my study who gave up their time to talk about their experiences. I appreciate how painful it was for some people to disclose their stories and I am therefore very grateful for their participation.

Finally, thank you to my husband John and baby Stephen for being so understanding over the past months.

**This thesis is dedicated to my son**

**Stephen**

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# INTRODUCTION

Universally, procreation is considered an essential function of adulthood, providing both a foundation and reason for marriage. It is not surprising, therefore, that the childless are viewed as dysfunctional, abnormal and considered objects of pity. The infertile may go to great lengths to change their sterile state. From early times, the practise of fertility rites and worship of fertility goddesses have been recorded, while nowadays, people will submit to intrusive medical interventions to facilitate their goal.

The general aim of this study is to examine people's perspectives of how infertility has exercised its effects on the psychological and social domains of their lives.

In the following section, I discuss firstly my personal experience of infertility which provides an insight into my depth of understanding of and sensitivity for the area. It also serves to explain my interest in conducting the research. A brief summary of the incidence and definition of infertility is given. Following this, the research on psychosocial effects of infertility, both adverse and positive, are discussed along with gender differences. Five theoretical models are introduced and critiqued which lead into my rationale for using qualitative methodology and, specifically, a grounded theory approach.

## Personal Experience of Infertility

As discussed in the Method Section under 'Rationale for use of Qualitative Analysis - Grounded Theory', it is important for me, as the researcher, to disclose any personal bias, so the following autobiographical discourse serves to fulfil that requirement. It therefore follows that the use of the first person, as opposed to the objective third person, is adopted throughout the thesis.

The motivating force behind the selection of the topic of infertility for my Masters thesis, is my personal experience of infertility. For five years, my former husband and I tried to conceive. The experience of being constantly disappointed each month as my hopes of conceiving were dashed, led me to despair. The growing impatience with intrusive examinations, questions, tests, several laparoscopies, was heightened by the continual waiting; waiting for results, waiting for ovulation as well as the dread associated with waiting for my period. I was finally diagnosed as having endometriosis, a chronic, non-life threatening disease which can cause infertility. On the one hand, I chose to believe that I may be able to conceive one day, yet on the other hand, I would often think that the endometriosis may be preventing conception and that I really was infertile. The thoughtless and insensitive, yet often well-meaning comments passed by family and friends, evoked anger and often only served to isolate me from, what I considered, "normal" fertile people. The pain experienced from sitting in a gynaecologist's waiting room with obviously pregnant women was often too much to bear. At times I experienced bitter resentment and great distress.

We finally gave up trying to conceive and, not long after, my marriage finished. Fortunately, my husband had always been a very supportive and encouraging partner. He suggested I undertake university study in order to help broaden my future and equip me with the skills to develop a new career. I have never looked back. I am now finishing a Masters degree in psychology while also training to become a clinical psychologist. In the past few years, my self-esteem has risen, and I consider that I have become a more confident, competent and empathic woman. As I came to accept my infertility and change my picture of the future; a picture which no longer included children, I realised that I had experienced tremendous growth.

A few months into this study, I discovered, at the age of forty, I was pregnant. My partner and I received this news with total surpise and delight. I was amused to read Oakley's comment "It is a standard sociological and medical joke to have a baby while doing research on childbirth" (Oakley, 1979; p.3). However, it led me to re-evaluate my research. I considered it unethical and insensitive to interview infertile couples, who were trying to conceive, while I was pregnant. If I did not tell them, I would feel I was being deceitful and, if I did tell them, perhaps I was being insensitive. Furthermore, I had become increasingly

aware of the gap in the literature with respect to experiences and outcomes for people who were no longer trying to conceive. I decided therefore, if I focussed on an older group of people, say over 40 years of age, I would be gaining information on a under-researched group while also overcoming my personal, ethical dilemma. I believed that I would be able to be honest with this group and that they would be less affected by my situation than a younger group of participants. However, as explained further in the Procedure section, I ended up with a diverse group of participants, owing to difficulties in contacting people with my preferred criteria.

In January 1994, at the start of the second year of my study, I gave birth to Stephen - a baby who has brought great joy and enrichment to our lives.

**Incidence**

Between 8 - 20% of couples are infertile (Pfeffer & Woollett, 1983; Department of Statistics, 1990; Brander, 1992). Such information is often based on the increase of people consulting health professionals for diagnosis and treatment. On the other hand, implicit in the findings from a recent Danish study is an increasing rate of male infertility. The study found that over the past fifty years, men's sperm count has dropped significantly, possibly due to environmental pollution and this will no doubt result in a greater proportion of males experiencing difficulties in fathering children (The Dominion, 1992). Chlamydia accounts for 5.7% of the factors causing infertility (Brander, 1991). However, with society's current greater awareness of the importance of condom use, it is hoped that the next cohort of reproductive age may show a lowered incidence of the sexually transmitted infection. Brander (1991) notes, however, that there is insufficient data to support the claims that infertility is increasing.

**Definition**

The current accepted definition of infertility, is failure to conceive after one year of unprotected sexual intercourse (Griel, Leitko & Porter, 1988). However, it is noted that up to 72% of couples with unexplained infertility may conceive within two years without specific intervention (Hull et al. 1985). Templeton and Penney (1982) suggest that about 34% of people with primary infertility and 21% of those with secondary infertility will remain infertile after nine years of trying to conceive. Primary infertility relates to those who have never conceived and secondary infertility relates to those who have conceived, but are no longer able to conceive. The one year rule has been challenged with claims that it derives from infertility specialists "marketing experimental and expensive new reproductive technologies" (Faludi, 1991 p.28). Faludi's (1991) stance is debatable. If the one year rule was changed, for example, to two years, then people may have to wait an unnecessary long period of time before receiving help. A longer wait could add extra stress to their difficulties. At present, the one year wait does enable many people to find out what may be causing their infertility within a reasonable timeframe.

## Effects

The adverse effects of infertility are diverse and far-reaching, touching all areas of an individual's life. The realisation of the infertile state is characterised by feelings of surprise, denial, anger, isolation, guilt, grief, depression, lowered self-esteem and hopelessness (Menning, 1980; Pfeffer & Woollett, 1983). The psychological effects can impact negatively upon the quality of life as evidenced by the deterioration of physical and mental health, careers, social interactions and all facets of a couple's relationship (Bresnick & Taymor, 1979; Mahlstedt, 1985; Draye, Woods & Mitchell, 1988). For example, great stress can be placed on the sexual relationship, when sexual intercourse can become a chore, lacking spontaneity and pleasure (Seibel & Taymor, 1982). Elstein (1975) notes that the psychosexual problems caused by infertility chiefly comprise lack of libido, inhibition of orgasm and impotence. As Jindal and Dhall, (1990) note "Extremely goal-oriented sex results in the measurement of success or failure of sexuality in terms of the ability to produce a child rather than the pleasure derived from it" (p.223).

Before accepting the "consensus in the literature" on the elevated levels of emotional symptoms among infertile people, it is necessary to examine more closely the methodology. The following two studies exemplify problems relating to sampling, measurement and making assumptions. Problems of sampling show up in Bresnick and Taymor's (1979) study. In their evaluation of the role of counselling for couples undergoing infertility investigation and treatment, of the 212 couples that were offered counselling, only 62 or 29.2% accepted the referral. Each was given a questionnaire to evaluate emotional symptoms before and after treatment with just over a 50% return. Although results confirmed a high degree of emotional symptomatology, those particular people may well have been the people who needed counselling. The people who chose not to participate in the study may not have been experiencing the same degree of guilt, anger, frustration and isolation and possibly had a higher level of psychological adjustment. On the positive side, Bresnick & Taymor's (1979) study highlighted the beneficial role of counselling couples with emotional symptoms.

Andrews, Abbey and Halman's (1992) comparison of the dynamics of stress in fertile and infertile couples contain measurement problems. The infertile couples, married six years on

average, were questioned only with respect to the fertility problem, while the fertile couples, married three years on average, used a self-identified large problem to base their answers on. In this study, an assumption has been made that the fertility problem is the biggest problem in the infertile group's lives, while ignoring the dynamics of other issues.

For some people, the experience of infertility can lead to positive change and growth (Mahlstedt, 1985) with resolution leading to renewed vigour, an altered perspective on life and the search for an alternative life plan (Menning, 1980). As discussed earlier, my personal experience testifies to this, showing that an altered life path engendered personal growth, a positive outlook and a sense of meaning, essential factors in my psychological wellbeing. Drawing retrospectively from my own experience, I consider that the attainment of such positive outcomes requires insight, meaning, social support and, for some of us, counselling. Dunkel-Schetter and Stanton (1991) claim that there is no particular pattern for adjustment to infertility as differing factors leave certain individuals more prone to distress than others. Hence, counselling would need to be individually tailored to address specific issues of an individual's infertility distress.

Previous research has focused on the experiences of people who were currently trying to conceive, particularly those receiving infertility treatment. Much emphasis has also been placed on the negative effects associated with infertility and, particularly with quantitative research, there has not been the opportunity for people to disclose any positive experiences. On the other hand, Menning's (1980) and Mahlstedt's (1985) discussions on the positive aspects of the infertility experience stem from their counselling and attending to people with infertility. Their observations give weight to the credence of qualitative study. People are able to discuss their feelings and experiences, rather than being limited to answering questionnaires relating to negative psychosocial effects.

If researchers only look for adverse effects to confirm their hypotheses, they will certainly miss the beneficial aspects. A possible example is when a couple comes closer together after sharing and working through a major problem. Drawing upon my own history, I also realised that perhaps positive experiences and outcomes are more likely to occur after one has given up trying to conceive. Cross-sectional studies do not show temporal changes in psychological

wellbeing and as there does not appear to be any substantial longitudinal research, we are not seeing the whole picture.

**Gender Differences**

There are gender differences in the ways people respond to their infertility. As Greil, Leitko and Porter (1988) assert, it is essential to understand the mediating effects of gender on infertility to fully appreciate couples' experiences. Greil et al.'s (1988) qualitative study found that women experienced infertility as a devastating role failure which led them to withdraw from contact with the "fertile world" while men viewed it more as a "disconcerting event" (p.191). Women became very focused on their infertility problem and, unlike their partners, would be prepared to take whatever steps necessary to conceive. This problem-focused coping approach is also supported by other studies (Draye et al, 1988; Abbey, Andrews and Halman, 1991), with women also tending to use more emotion-focused coping than men (Draye et al, 1988; Abbey, Andrews & Halman, 1991).

Overall, women tend to perceive infertility as more stressful than men, thus experiencing higher distress (Brand, 1989; Abbey, Andrews & Halman, 1991; Wright, Bissonnette, Duchesne, Benoit, Sabourin & Girard, 1991), resulting in lower self-esteem (Draye et al, 1988; Wright et al, 1991) and higher levels of anxiety and depression (Wright et al, 1991). Bresnick and Taymor's (1979) research showed that females experienced guilt, anger, frustration and isolation more intensely than males. Andrews, Abbey & Halman (1992) found that the fertility problem did not cause more stress on marriage for men than any other problems, while, for women, infertility had stronger effects on sexual self-esteem, sexual satisfaction and self-efficacy than other problems.

Kedem, Mikulincer and Nathanson's (1990) study showed that infertile men had lower levels of self-esteem and higher levels of anxiety than fertile men, while Callan and Hennessey (1988) found that infertile women and mothers did not differ significantly on measures of self-esteem. Infertile women did report a sense of unfulfilment, loss of control and less satisfaction in their lives. Callan & Hennessey's (1988; 1989) subjects were part of an IVF

programme and it is important to bear in mind that the rigours of this long-term medical intervention calls for psychologically, well-adjusted couples who have a strong commitment to their relationship. Results of Downey and McKinney's (1992) study of white, middle-class women in the initial stages of infertility investigation and treatment, showed that although emotionally distressed at their inability to have children, the psychiatric symptomatology of infertile women did not differ from controls. They also reported being more happy with their marital relationship than did the control group.

Wright, Allard, Lecours and Sabourin (1989) in their review of the literature, found consensus among researchers that infertile people experience significantly higher levels of psychosocial distress than control groups. However, there are salient factors which need to be considered before drawing such conclusions from infertility studies. These factors are whether the infertility is primary or secondary; whether the couple has adopted children; if they are currently receiving medical treatment; the presence of social support and/or counselling; if a cause for infertility been diagnosed and, if so, is it a female, male or shared problem and finally, what is their stage of infertility, that is, how long have the couple been trying to conceive, or are they no longer trying. Other interacting factors such as people's perceptions, expectations and attributions, should also be taken into account. As noted earlier, the methodology of some of the studies is limited, particularly where the subjects do not form a representative sample of infertile people and from whom generalisations have been drawn.

## Summary

The experience of trying to conceive can lead to psychosocial distress, affecting all areas of a person's life. Research shows that it is during this experience that individuals may withstand adverse psychological effects. The small amount of qualitative research proposes that people can also experience positive effects, characterised by growth, resolution and a new perspective on life. The positive effects tend to be experienced longer term. Some people may benefit from counselling to help them cope with the stress of trying to conceive. The

diversity of factors which can impact upon an individual's psychological well-being signals the need for a counsellor to attend to the individual's specific needs. The studies to date have been predominantly quantitative and cross-sectional, some containing sampling and measurement problems.

## THEORETICAL MODELS

The experience of infertility is characterised by a range of responses. Researchers have attempted to fit the experience of infertility into differing theoretical models, but owing to its chronicity and complex nature, infertility does not yield easily to such manipulation. While some people's experiences may conform to a particular model, other individuals' experiences may partially fit or not conform at all. A brief overview follows on the grief model, situational crisis model, developmental theory, cultural paradigm and the medical model. These models seem to constitute the main paradigms used in the literature to help further understand the experience of infertility.

### Grief Model

The following discussion critiques the bereavement stages of the grief model as this paradigm is often used when discussing the experience of infertility (Menning, 1980; Mahlstedt, 1985). Menning (1980) asserts that grieving is "the appropriate and necessary response" (p.316).

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

The initial stage is characterised by shock, the unexpectedness of the loss, numbness, disbelief and denial. Kast (1988) contends that the reactions of numbness and denial stem from an individual not coping with the overwhelming emotion associated with the shock. A person who is experiencing a fertility problem may well deny such a problem, but does not suddenly experience infertility. It is a gradual realisation over time, so, unless a physical trauma had suddenly rendered a person infertile, an individual is highly unlikely to experience this stage of shock. This observation is drawn from my own personal experience and from discussions with other infertile people. To be able to grieve, a person must experience a sense of loss.

The stage of anger, or emotional chaos (Kast, 1988) can be accompanied by despair, fatigue, sadness and helplessness. These reactions are experienced by many infertile people. As most people's infertility is inconclusive, these feelings may be delayed if they believe they may still be able to conceive. Grief reactions are more likely to be experienced after some duration of trying to conceive. While many people may experience a feeling of loss related to a potential child, others may not have reached that stage as they think "maybe this month we will conceive".

The anger and anxiety associated with separation reactions also reflect an acknowledgement of loss. Rarely is a couple told definitively "you will never conceive" and, consequently, the recognition of a loss, may take a couple of years or more. Present day technology offers greater hope for infertile people compared to several years ago. As 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 next stage is sometimes known as a phase of searching (Kast, 1988) where the person longs for the lost object and is subject to much weeping. Some infertile people may experience this but on a different dimension. The yearning is for the child that might have been rather than something they have lost. In extreme cases where a woman is obsessed with having a child, she may take another person's baby, which may exemplify the searching phase. For other people, this stage may be characterised by a preoccupation with making preparations for a baby, for example, buying nursery furniture and baby clothes.

The reintegration or resolution stage relates to the acceptance of a loss, or, in some cases, the development of pathological outcomes. As discussed earlier, infertile people may take many years to accept their infertility. The experience may therefore be open-ended and ongoing, with the loss of control over fertility leading to a sense of helplessness and depression. Menning (1980) talks of this common problem as 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 to 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.

Sandelowski (1988) considers the grief model a limited framework as "the emotional responses to infertility do not follow a sequential pattern" (p.159). On the other hand, the model is a useful paradigm from which to understand the psychosocial effects if infertility is construed as a collective loss. The losses commonly held to be causal in the etiology of depression are also experienced by infertile people (Mahlstedt, 1985). The collective loss refers to those of a relationship, health, self-esteem, self-confidence, competence, control, fantasy, security and the "loss of something or someone of great symbolic value" (Mahlstedt, 1985, p.340). The latter refers to the child that will never be; the loss of the potential family. It is not tangible and, particularly when infertility is inconclusive, true 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.

To summarise, the grief paradigm goes some way to explaining the experience of infertility, but as infertility is not sudden, definite or tangible, the model fails to capture some of the characteristics.

**Crisis Model - Situational Crisis/Life Crisis**

Infertility as a situational crisis presupposes a short-lived experience and implies the concept of illness (Sandelowski, 1988) thus limiting its utility as a model. For 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. Viewed in this light, the crisis can be seen as an opportunity for learning new coping patterns, for developing insight and for growth and change. For many

people, the state of disequilibrium poses a threat of maladaptive functioning, particularly with the possibility of multiple crises throughout medical intervention.

Menning's (1980) discussion focuses on the experience as a life crisis, which is a better description of infertility, for some individuals, than a situational crisis. Menning (1980) notes that couples do not usually go into crisis at the same time, so when one partner is dysfunctional, they may believe the other does not understand. Differing styles of coping can also cause misunderstanding and resentment (Abbey, Andrews & Halman, 1992) with the resulting breakdown in communication driving a wedge between the couple as they are less able to attend to each other's needs. Men often find it difficult to express their sadness and disappointment which can lead to their partners mistaking their silence for not caring (Mahlstedt,1985).

The extreme consequences on a marriage may be divorce, while Durkheim (1951) found that suicide among childless couples was twice as high as among couples with children. In his discussion about counteragents against suicide, Durkheim asserted that "the family is the essential factor in the immunity of married persons...this immunity even increases with the density of the family, that is with the increase in the number of its elements" (p.198). I am not able to comment on whether this claim holds true for today.

As discussed in the grief model, 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 of fertility. The situational crisis model certainly does not fit into the realm of infertility.

### Developmental Crisis

Infertility is commonly viewed as a developmental crisis (Kraft, Palombo, Mitchell, Dean, Myers & Schmidt, 1980) particularly in terms of Erickson's (1950, cited in Draye, Woods & Mitchell, 1988) developmental theory. Failure to achieve the adulthood task of generativity can lead to self-absorption and stagnation while non-resolution may hinder progression to the

next developmental stage of integrity, where people try to find meaning in their lives (Berger, 1983). In this context, generativity refers to adults performing meaningful and productive work and raising a family. For those who successfully resolve this developmental crisis, meaning and fulfilment can be achieved through other avenues. 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 (Potts & Selman, 1979). Most societies tend to focus on the importance of children and, for those who are childless, they are made to feel that they have somehow failed to fulfil their life's role.

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. The developmental model can be used to conceptualise infertility if one considers infertility as a "failure to achieve the adulthood task of generativity", especially if generativity equates with procreation. However, if infertility is seen as just another one of life's hurdles or an adjustment to be made, the developmental model may not give a complete explanation. Generativity does not have to be achieved by having children. Some people choose not to have children and are not developmentally retarded. Employment, fostering an interest in community issues, fundraising, environmental conservation are a few examples of activities which can fulfil the task of generativity.

## Cultural Paradigm

Compared to other theoretical models, the cultural paradigm takes better account of contextual factors, attending to both personal and sociocultural experiences of the individual (Sandelowski, 1988). People have internalised social norms which direct them to have children and fulfil the parental role. For those who fail to achieve this role, it is as though permission is denied to enter the dominant culture and, instead, they are forced to join a "deviant subculture" (Sandelowski, 1988, p.148). Matthews and Matthews (1986) propound the idea of involuntary childnessness involving a "major reconstruction of reality by both partners" and often by their families and friends (p.643).

The following examples illustrate cross-cultural differences in terms of the context in which people experience infertililty.

In North American society, Miall (1985) claims that childlessness is viewed akin to a physical disability provoking stigmatization by the rest of society. Jindal and Gupta's (1989) account of the social problems of infertile women in India highlight 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.

Failure to conform to society's expectations can 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, menstruation (Sandelowski, 1988) or even just standing in the check-out queue in the supermarket. Such reminders reinforce a sense of being apart and not belonging.

Shattuck and Schwarz (1991) point out that traditionally, women have been held accountable for a couple's infertility, explained by delayed childbearing, sexual promiscuity and inappropriate use of contraceptives. Inferences are thus drawn that infertility is self-imposed and results from poor decision-making in the past. Women are also the primary targets for medical intervention in the treatment of infertility, resulting in a greater assumption of

responsibility for both their own and their partner's fertility, leaving them at increased risk for psychological distress and physical damage (Shattuck & Schwarz, 1991).

Understanding infertility from this model, puts the experience in context; a context of being different, of failing to meet societal expectations and of changing life goals and personal aspirations. All these factors can contribute to overwhelming stress and unhappiness.

**Medical Model**

Medical professionals tend to view infertility as a medical problem, a dysfunction which needs to be cured. The medicalisation of infertility overlooks the accompanying social factors and imposes the notion of sickness upon women. Becker and Nachtigall (1992) claim that the high value placed upon children in society is the essence of the medicalisation of childlessness. Sandelowski, Holditch-Davis and Harris (1990) express it well "infertility is a situation frequently only inferred from the absence of an event, conception and birth, rather than documented by the presence of disease" (p.198). The medical practitioner's role, therefore, is to do his or her utmost to bring about a pregnancy. As Mahlstedt (1985) notes, medical personnel are trained to minister to the physical side of the problem and are not equipped to deal with the psychological aspects. The longer couples are involved in medical investigations, the greater the strain, particularly with respect to their marriage and sexual functioning (Berg & Wilson, 1991). Berg and Wilson's (1991) study found that during the first year of medical investigation, couples' marital and sexual relationships were stable but did suffer from stress which manifested in depressive symptoms. In the second year, emotional strain was lower, but by the third year, psychological stress had increased while marital adjustment and sexual functioning had markedly decreased. It is important, therefore, to be aware of what stage of infertility couples are in, when interpreting or making generalisations from studies of psychological effects of infertility. It is also important to bear in mind that the distressing effects of infertility may be caused not only by the infertility itself, but also by long-term, intrusive medical procedures.

The medical paradigm is an inadequate model for infertility. It assumes a pathological stance and does not account for psychological or social issues contributing to etiology. As discussed briefly above, medicalisation of the problem, can itself lead to emotional symptomology. Such distress may, in turn, further exacerbate problems with attempts to conceive.

Owing to the multi-dimensional nature of the experience, the above models are inadequate in their portrayal of infertility. While they tap into some facets which may exemplify some people's experiences, they do not illustrate the total picture. Most models do not deal with contextual factors adequately, if at all. Infertility has been addressed more as an event, rather than a process.

The predominantly scientific, rigid methodology used to research infertility, fails to provide a holistic view as the effects of infertility may represent more to an individual than not having a child. If, for example, research shows that those who are unable to conceive are significantly more depressed than those who are not, what does that tell us? What is it exactly about infertility that 'causes' depression? Is it the loss of a picture of the future; is it the effects of prolonged stress or disappointment; is it a feeling of being different from the norm or perhaps a feeling of having failed? Finding answers to these questions may enable health professionals to better understand the dynamics of trying to conceive and thus better attend to the psychological needs of people wanting a child.

I decided that the only way to be able to answer these questions was to invite people to relate their stories in their own words. The less formal approach of having a conversation can help people disclose their feelings and experiences.

# METHOD

## Rationale for use of Qualitative Analysis - Grounded Theory

Although quantitative research has generated much data about infertility and its effects, it has tended to reduce the experience to one or two dimensions. For example, some psychological effects such as depression and lowered self-esteem, can be manifested secondary to the primary consequences of infertility, a fact which can be missed in a quantitative study. Qualitative research, on the other hand, can make better sense of interacting variables which imply non-linear causality (Stiles, 1990) while data collection permits inclusion and analysis of both variation and consistency of accounts. The traditional positivistic approach can fail to grasp the complex dynamics of psychosocial functioning with the superimposed effects of infertility. The psychosocial effects of infertility need to be considered contextually.

The less structured style of qualitative research opens the way for spontaneity, flexibility and open-endedness (Dooley, 1984). This contrasts with the hypothetico-deductive model which, though useful for testing hypotheses, suggests that the researcher already has an expectation of what he/she is going to find (Kirk & Miller, 1986). Testing hypotheses is not always appropriate to a particular research question and further inhibits insightfulness and thus the emergence of new discoveries and models.

Non-quantitative methodology allows interpretation of the data within its particular context. Specifically, the application of grounded theory, as adopted in the present study, can guard against "the opportunistic use of theories that have dubious fit and working capacity" (Glaser & Strauss, 1967, p.4). Grounded theory employs "a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon" (Strauss & Corbin, 1990, p.24). Conceptual categories abstracted from the data are gathered from intense analysis, involving comparison and provisional testing of the data. For example, once a relationship between categories emerges, the researcher then examines the data for further verification as well as seeking out conditions when such a relationship may not exist. Strauss and Corbin (1990) point out that rather than disproving such statements of relationships, these instances qualify

and add depth and variation to theory. The aim, therefore, is to develop a theory which is "conceptually dense and that has specificity, plus enough theoretical variation to enable it to be applied to many different instances of any given phenomenon" (Strauss & Corbin, 1990, p.109).

Data collection in grounded theory can involve in-depth interviews, field-work observation and analysis of documents. My research lends itself to in-depth interviews, so my rationale for the use of grounded theory is focused on the interview.

Grounded theory reflects the way people view their situations and interactions, and strives to uncover "social-psychological problems and processes" (Wilson & Hutchinson, 1991, p.266). New models or theories are generated while remaining true to and illustrative of the event being studied (Strauss & Corbin, 1990). Stiles (1990) suggests that "apollonian discourse (story) in scientific reports might capture underlying causal mechanism of human behaviour better than senex discourse, (theory) albeit implicitly" (p.49). Thus, people's stories can convey useful information of which they have direct knowledge, thereby enabling the researcher to extract a theory by analysing the stories.

With grounded theory, data collection does not stand alone. Analysis of the data and evolving theory can develop alongside the data collection (Strauss & Corbin, 1990). One of the strengths of the in-depth interview is the opportunity to ask follow-up questions (Marshall & Rossman, 1989) and to clarify or enlarge upon particular points. On the other hand, Marshall and Rossman (1989) point out that interviewers may bring personal bias to the interview. This situation cannot be totally avoided, and, as long as the researcher's relevant personal experience is disclosed at the beginning of the study, then the researcher, the participant and the reader will all have better awareness of possible bias when analysing, participating and critiquing, respectively. As Stiles (1990) states, a good researcher should be seeking disconfirming evidence of his or her expectations anyway. Grounded theory offers techniques which help guard against our assumptions and biases being imposed on the data, thus enhancing theoretical sensitivity.

Oakley (1981) asserts that the best way of uncovering people's experiences through interviewing is when there is a non-hierarchical relationship between the researcher and participant and "when the interviewer is prepared to invest his or her own personal identity in the relationship" (p.41). This fosters a situation where the interviewer is allowed to enter into the interviewee's life and learn of their experiences. In my study, my personal experience of infertility was able to break down the barriers often associated with a researcher and participant. The interview became more like a conversation, with both parties being able to share experiences.

One of the advantages of using grounded theory is that no particular structure is imposed upon data analysis. Psychological terms such as 'coping strategies' or 'mediating variables' which might carry certain assumptions, are thus avoided. For example, one of my participants relates how he became an alcoholic, attributing his addiction to the discovery of his infertility. It would be easy, in psychological terms, to interpret this as a coping strategy and consequently become blinded to alternative explanations. In his case, it was also a consequence of being told "to be a real man, you have to father a son, drink booze and play rugby". Relationships between variables are thus explored, always bearing in mind that they can take on a different status; in one relationship a factor could be an antecedent, at the same time being a consequence or influencing factor in another. In quantitative analysis, linear relationships are often sought and, in so doing, non-linear, or circular relationships are missed. My study is essentially looking at a process, along a time line. Consequences occur at certain times, evolve and become antecedents for a different set of consequences.

Grounded theory ensures that the building of theory pertains directly to the area of study and that generation of new dimensions and discovery of relationships between variables can be fostered. Illustration of and support for new categories and relationships between concepts are provided by direct quotations from the interviews. Models which have been used formerly as a framework from which to research infertility have not taken account of the process of the experience. The use of grounded theory enables the researcher to elicit information spanning a number of years and not reducing the dynamics of infertility to one event.

The present study examines the psychosocial effects of infertility in order to discern patterns in both individuals' and couples' experiences and so guide the structuring of a theoretical framework. Prior research has focused mainly on women's experiences and, to some degree, on differential experiences between genders. The present study examines both individual and couples' accounts. A further area of concentration is the temporal effects of infertility and is reflected in the diversity of participants.

As the present study involves in-depth interviewing, it is essential that the researcher has theoretical sensitivity (Strauss & Corbin, 1990), good listening skills, good interpersonal skills and is adept at framing questions (Marshall & Rossman, 1989). I have developed theoretical senstivity through previous reading of the literature as well as personal experience of marriage and infertility. Such prior experience facilitates insight and ability to make sense of the data in conceptual terms, along with heightened sensitivity to the subjects' experiences (Strauss & Corbin, 1990). My experience can also be used as a comparison with that of others', which may illuminate new meanings and relationships. Stiles (1993) believes that the researcher's experience can facilitate empathy which in turn can help make meaning of other people's experiences. I am also a trainee clinical psychologist who has had good training in listening skills, together with many years' experience of skilled personal interaction outside the academic setting.

The study lends itself to qualitative research to disclose new slants, illuminate prior quantitative findings, and to interpret events as they are reported contextually. Grounded theory has enabled me to find out what the experience of trying to conceive has been like for some people. The data, although retrospective, gives a sense of the process of trying to conceive, rather than viewing this as a one off event.

## Procedure

The following sets out the procedure of this study, covering the areas of participant recruitment, interview conduct and interview follow-up. More detailed information can be accessed from the relevant appendices.

Before any participants could be recruited, a detailed proposal was first submitted to and approved by the Massey Human Ethics Committee. (See Appendix 1)

### Participant Recruitment

Advertisements were placed in the local Palmerston North papers, namely the Tribune, Guardian and the Evening Standard. One was also placed in the Massey University weekly publication, MU, and another advertisement was posted on the noticeboard at the local Palmerston North Women's Health Collective rooms. A few interested people made contact from the local advertisements, but only one was suitable. No replies were forthcoming from either MU or the Women's Health Collective.

When I found I was pregnant, I changed the focus of my study to only interview people who were no longer trying to conceive. No volunteers were forthcoming from this group, despite further advertising and word of mouth inquiries. A revised information sheet (see Appendix 2) was drawn up outlining my position and inviting any people who were, or had been experiencing conception difficulties and who were not uncomfortable with being interviewed by a pregnant woman, to participate in the study. Subsequently, contact was made with the Manawatu Infertility Support Group. The President offered to send out to members the revised information sheet, together with her supporting letter. In this way, I overcame any ethical dilemmas, as potential participants were informed of my situation before ever meeting or talking with me. If they felt uncomfortable with my pregnancy, they did not contact me. This approach yielded a little response, sufficient to make up the minimum number of participants. Finally, the seven interviews derived from two responses to newspaper advertisements, three from the Infertility Support Group and two from word of mouth

inquiries. Four of the interviews involved couples who were interviewed individually and then together, while the other three interviews were individual participants.

I also had a brief conversation with a 92 year old woman who agreed to participate in the study. However, as she was about to have surgery, she decided not to go ahead with the scheduled taped interview. She was quite agreeable for me to use what we did talk about in my study. As this contribution was not recorded, I have not included her among the other participants, but do make reference to the conversation.

The volunteers from the newspaper advertisements and by word of mouth, were initially informed about the research over the telephone. On indicating that they wished to participate, an information sheet and consent form was posted to them, while also being advised that they could withdraw from the study at any time. An appointment to conduct an interview was made, which was later confirmed by a further telephone call. The volunteers from the Infertility Support Group responded to the information sheet by sending back a form indicating their interest. A telephone call was made to answer any queries, subsequent to which an appointment was made. A further telephone call was also made to confirm this appointment, while also informing the participants of their right to withdraw from the study at any time.

During each initial telephone conversation, I discussed the situation of my pregnancy. Each person stated that they would feel quite comfortable being interviewed by me, some adding that they would be pleased to have the opportunity to talk about their experiences with someone who had been in a similar situation. One person said my experience made her feel that there was indeed a light at the end of the tunnel. I made a concerted effort to ensure that a reasonable rapport was established during the first telephone conversation.

### Interview Conduct

At the interview, a consent form (Appendix 3) was obtained from the participant. Each person was asked to choose a pseudonym. Some of the participants were happy for their real names

to be used, but I decided that they would all be given pseudonyms. Before recording the interview, ten to fifteen minutes were spent on building rapport and informing the interviewee of areas which would be covered in the interview (Appendix 4). I chose these areas in order to give a broad framework to the discussion, while still giving people the room to discuss any other aspects of their experiences. I stressed this point to each participant. Each person was also encouraged to freely express their emotions throughout the interview. A brief mention was also made of my pregnancy, as I considered that acknowledgement of it may help reduce any barriers.

Each interview took approximately an hour, terminating when each party felt they had said all they had wanted. Rapport had been sufficiently established for the interview to take more the form of a conversation, with sometimes mutual sharing of experiences. After the interview, at least fifteen minutes was spent in winding down the discussion. Often people felt the need to continue talking about their experiences, not necessarily directly related to their conception difficulties.

**Interview Follow-Up**

Within five days, I had transcribed the tape and posted a copy with a covering letter (Appendix 5) to the participants. I requested the return of the transcript within a few weeks. I felt it wise not to put pressure on having it sent back too quickly as, for some people, reading their personal disclosures may have been quite painful and not something they wished to attend to directly.

I met up with two individual participants again, at their request. Agapanthus called in one day for coffee and was keen to hear how the study was progressing. Anna invited me to have a further chat about our experiences after she had read through her transcript. We also met for lunch on one occasion.

All participants sent back their transcripts, most with very few amendments.

en I started the analysis of the transcripts, I realised that the reasons for wanting a child y have a bearing on how people later react when finding they may not be able to have ldren. For those participants who had not already discussed this aspect, I rang and asked m to write down their reasons for wanting children and to post these back to me. They willingly did this.

## EXPERIENCES OF PARTICIPANTS

The following outlines the participants' experiences with respect to trying to conceive, subsequent events and contextual factors. I have put the age of each person at the time of the interview in brackets after their name. These vignettes have been set out in the order in which I conducted the interviews. I have written people's stories in a rather 'chatty' vein, in order to preserve and convey the way they related their experiences to me.

**Agapanthus** (68)

At 22 years old, Agapanthus married a very military-minded, domineering man who had just returned from the Second World War. She did not find out until their wedding night that he did not want children and said that if she had known this prior to their marriage, she would not have married him. Agapanthus worked as a school dental nurse, a job she really enjoyed, particularly for the contact it gave her with young children. After about eight years, Agapanthus decided to do a "little changing of my dates" and consequently became pregnant. Her husband became very upset and verbally abused her. She lost the baby at 3 months, which she attributes to his abuse. She went on to lose two more babies, the last one at six months and, by this stage, the abuse had become physical. A few months later, Agapanthus contracted rheumatic fever and later, glandular fever. She believes these illnesses were a direct result of losing the babies and her husband's abuse.

Although the school staff were very supportive towards Agapanthus during this period, she never confided the abuse she suffered nor her unhappiness within the marriage. She also did not talk to her parents or sister about her unhappiness as she did not want to upset them. Later, she talked to an elderly aunt and told her she wanted to leave her husband, but the aunt told her to be loyal and stay with him.

Agapanthus continued in this very unhappy marriage, suffering verbal and physical abuse. At the age of 60, she resigned her job of dental nurse and decided to start living her own life.

She went off on holidays without her husband, learned how to drive, and continued to take comfort in her embroidery. At the age of 64, with the help of a solicitor, Agapanthus finally left her husband.

Since the separation, Agapanthus has really enjoyed living life to the full. She says she feels happy and positive, although a little sad at times that she has not got grown up children or grandchildren.

**Anna** (40)

When Anna was 25, she became pregnant and had the pregnancy terminated. It was a distressing experience for her as the termination was not straight forward. She received no support from her boyfriend during this difficult time. However, she eventually married him, but felt at the time it was not going to be permanent. During the following twelve years they had together, they used no contraception and Anna never again conceived. She did not enjoy their sexual relationship and often "just gritted her teeth" to make herself have intercourse in order to conceive.

Over the years, Anna became more and more dissatisfied with her marriage and felt that the reason she could not conceive was because she was with the wrong mate. Investigations found nothing medically wrong with Anna. As an only child, Anna had been used to functioning in "an isolated way". They never discussed what it would be like to have children. Anna also never shared her feelings with her husband, for example, when she menstruated.

Anna decided to become financially self-sufficient so she built up her own business, something she said she would not have done had she had children. Her marriage finished when she was about 36. Not long after, she fell in love with another man; a man she spent the next three years with. Anna describes the relationship as exciting, but incredibly destructive. After three years, she told him she would like to have a child. He said no, then changed his mind and agreed to the idea. A week later he left her and Anna felt devastated. She became very ill for six months with bronchitis, pneumonia and pleurisy. Anna felt that her experience of rebirthing enabled her to achieve personal growth and be spiritually awakened during this ordeal.

Nowadays, Anna is enjoying her rural lifestyle and continues to do personal growth work. She describes herself as having become a very positive and self-sufficient person, who is also very happy with her life. Anna is still hopeful that she will one day conceive and have a child.

**Toni** (30)

When Toni was 22, she conceived and then miscarried. After that, she had an ectopic pregnancy and consequently the foetus had to be removed. Toni attributes the termination of her first relationship to the distressing time she experienced due to the ectopic pregnancy. She tried to conceive again in her next relationship, but ended up by having a breakdown and being admitted to Manawaroa for postnatal depression. Toni also had endometriosis which left her with many adhesions in her abdomen. Her specialist suggested she try the IVF programme but owing to the long waiting list and her doubts about whether she could cope with the programme, she decided against it. She ended her relationship as she felt that if she could not conceive, she did not think her partner would be happy long term without children.

Toni did not receive much support from other people with respect to her not being able to bear children. She found it difficult to cope at times when friends and relations got pregnant and consequently Toni felt great disappointment. She is now in a happy relationship with a man who does not want children. Toni is quite optimistic about her future and, although still sad about not having children, she is rebuilding her life to be a happy, positive one. Not long after the interview, Toni had a hysterectomy which she expected would end the pain and frequent periods she endured with the endometriosis.

**Bill & Shirley** (34 & 35)

Bill and Shirley married in their early 20's, when Shirley's son, from a former relationship, was three. They decided to try and start a family straight away so that he could have some brothers and sisters without a big age gap. A few days before he married, Bill's mother told him that he may not be able to father children. When he was a young boy, he had had surgery to correct a urinal tract problem, and somehow this led to Bill being sterile. Bill did not really take this all in and went ahead and tried to conceive. As nothing happened, they consulted a GP who asked Bill to give a sperm sample. Bill was found to be sterile.

Bill became an alcoholic, but Shirley stood by him, even though their marriage was adversely affected. Bill eventually stopped drinking and, at the time of the interview, had not drunk alcohol for five years.

Shirley was not interested in the artificial insemination programme, as she wanted to be pregnant with her husband's child, not someone else's again. However, Shirley's sister became pregnant and offered her child to be adopted by Bill and Shirley. They accepted and spent six happy months preparing for the birth; getting the baby's nursery ready and buying baby clothes. Shirley was present at the birth and participated in the care of the baby while it was in hospital. Shirley's sister and the baby came to stay with them when they left the hospital and then the sister went home. Three days later, she came back and took the baby - she had changed her mind. A little later, she changed her mind again and offered the baby back to them. For about three weeks, Bill and Shirley cared for her, but were being told constantly how to bring up the child by Shirley's sister. She had changed her mind about the adoption, but said they could have guardianship. Finally, they could no longer cope with this situation and decided it was best to give the baby back to the mother.

Bill and Shirley went through a very painful time and Bill is left feeling bitter and resentful. However, their marriage has been strengthened and they now have other goals in their life.

**Martin & Caroline** (35 & 32)

Martin and Caroline decided to start a family after they had been married about four years. When nothing happened, they went to their GP. After a couple of years of waiting around to find out if something was wrong with either of them, they decided to seek a second opinion. The next GP did find something wrong with Martin. Apparently, the minor surgery required to correct the problem increases the sperm count in 99% of cases, but Martin was the 1% who went the other way.

They later decided to try in vitro fertilisation and were fortunate enough to conceive after the first session. It took eight years from the time they decided to start a family until they finally conceived. During this period, their marriage was strengthened as they endured the process of not conceiving. They both kept busy with other activities such as playing sport and Caroline, in particular, was able to talk about any difficulties with family and friends. Martin always kept positive though, being a private person, did not share his feelings with other people.

At the time of the interview, they had just learned that Caroline was pregnant again. However, this time, they had conceived naturally.

**Wendy & Jim** (34 & 35)

After being married for six years, Wendy & Jim were ready to start their family. At the time of the interview, they had been trying to conceive for seven years. During this time, they had been very involved in their careers and, in their leisure time, kept busy with outdoor activities.

It was found during investigations that their infertility was a shared problem which led them to try the in vitro fertilisation programme. They had two attempts and found it a very intensive process. At the start of the programme they had put a limit on trying to conceive until the end of that year, but at the time of the interview, had extended that until March of the following year. The decision to extend was due to having six eggs fertilised on the programme, thus giving them hope for future attempts.

Over the years, their marriage has remained strong and the experience has brought them closer together. They have been able to communicate well with each other about their feelings throughout the experience. Although Jim is a private person and does not normally talk about what is happening to other people, overall, the two of them have received good support from family and friends.

The infertility experience has left them feeling quite sad and disappointed at times. However, overall, they have remained optimistic and run their careers in parallel with their plans to have children. They had recently decided on an alternative plan of buying a small farm if they did not conceive.

Some months after the interview, I had occasion to ring them to elaborate on why they wanted children. Wendy was about four months pregnant and they had conceived naturally.

**Kate & Steve** (35 & 34)

Kate and Steve decided to start a family after being married for eight years. After a year of not conceiving, they duly went and had the usual tests done. After about two years, it was found that Steve's sperm were abnormal and could not survive longer than an hour. The sperm were also not suitable for the in vitro fertilisation process.

They decided to try the artificial insemination by donor method, when Steve's brother offered to be the donor. Kate was not happy with having an anonymous donor. At the time of the interview, Kate & Steve had been to Australia several times to have the sperm artificially inseminated, as Steve's brother's sperm will not thaw. It had been quite a stressful time, particularly with friends and workmates asking Kate whether the trip had been successful and people generally being very curious about the procedure.

Over the years, trying to conceive has improved their communication and brought them closer together. It has also triggered arguments and Kate has felt very distressed with the whole experience. Kate has always talked about her feelings with others, but Steve is a more private person and only talks to Kate. Steve's family, in particular, have been very supportive of their endeavours to conceive.

If they do not conceive, they have plans of travel and have recognised certain advantages that a childfree life can bring.

## ANALYSIS

Analysis of the transcripts has produced a paradigm as shown in Figure 1. With respect to psychological factors, the experience of infertility has been perceived as having cause and effect properties. My model illustrates how wanting to have a child is a process. Relationships among variables are viewed as influencing and interacting factors along a timeline.

I will review the categories within the model in general terms, highlighted by excerpts from the transcripts. I will then examine certain categories and subcategories in depth, while discussing the implications of the relationships within the model. People's feelings in response to the whole experience of not being able to conceive are discussed generally under the category of 'self'. However, each experience carries its own set of feelings and as each category is an experience, feelings are also discussed in their context. The model illustrates the essentially processual nature of the experience.

The core category in the model is **"WANTING A CHILD"**. At the beginning of the study, my assumptions were that the core category would be "infertility" or "inability to conceive"; these assumptions being based on common sense. Early on, therefore, my assumptions were tested and, in this case, proved incorrect.

Not all participants, in fact, could not conceive. Agapanthus conceived three times but, owing to her husband's abuse, lost all three pregnancies. Her experience, therefore, cannot be talked about in terms of being infertile or unable to conceive. Toni conceived twice, but miscarried with one and the second, an ectopic pregnancy, was subsequently removed. Anna conceived once and had a termination, but was unable to conceive after this. I found, therefore, that **"WANTING A CHILD"** was common to all participants and stood as an antecedent to the experiences which followed. Of course, there are antecedents to wanting a child, which are discussed later in the category **"Reasons for Wanting a Child".**

Participants did not neatly fit into a concise model, rather, they were characterised by both similar and different experiences as illustrated in the paradigm. However, they all started with the core category of **WANTING A CHILD** and, at the time of interviewing each participant, they all shared the category of **'Growth'**, characterised by their positive outlooks and/or feelings of happiness. The study examines the process of reaching these stages and, as later discussed, possible reasons why some people experienced more distress along the way.

It is important to note the context in which the categories stand. Gender and age differences can have a bearing upon the way people respond to infertility. The degree of happiness or satisfaction within the marital relationship.

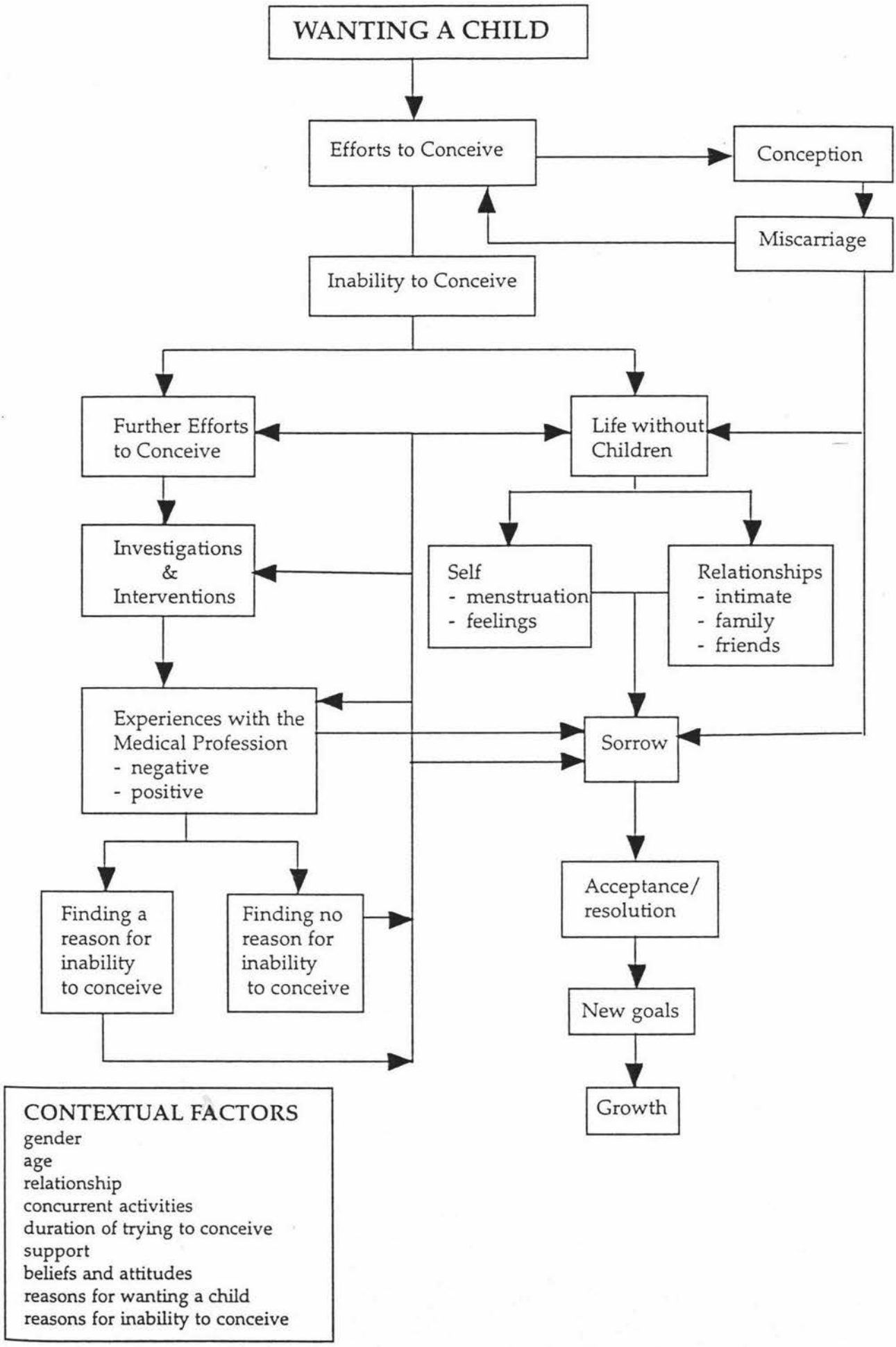


**Figure 1:** Model of Process of Wanting a Child

relationship can also influence the way a person deals with difficulties. The presence or absence of support is an important element in the way people cope with distressing events. Support, in this context, can comprise emotional and/or practical assistance. Therefore, the support offered should be appropriate to the needs of the individual or couple. These, along with other contextual factors, will be discussed further.

The categories which are subsequent to **"WANTING A CHILD"** are **"Efforts to Conceive"**, **"Inability to Conceive"** and **"Consequences"**. These lead on to the subcategories of **"Conception"**, **"Further Efforts to Conceive"**, **"Self"**, **"Relationships"**, **"Life without Children"**, and further subsequent subcategories of **"Investigations and Interventions"**, **"Experiences with Medical Profession"**, **"Consequences of Further Efforts"**, **"Menstruation"**, **"Feelings"**, **"Miscarriage/Termination"**, **"Sorrow"**, **"New Goals"**, **"Acceptance/Resolution"** and finally, **"Growth"**.

### Reasons for Wanting a Child

I considered it was important to find out people's reasons for wanting a child as this could help understand how they reacted to not having children and their future life. Individuals' reasons for wanting a child included:

* role fulfilment
* expectations of parenthood, including societal and parental expectations
* to be part of a family, continue bloodline, provide a sibling
* the experience of pregnancy and birth
* the intimate parent/child relationship
* love of children
* to allay feelings of loneliness and isolation in old age.

Some women felt that it was their role to have children. Toni grew up with strong expectations of motherhood and described herself as very maternal. Wendy also felt that having a child was:

> "part of being a woman".

The men did not discuss fatherhood in the same way, although Bill talked of feeling a failure when he found out he was sterile. Implicit in his reaction is his earlier expectations of being a father.

The theme of being a family came through strongly. Most of the participants wanted to be part of a family and enjoy the activities which families shared. Both Kate and Caroline wanted to enjoy family Christmases with their own children the way they did with their parents. This feeling suggests a desire for continuity and sameness. Jim's sense of missing out on something a family can provide is reflected in his comment:

> "...family with kids all sort of running around and having a lot of fun and I would think 'hmm, that's not me, I'm not achieving it'. ...what I desired in a family, when I saw a family, particularly having fun in the part...then I'd sort of feel down about it".

Jim's feelings also reflect a degree of fantasy we share when we are longing for something. His thoughts triggered my memories of wanting a child. I used to have a picture in my mind of the future; there were two children playing. I eventually changed my picture of the future to exclude children. The imagery was quite strong.

Bill and Shirley wanted to provide a sibling for Shirley's child. Bill, who is adopted, also felt a strong need to carry on his bloodline. He commented:

"If you're an adopted person, you cannot look backwards or sideways. You can look forward, you know, with children and grandchildren - you can see your blood line which is important.....When I found out I was sterile, then that was taken away - the forwards. So I felt very much like an island...that's best how I could explain it".

Societal and parental expectations of raising a family were firmly evident. The inability to match up to cultural and parental ideals can leave people feeling they are a failure, particularly so for the women. Wendy's comments exemplify this feeling:

"I guess it is a feeling of a failure as a woman and the expectation that I would be a mother and the sense of failure that that's not happening".

Several of the women desired the experience of pregnancy, birth and breastfeeding. Anna related:

"I wanted to give birth...I wanted to feel my breasts swell up with milk and lactate and feed. I wanted the whole experience".

Looking back to the early days of trying to conceive, Anna recalls:

"I think to me it was the idea of having a child...it wasn't that I was with someone that was really right and it was a perfect time in my life...it was like, 'I'm getting on, you know, I'll be 30 in a couple of years'...it was quite theoretical in some ways and didn't come from my heart".

The intimate relationship between a parent and a child was another reason given. Jim desired:

"the companionship and love that occurs between a parent and child".

Anna felt that children would bring a sense of purpose, belonging and intimacy to her life.

Several participants expressed a love of children and the chance to raise their own.

Not having one's own family can create a sense of isolation and loneliness. I remember when I was trying to come to terms with being childless, feeling sad that I would not have grandchildren to come and visit me. Kate also felt this:

> "I suppose the worst thing about not having kids is being sort of lonely in your old age, not having children around".

A range of reasons were given by participants as to why they wanted children, with some individuals offering several reasons. Most participants shared the desire to have their own family and participate in family activities.

**Efforts to Conceive and Inability to Conceive**

The model (Figure 1) illustrates how efforts to conceive, for some participants led to conceptions, then miscarriage, while others were unable to conceive.

For most of the participants, these categories are self-explanatory. The following extracts typifies most participants' effort to conceive.

Wendy and Jim planned to work and travel for a few years before starting a family.

> "...a year after we came back from travelling overseas, we decided that at that stage, right, I'd go off the Pill and we'd see what happens. I suppose at that point we expected that, within that year, I'd get pregnant, and then by the end of that year, we started to realise that that wasn't happening, and went to

> Family Planning. At that stage started asking questions. What are we meant to be doing?"

Wendy goes on to relate how it was over a period of time that she realised they may not be able to conceive:

> "I thought, 'oh, maybe this is a hiccup, it's going to take us a bit more.' But I didn't really think at that stage...it's really only been, I suppose it's a gradual process, um there's been a few times when it's really hit me and I've thought, 'yeah, I'm infertile', or, 'we're both infertile'".

The participants all made efforts to conceive and consequently found they were unable to conceive, although two couples conceived after several years.

For Agapanthus, the situation was quite different. On her wedding night, her husband told her he did not want children and it was a while before the marriage was consumated. Through her subterfuge, Agapanthus did conceive, but was unable to sustain the pregnancies.

**Consequences :**

**Investigations & Interventions** and **Further Efforts to Conceive**

**Experiences with the Medical Profession**

The following looks at the investigations and interventions which participants undertook, along with their further efforts to conceive. The subsequent section addresses their experiences with the medical profession. Figure 1 shows the process of people's further efforts to conceive, followed by investigations and interventions, experiences with the medical professions, followed by either finding or not finding a reason to conceive. This process can be circular with people making further efforts to conceive. Note should also be made at this point as to how all these categories can also lead to sorrow.

When participants' efforts to conceive failed, they all consulted a medical practitioner and went through various investigations and interventions. People responded differently to the amounts of intrusiveness they were prepared to undergo. Set out below are the investigations and interventions in order of intrusiveness:

* keeping a temperature chart
* sperm counts
* homeopathy
* blood tests
* post-coital tests
* urological tests
* hysterosalpingograms, that is checking if the Fallopian Tubes are patent
* artificial insemination by donor or by husband
* surgery such as laparascopy
* in vitro fertilisation (IVF).

For most participants, their inability to conceive and investigations and interventions led to further efforts to conceive.

Wendy went on fertility drugs, had a laparascopy, tried homeopathic measures and underwent artificial insemination with Jim's sperm before finally commencing the IVF programme. Wendy reported that it was "an emotionally intense time" and that she felt very lonely at times:

> "...with the physical side of the artificial insemination on the IVF programme, the blood tests, were the main times that I felt really lonely...it was something only I could do and, yeah, it was something that knowing Jim's sort of feeling about needles...it wasn't OK for him to be there".

Caroline also had a laparascopy and went on fertility drugs. Mike consulted a urologist and was put on medication. They finally went on the IVF programme and conceived on the first attempt.

Some participants did not continue to make further efforts to conceive. Responses varied from clinical depression, alcoholism and marital separation.

After Toni had a miscarriage, an ectopic pregnancy removed and, along with her experience of severe endometriosis, she knew her chances of further conception were quite remote unless she went on the IVF programme. She doubted whether she could cope with the rigours of IVF, particularly after suffering postnatal depression followed by a suicide attempt after losing both pregnancies.

Bill and Shirley tried for one year until they found out why they were unable to conceive. Bill was sterile due to a surgical error when he was a child. Bill became an alcoholic.

For Anna, on the other hand, no medical reason could be found for her not conceiving. She tried for twelve years until she separated from her husband. As Anna had already conceived once (and had a termination) she was experiencing secondary infertility.

Learning that there is a physical reason for failing to conceive can be disappointing, before moving on with one's life. On the other hand, the reaction can be also one of relief. Before

Wendy and Jim learned that they had a combined reason for infertility, they found the uncertainty of not knowing what was wrong very frustrating. These feelings were shared by the other participants. Kate said:

> "I remember spending half of that year in tears..... I think once we actually knew from... what the actual problem was and what we could do about it, I felt much better. Whereas before that, you didn't really know. And it was the uncertainty, and um, not being able to take any action....and all that bloody waiting drives you nuts".

However, when they found out Steve had abnormal sperm, Kate was upset, but for Steve:

> ".... it just floated over me. I don't know whether I was just prepared to accept it or whatever... it was probably months later that it actually dawned on me. But it really didn't have any affect at all. I hadn't had any kids, I wasn't going to have any kids, so it was no different in a way...I can rationalise a lot of things (laughs)"

However, Steve also felt relief :

> "there wasn't any of this doubt...it was the uncertainty that was the most unpleasant thing...I believe we could actually go on and do something about it, and it kind of gave us the control again".

As Steve recognised, once a couple understands why they are not conceiving, they regain some control over the situation. They are then able to make a more informed decision over what further steps to take. Not knowing what, if anything, is wrong, is disempowering and may block alternative goal-seeking.

The dimensions of the various investigations and interventions undertaken by the participants ranged in degrees of intrusiveness and time. As a consequence, some participants were able

to establish causal factors of their inability to conceive. People's responses ranged from depression, turning to alcohol, separation, relief, a sense of regaining control over their life. Those people without a definitive reason for their infertility had feelings of disappointment and uncertainty.

**Experiences with the Medical Profession**

Participants' experiences with the medical profession 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, discounting of their ideas, incompetence, not listening, not being supportive and understanding and having to wait a long period of time before they could establish what their problem was. For those who went to clinics at a hospital, they found it distressing to encounter pregnant women attending antenatal classes at the same time.

The following extracts testify to the general dissatisfaction felt by the participants in this study. Those participants who felt dissatisfied, eventually changed their doctors or specialists.

The attitude of some practitioners, characterised by insensitive and patronising remarks, was criticised by several participants. The unhelpful advice some people received highlighted the lack of understanding of infertility by some doctors. Wendy was told to just go home and keep trying:

> "He wasn't helpful emotionally. It was like I was just another number. I suppose it highlighted even more the specialists that are good and that do consider your feelings. ...the difference when you get a specialist that does actually talk about your feelings and acknowledge the sadness and the excitement".

Martin and Caroline were dissatisfied with the first general practitioner they consulted. Martin's sperm count was tested twice; the first test showed it was low and the second was high. However, Martin and Caroline felt there was something wrong with Martin and kept going back to the GP for a couple of years, who assured them nothing was wrong.

> "He had a terrible attitude. You know we'd walk in there after two years and he'd just say 'oh, you're not holding your tongue right; you're worrying about

it too much, you're too tense, come back and see me in six months' and just shove us out the door. And that just went on for six months after six months and it was just berserk".

Caroline felt:

"we had become a problem to him..and he just didn't want to know. And that was worse than the infertility itself - the doctor!"

They eventually sought a second opinion and were told after one test there was a definite problem with Martin's sperm.

Toni knew her doctor did not understand what she was going through when he knew she could not conceive:

"My doctor turned around and said to me, 'OK Toni, well you can't conceive...you should spend time with your sister's children'. I've accepted that I'm not going to have any children in my life, so I don't see why I should have to look after everybody else's."

When Toni discussed with her specialist a possible hysterectomy, he told her:

"he said to me 'you never really accept a hysterectomy, you'll always feel not a full woman' and of course I could have burst into tears...your self-esteem just goes, because you really think you're a failure as a woman".

The specialist should be presenting the facts of the matter and not make sweeping generalisations. In Toni's case, it would have been more appropriate to suggest she read more about the possible benefits and/or disadvantages of a hysterectomy and perhaps talk to other women who have been through the experience. In this way, a woman can make an informed choice. Counselling should also be offered to help women work through any adverse emotional reactions.

Bill's GP was very insensitive when he telephoned Bill with the results of his sperm count:

> "He said to me. 'oh, I've got your tests back; there's no way you can father a child. You're exactly the same as a vasectomised male... There's nothing we can do for you' and hung up. It knocked me off my feet."

It would have been preferable for the doctor to talk to Bill about the results in person and offer some understanding and support.

Some doctors are not respectful of their patients' opinions and ideas. For example, Anna described herself as:

> "a mindful person, I like to think about things".

She liked to ask questions and related:

> "I felt quite dishonoured...I didn't feel I was often given the respect that I would have liked from gynaecologists.... my theories...as a woman, because it was men I was dealing with."

Anna would tell her specialist that she was not getting the fertile mucous and asked how she could rectify this. But, in those days:

> "it was just a theory... I was fobbed off... I started feeling a bit of an isolate too and I felt, yeah, resentful."

Wendy described an instance of incompetence. She was prescribed a fertility drug to help ovulatory problems. Wendy related:

> "I feel that that wasn't really well done. It wasn't monitored. Oh, I think I had a couple of blood checks in the middle of it. But they were often at the wrong time of the month...it really didn't feel as they guy knew what he was doing".

At one stage, Wendy and Jim decided to try Gamete Intra-Fallopian Tube Transfer (GIFT) and the specialist said he would put them on the GIFT list. Wendy recalls:

> "but that was several years ago and nothing's come through from that, so I don't actually believe that he did".

Kate and Steve also spent a long time with investigations with respect to analysis of Steve's sperm.

> "...they mucked around with us with the sperm count thing and the count coming up to normal and waiting another six months, and you know, 'OK, come back in six months'... "

It was not until they were finally sent to another specialist that they were conclusively told that Steve's sperm were abnormal.

Wendy was very dissatisfied with both the specialist and the fact that the infertility clinic at the hospital was scheduled at the same time as antenatal clinics:

> "and you were before and after a pregnant woman".

I have heard this complaint many times and have personally experienced it with the first gynaecologist I consulted. I visited him at his rooms and he did not have separate days for the antenatal women. I found it very distressing to wait in the waiting room with pregnant women.

When people are going through the process of infertility investigations, feelings of disappointment, anger and frustration are common, leaving them quite vulnerable. When they have adverse experiences with a doctor, they can become disempowered and unable to be assertive. Wendy recalled the time when the specialist had taken a swab from her for analysis during an internal examination:

"He hadn't told me beforehand that he was going to do that, and I was really annoyed, but unable to say at the time. I didn't feel strong enough in myself."

Caroline also felt disempowered by her dealings with their first GP:

"If the doctor starts being negative, then that starts putting really negative vibes on you as well. And you do start feeling that you're a failure... He'd be so rude. And you don't have to take that from them I don't think. ...you almost look to them as God...and they just treat you, you know, terrible".

They knew something was wrong with Martin's sperm, but with respect to their doctor:

"we couldn't convince him".

In contrast, Wendy and Jim's recent experience with the doctors involved in the IVF programme had been extremely positive. They felt they had become more confident in dealing with medical staff and better able to question procedures. Caroline and Martin's experience with the IVF team reinforce what Wendy and Jim felt.

"You get treated so well...you couldn't be treated any better. You were treated like something special".

My own experience with doctors and gynaecologists over the past 13 years have mostly been positive. My only criticism would be that when the medical professional does not know what the reason is behind the infertility, it is easy for them to make assumptions as to its cause. Perhaps these assumptions underlie some of the unhelpful advice couples often receive, for example "take a holiday"; "relax".

The above examples of negative encounters with the medical profession are unfortunately all too common, particularly for women consulting health professionals. They reflect the degree of powerlessness of many people, more often women, in relation to the relative power of

medical practitioners. The doctor/patient relationship is characterised by one who has knowledge and therefore power, the doctor, and one who seeks information and advice, and therefore little power, the patient. Barrett and Roberts (1978) suggest that it is the intense personal relationship between doctor and patient which helps maintain the doctor's control. "Patients are not encouraged to see their doctor as a technician with a certain expertise as they might a car mechanic. He is very much more" (Barrett & Roberts, 1978, p. 50).

Although the patronising comments made by a male doctor to a female patient may reflect the condescension often found in the male-female relationship in wider society, it does not explain the same attitude demonstrated towards some of the males in this study.

By the time a couple consult a physician about their non-conception, a year or more may have passed since they first tried to conceive. By this stage, they may be feeling frustrated and disappointed, and will be seeking answers, understanding and support. People often find it embarrassing to discuss intimate matters with their doctor and may experience difficulty in communicating their feelings and concerns. Doctors generally spend only a brief period of time with their patients, often not long enough to establish rapport, nor foster a relationship of trust and understanding. The distress and frustration of not being able to conceive can create dissonance not only among the the two partners, but also between the patient and the doctor.

The loss of control commonly experienced by people trying to conceive, can be reinforced by the demands of fertility treatments and investigations. As noted earlier, treatment often entails the doctor directing when and how often intercourse should take place. Unless the doctor is sensitive and shows due respect to the couple, such requirements may create resentment towards the practitioner.

The causes of infertility can include both medical and psychological elements and many physicians neither have the training nor inclination to attend to their patients' psychological needs. However, it is of paramount importance that the physician explain what he or she is planning to do, over what period of time and provide a degree of support. Mahlstedt (1985) asserts that patients often expect more from their doctor than he/she may be able to

give. Ideally, infertility specialists should be aware of and attend to the psychological aspects of their patient's medical problem.

The next stage of the model (Figure 1) refers to **Life Without Children**. The consequences of life without children are discussed in relation to **Self** and **Relationships**. Following on from these categories, the consequences of **Sorrow, Acceptance/Resolution, New Goals** and **Growth are** examined later.

**Consequences: Self: Menstruation and Feelings**

**Menstruation**

Menstruation, as a response to failure to conceive, represented a sad and disappointing time for the women and, to some extent, their partners. Toni felt both disappointed and angry:

> "I'd cry half the day and stomp around; it's not fair".

For Anna, it was a mixture of feelings:

> "I used to get really disappointed, really disappointed, becaused I had started to get all excited and paint all sorts of scenarios in my head... I'd envisage me billowing out...and I'd get this huge disappointment and, at the same time, it was an incredible relief...the relief was something I never questioned a lot then.."

Kate reported she felt "terrible" each month:

> "I'd loll about in bed and feel terrible and feel sorry for myself. It's sort of been a bit better having a job to go to and having to be somewhere. And you can sort of put it to the back of your mind more".

Both Anna and Toni shared that they pretended they were pregnant at times and that they were not in fact about to menstruate. Toni recalls:

> "Sometimes I'd pretend it wasn't there. And sometimes I'd pretend that much, that my breasts would actually swell as though I was pregnant. But it was just a hormone imbalance. It was like a phantom pregnancy. I'd be emotionally upset. I used to find that I'd put a dress on... and I would push my stomach out, you know, and just walk around like that".

Anna relates:

> "Sometimes I would imagine I was pregnant...I had these months where...my breasts were, looked so much firmer than usual and ... everything would be, you know, just a little bit different... it got to be hilarious. In the end, there was a part of me that would stand back and laugh, but sure enough, these symptoms were there, imagined or real".

For these women, menstruation served as a regular, monthly reminder of their failure to conceive. It was part of a continuing cycle; a cycle that started with hope and ended with disappointment. And, for some, great distress.

**Feelings**

Further efforts to conceive, led to further investigations and interventions bringing a range of feelings and experiences. People reported many negative feelings as a result of their experiences. Feelings of disappointment, anger, resentment, sadness, moodiness, uncertainty, guilt, insecurity and isolation were reported by several people. Except for Toni, nobody used the term depression, rather sadness. In Toni's case, she attributed her depression to postnatal depression after losing two babies. For some people, the longer term effects led to a sense of failure; for Bill,

> "at the beginning you were made to feel a failure as a man and you took upon yourself to be a man"

Bill's foreman told him "you'll never be a real man..there are three things real men do - they father a son, you play rugby and you drink booze" and so Bill relates..

"I couldn't father a child, I wasn't all that keen on rugby, so I decided to hide it in alcohol, and I drank, I wanted to be a man, and I drank, I wanted to be a man, and I drank and I got my buzz. As a result I became addicted to it. I don't say that is the whole reason but that is some of the reason.....I'll drink like a fish, I'll be one of the boys....It all but broke my marriage up, not at the point of being sterile but through the alcohol".

Bill felt let down by his mother and isolated.

"The pressures that I've got. First of all I come from sterile parents. I am adopted myself and my two sisters and I have a brother that died. They're all adopted, the whole family is adopted. So I thought my mother would understand for a start. She was...very insensitive. Every time that Shirley and I would be up at my parents' place...there would be something in the Women's Weekly about some miracle cure...some guy had been to Asia or something and been fixed".

When Toni found she was not going to have children, she felt a failure as a woman.

"...and, you know, as a little girl, you know, a mother will say to you, 'oh, you'll have a baby one day' and you sort of feel, that's what women are here to do (laughs) and when you can't, you're not a full woman".

After a few years of non-conception, Wendy felt:

"a feeling of a failure as a woman and the expectation that I would be a mother and the sense of failure that that's not happening".

The loss of control which goes hand in hand with infertility is an important feature of the experience. As noted earlier, Steve felt that once he knew the reason for their infertility, he felt he had regained control. Kate describes the infertility experience as having her choices taken away:

"Just not being able to choose is one of the things that make you angry. At least you can choose if you're taking contraceptives if you are fertile to have or not to have a baby.... and I suppose choice is what it's all about for me".

Agapanthus also went through a loss of control when she realised that her attempts to bear children had failed. She wanted to leave the marriage but, in those days loyalty and "old-fashioned ideas" stopped people separating.

Loss of control can affect different areas of people's lives, including their sexual relationship. Comments like "We were having to sort of perform on demand when the cycle was right" and "there were other times like we had to abstain for a few days beforehand" were common. As participants related their experiences, the loss of control issue came through quite strongly. It reflected their powerlessness and subsequent feelings of frustration and anger.

An important point to note is that feelings do not happen in isolation. Feelings, in this context, occurred in response to being unable to conceive, interventions and investigations, experiences with the medical profession, as well as being linked to people's social relationships. Relationships are discussed in the following section.

**Consequences: Relationships - Marriage, Family, Friends**

The feelings of the participants were often in response to experiences with the medical profession, their partners, families and friends. The insensitive attitude demonstrated by some members of the medical profession appeared as a prominent factor in affecting the way people managed long investigative procedures. The unfeeling comments that were received, not only from the medical profession, but also family, friends and acquaintances, fostered anger, resentment and isolation. These feelings are discussed in the following section with respect to relationships with family and friends.

The way efforts to conceive seems to effect people's relationships reflects the diversity of factors involved. The main consequences related to participants' relationships with their partners, including their sexual relationships. Some people separated from their partners, while others felt in retrospect that their marriage had been strengthened. For some participants, their relationships with some family members and friends became strained. Starting with the intimate relationship of marriage, I asked people what effects if any, they had experienced upon their relationship generally and their sexual relationship in particular.

For some people, finding out that they were unable to conceive, signalled the possible end of their relationship.

Instead of continual further efforts to conceive, Toni ended her relationship.

> "...he was a lot younger than I was and for some reason, I just could not accept it, that if we didn't end up having children, that he would be able to accept that and that's why I finished the relationship, because I couldn't believe that he could be quite happy if we didn't have children and so it was my insecurity about it I suppose that we split up".

Bill reacted by offering to leave the marriage if Shirley wanted children but Shirley:

"turned around and the comment I've never forgotten..'I didn't marry you for what you could produce'. So, that was, you know, that blew me away too; it made me feel good".

Anna developed her own theory:

"I was with the wrong mate and I wasn't meant to have a child with.. I'm kind of fatalist too I suppose."

Anna's marriage did end after twelve years.

Martin's initial reaction was to say to Caroline:

"maybe it might be best to find somebody else".

However, they did not go for that option and Mike and Caroline felt a sense of relief "we could work on it... they reckoned we could fix it".

For most participants, the sexual relationship became strained and a chore. Jim noted:

"Having to perform a bit sort of yuk".

Kate and Steve found intercourse strained and uncomfortable, but Steve saw a positive side:

"now we don't have to worry about contraceptives and all that sort of thing ...is a bonus".

Martin and Caroline found sex lost its enjoyment, particularly when the doctor:

"started running tests where we had to do it at 3.00 in the morning and then not have a bath or shower or wash, go to him at... about 1.00 in the afternoon

and he'd give me a smear test to see if there was any live sperm...we did three of those".

Anna said that her sexual relationship had never been particularly enjoyable with her husband, and only deteriorated. Towards the end of their marriage they "wouldn't make love at the right time". Perhaps this exemplified Anna's growing aversion towards her husband and was a reaction to her feeling that he was not the right mate for her. Toni "went off sex" while Bill and Shirley relate:

"We used to do it more often and hoping that we would get pregnant, but now we do it because we enjoy it".

The participants who reported that trying to conceive placed a strain on their marriage, reported that they did not have a strong relationship to start with. Even before Anna and her husband married, Anna said there were negative feelings on her part. He never gave her the emotional support she sought after the termination and so Anna bore a grudge. He had a small daughter from a previous relationship to whom he "always poured all of himself". Anna said she was left feeling jealous of the child, particularly when she could not later conceive her own. These contextual factors obviously had a bearing on the way Anna felt, along with her distress about not being able to conceive. Anna and her husband never communicated with each other about having a family:

"We didn't sort of see ourselves and talk about having children and what we would do with children. It was never talked about. We never talked about the dreams of having children...It was strange. ...and I think because we didn't (have children), we just went our own ways more and more and more. Our lives just really separated".

Agapanthus' marriage started with the shock of finding out her husband did not want children and, along with his abusive ways, Agapanthus found herself in a very unhappy relationship.

Toni used to take it out on her partners:

> "... and it was awful because I was starting to blame them. And I knew all along it was me. You can really be quite nasty to your partner".

Although she shared her disappointment, she noted:

> "I just feel as though men don't take it to heart as much as women".

Toni felt she carried the disappointment and anger on her own and that:

> "because of that, you bring everything else into it as well; any problems you've got and it all just rolls into one big thing. And your main problem is because you feel a failure".

Toni's reactions exemplify the gender differences previously found in infertile couples. Dunkel-Schetter and Stanton (1991) note that while such differences have been observed in previous research, few studies have tried to tease out the effects of gender from effects of diagnosed infertility. If Toni's partner had been diagnosed infertile, perhaps her responses may have been different.

Martin and Caroline, on the other hand felt that their experience strengthened their marriage. Caroline reflects:

> "because we could always go through it together and talk with one another".

Kate reflected:

> "I think some things brought us closer together...I guess it's made me realise that I sort of really wanted Steve's child and nobody else's, and that's been the hardest thing for me to come to terms with (Kate cried at this point). It still affects me. He's a nice chap you know".

However, Kate also recalled:

> "we've had some bloody good arguments".

Steve found it difficult at times to cope with Kate's distress:

> "the things that got me upset were her getting upset and moody".

Bill and Shirley went through a very difficult time, particularly when Bill became an alcoholic and, later, when they gave the child back to Shirley's sister. However, Shirley, on occasions said things to Bill which "blew me away" and as Bill notes:

> "well for Shirley to have put up with what I put her through in 12 years, and I mean this seriously and has still stayed by me, is a miracle".

Throughout their interview, it came through very strongly that Shirley's love for Bill was very enduring and her demonstration of this was what pulled Bill through some very painful times.

Wendy and Jim said that they have always been able to share the negative side of trying to conceive. For example, when Wendy got her period, Jim was quite sensitive and:

> "Jim would pick it up and would make a comment that, um, let me know that he was really supportive and he was as sad as I was.....that really helped because I guess that sort of took away the feeling that it was just me going through the ups and downs".

Wendy found that the knowledge and experience she had gained from her counselling training really helped in communicating her feelings to Jim. When I asked Jim if he felt that their experiences had had any effects on their marriage, he said:

> "Not that I've noticed. I'm sure that because we are going through this, it must affect us in some ways. It's nothing that I can put my finger on".

Obviously, in some cases, it is difficult to judge whether, or in what way, an experience affects individuals. In Wendy and Jim's relationship, it is obvious that the experience has not pulled them apart in any way.

Agapanthus' experience was different from the other participants as she was involuntarily childless. Her marriage had never been a good relationship from the beginning. After her traumatic experience of being abused and the subsequent loss of her pregnancies, she became very ill and unhappy. She said that her marriage deteriorated more and more over the years, until she reached the stage where she was strong enough to leave her husband.

The differing effects of trying to conceive upon people's relationships reflect former research findings. There were gender differences in participants' responses to their efforts, along with both negative and positive effects on marriages. In Dunkel-Schetter and Stanton's (1991) discussion on the positive effects of infertility, they question whether in fact they actually occur, "or if the self-reports reflect adaptive cognitive coping techniques" (p.202).

Family members were a source of annoyance for some participants. Often well-meaning, their comments often served to irritate and hurt. On the other hand, some participants perceived their families as helpful and valued their support.

Bill and Shirley found Bill's mother particularly insensitive as she continually pressured Bill to try "miracle cures" for his condition, even though he was completely sterile. They have not found her supportive or helpful and, overall, Bill and Shirley have had to bear their difficult times on their own.

Toni also found her mother just did not think at times. When visiting her with Toni's pregnant sister her mother said:

> "let your sister choose first, (bread rolls) she's pregnant".

Toni felt that her mother's focus on her sister reinforced her sense of failure as a woman. She would also feel hurt by comments from her mother's friends, such as:

> "you haven't given your Mum any grandchildren yet Toni, you're a bit slow".

Kate's mother had been quite critical of their latest attempts to conceive and Kate felt this had caused some strain on her relationship with her mother.

Wendy found it difficult discussing their infertility with her parents in the early stages and found herself holding back a bit at times with her mother.

> "She's obviously really keen for us to have children and probably verbalises what I'm feeling and sometimes I can't cope with that, so I need to be careful...I notice after going through a cycle that I sometimes actually avoid contacting her just for a couple of days, just to give myself that space".

Anna and her mother were finally able to talk about the sadness of Anna not having children and her mother not having the grandchildren she would like:

> "and we both howled a bit and it was lovely".

Martin and Caroline agreed that they have had a good relationship with their families, who have also been very supportive. Kate and Steve have also received much support from Steve's family over the years.

Kate's sister has also been trying to conceive and, because Kate feels she "over-dramatises" what she is going through, Kate said she becomes annoyed with her.

The above examples illustrate the differences in communication between people. Often family members' comments have been construed as insensitive and unhelpful and thus, unsupportive. Yet, the perpetrators of these comments may in all sincerity have been trying

to be of help. The need for more effective communication and a better understanding of the process of infertility is therefore highlighted.

Overall, there did not appear to be great changes for people with respect to relationships with their friends and family. As related earlier, the inappropriate and thoughtless remarks passed by others were hurtful and did isolate people at times. As Anna noted, when one has friends with children, one tends to move in different circles. Often, Anna would not be included in activities, for example:

> "...they would have a first birthday for their son, and all my women friends would sort of go along and all their children would go along and everyone would be there and I wouldn't be there, and sometimes I would, like, I wanted to have my cake and eat it too, because there were occasions I felt, you know, I felt really hurt. I thought, oh, you know.. 'what about me'... but then more often than not, I didn't want to be there".

Often people avoid inviting infertile couples to functions as they feel awkward about having them around their children (Mahlstedt, 1985). Situations like these are difficult both on the person without children and those that do have a family. I recall my feelings of sadness and a sense of being different and apart from others when attending children-oriented functions. I remember one Christmas morning, while staying at my sister's house, having tears pouring down my face as I looked at the Christmas Tree and wishing I had children I could watch unwrapping their presents. It was several years before I could face joining my family for Christmas again. It is often easier not to attend these gatherings. At the same time, I did not want to be left out or be 'protected' from possible sadness.

Once again, the need for improved communication between people is featured. There are times when people who are trying to conceive may choose not to attend a particular function, while, on other occasions, they may really enjoy themselves. Ideally, the host/hostess and/or the infertile person should be open and acknowledge the difficulty of joining in an event with several children. In this way, the decision is left open to the invitee as to whether they wish to attend without hurting anyone's feelings.

Toni and her partner's friends do not inquire about children, unlike her mother's friends:

"I hated having to explain myself".

Toni seemed quite at ease when discussing her relationships with friends, but looked rather tense when talking about her mother. However, her father was concerned for her and said "life doesn't revolve around children, Toni". When Toni related this comment to me, her manner seemed to soften, leading me to believe that her father's attitude may have helped ease the pressure a little.

Wendy and Jim have made sure they have kept up with friends who do have children, although, at times it was easier to go out with people who do not have children. Overall, they have kept their friends and mentioned they have found them quite supportive.

Caroline said she has had a couple of very supportive, good friends throughout their difficult times. Kate also said she has had one particularly good friend who:

"always knows the right thing to say".

Steve commented that he is quite a private person and has not really discussed their fertility problems with other people. Martin and Jim expressed similar views. For these men, therefore, it appears that their relationships with their friends have remained unaffected.

Mahlstedt (1985) noted that her male infertile clients were not so open in expressing their fears as her female clients. Abbey, Andrews and Halman (1991) observed from their review of the literature that men are generally less expressive than women. These gender differences in expression may therefore reflect a difference in coping styles as women seek social support by voicing their fears.

When individuals discuss openly their desire for a child, they become vulnerable to other people's advice and, often insensitive remarks. Kate found that other acquaintances and

friends have been quite unhelpful with their inappropriate comments. She talked about a classmate at university who got pregnant:

> "and she used to make such inappropriate comments...'Oh, I bet you're pregnant and just not saying anything' ...just used to rub me up the wrong way and really upset me. I used to..come home and cry all the way in the car.....it was terrible. Sometimes I was just a mess; I'd come home and cry and cry and cry".

> "All these bloody nurses that I know...insensitive half-wits, saying 'you should relax, it will make a big difference'. All this bloody relaxing...after five bloody years, you'd think I'd relaxed at least once....or, 'why don't you get pissed?'".

Friends of Martin and Caroline's passed insensitive comments like "oh, you're not a man till you've had kids" or "you're not a man until you've had a boy".

As Mahlstedt (1985) noted "well-intentioned but insensitive remarks by others ...leave the infertile person feeling unacceptable, misunderstood, unloved, or ashamed" (p.337). Before a person discusses their plans for a family with other people, they may need to weigh up the advantages and disadvantages of disclosure. Most people would not have the foresight to make that decision.

Some people felt a mixture of feelings when friends got pregnant. Wendy recalls:

> "I'm very aware of close girlfriends that when they get pregnant, their feelings and how they are constantly aware of'how do we let them know', that sort of thing....a friend's just had a child recently, and, um, wanting to be really happy, I think I achieved that at the time, having to put the extra energy into that to be happy for her. And then feeling really down afterwards and sort of coming away, and thinking 'it's not fair'".

Toni felt a bit rejected after her sister got pregnant and, when her close friend became pregnant:

> "I ended up putting my arms around her and gave her a kiss on the cheek and said 'congratulations'. But it took me a while... And I didn't understand why friends expect you to be excited over it when they know what you've gone through because they've known right from the start".

Toni explains her experience of not being able to conceive as:

> "when you can't conceive, you just go through terrible, just horrible emotions, like of jealousy...you go up town and it's like, every woman's pregnant....your self-esteem just goes"

Agapanthus was the only participant who did not relate such experiences possibly due to the fact that she did not discuss her problems with her family or the medical profession.

As noted earlier, Agapanthus had good support from her workmates and employer when she lost her babies, but she never talked about her difficulties with respect to her husband. She cared very much for her parents and sister but missed out on the possible support she could have received from them due to her silence. In later years, Agapanthus has enjoyed good friendships as well as other people's children and grandchildren.

The women in the study tended to discuss their fertility difficulties and share their feelings of disappointment with friends and family. The men, on the other hand, Steve, Martin and Jim in particular, preferred to discuss these matters only with their wives. Both scenarios have positive and negative aspects. In this study, the people who shared their experiences with others were able to receive support. At the same time, they were also open to thoughtlessness and insensitivity from other people. However, for those who chose to remain more private, they were less likely to gain support from others, but were not subject to the same degree of insensitivity.

It can be advantageous to share one's problems with other people but, where possible, it is wise to be selective in who one talks to. However, as Abbey, Andrews and Halman (1991) point out, significant others often unintentionally say things which are upsetting, which can cause the other person to withdraw. This response can then make the significant others feel unappreciated "so they too withdraw. ...the infertile individual becomes even more isolated" (p.67).

**Life Without Children: Sorrow - New Goals and Acceptance**

Although the category **Life Without Children** does not apply to all participants, it did apply for a period of time. In Bill and Shirley's case, there was already the child from Shirley's former relationship. **Life Without Children** is not static. There are temporal effects resulting in people experiencing a range of responses. I report on this category in conjunction with the subcategories of **Sorrow, Acceptance, New Goals** and **Growth**.

The participants spoke of having a "positive outlook" and/or feeling "happy" with their lives which I have construed as **Growth**. I was able to relate the sense of feeling and positive to my own sense of growth after several years' experience of being infertile. I consider that growth is the outcome of having adopted a positive outlook and feeling happy with one's life.

The model (Figure 1) illustrates how most categories lead into **Sorrow**. Wanting a child and making efforts to conceive has, for these people, lead to a degree of sorrow. **Sorrow** also stands as an antecedent to **acceptance, new goals** and **growth**.

**Sorrow**

Toni experienced great sorrow, to the extent of trying to commit suicide. In the early part of the interview, she said she tried to commit suicide because she had antenatal depression, but towards the end of the interview she said:

> "I started thinking about not being able to have children, and I couldn't handle it, and I ended up going to Manawaroa...I had tried to commit suicide...and I felt useless and I felt guilty about how I didn't give them any children (her partners)"

At the time of the interview, Toni still felt sad about not having children. She felt if she had had someone to talk to who really understood, she may not have gone through all the anguish she experienced.

Bill and Shirley also experienced great sorrow, particularly after the planned adoption fell through. Although Bill seems to have accepted that he will neither father a child, nor adopt one, he still feels bitterness and resentment.

Agapanthus experienced sorrow and suffered her anguish in private. Anna too certainly experienced sorrow, not only during her marriage, but also following the separation from her next partner. Like Agapanthus, her feelings of sadness were compounded by the long period of ill health she endured.

Martin, Caroline, Wendy, Jim, Kate and Steve did not talk of their feelings in terms of great distress. Rather, their responses to life without children were characterised by disappointment, periods of sadness and often, frustration.

**New Goals and Acceptance**

For some participants, their work took on a new dimension. Toni said that she was feeling positive about life and had developed new goals. She had recently started working full-time. Agapanthus continued her career as a dental nurse, a job she thoroughly enjoyed. She loved children and this position gave her the opportunity to mix with small children.

For Anna, life without children, has meant the development of her business and finding dimensions in her life that she may not otherwise have found.

> "Yes, it's certainly made a different life for me...very self-contained, very autonomous and very independent. You know I've got my own chainsaw...and I've done valve grinds on my car".

Wendy continued with training for her work and also changed jobs at one stage. Jim felt it was particularly important not to just wait around trying to get pregnant:

> "forget about what you may end up doing in terms of having a family, you put that to one side and say, OK, you actually run with both things in parallel. You go for your job....at the same time as trying to have a family".

Some participants talked of travel. Toni, for example, said that she and her partner were very happy and enjoying their life together. They were looking forward to buying a Harley Davidson bike and go travelling around. Bill and Shirley enjoy being able to get out a lot more, now that Shirley's son is older and becoming more independent. They can see the benefits of being childfree, unlike the early days:

> "we always had a child to take out...now we've got the reverse role, so we're going to go back and be like young people again...37, 38 we're going to be yuppies. ...we have talked a fair bit about going overseas".

Since Agapanthus' retirement, she has learned to drive, which has given her a greater measure of independence. She has travelled to visit friends out of town and has also been overseas. She also plans further excursions.

Kate and Steve plan to travel overseas if they remain without children.

Other interests have featured in participants' lives. For some, these interests have been pursued during the years of trying to conceive, while for others, they have developed in response to not having children.

Toni plans to help infertile people in some way in the near future, as she recognises the need to offer and receive support.

With respect to future goals, Bill said:

> "and we decided that if we couldn't have children we'd become capitalists and that's what we're working towards".

Agapanthus appreciated the importance of pursuing the activities she enjoyed. She seemed to accept her childless state after the loss of the third child and her consequent illness. She kept positive and went after different goals. She found creative fulfilment in her needlework. Despite her husband's opposition, she learned to drive and bought a television set.

Martin and Caroline did not talk of alternative plans or other goals should they have not conceived. However, they did carry on with sporting activities and seemed to have a fairly balanced lifestyle during the years of trying to conceive.

Life without children for Wendy and Jim meant continuing to enjoy other activities, particularly outdoor pursuits in the weekends. They also made plans to shift and start living a different lifestyle on a small farm the following year after I talked to them.

Kate said she enjoys the lifestyle of not having children, despite being very sad at not having a family:

> "I quite enjoy the lifestyle that we've got. We can spend money and you know, go to bed or go out or do whatever we want whenever we want to. And I think, if I do have a baby, I'll miss the lifestyle (laughs)".

Anna was about to move on with new goals, including a lot of "growth" work on herself. She added:

> "I feel happier within myself than I have ever felt in my life, which is really a wonderful feeling...and I still feel very open to the possibility of it happening one day,...and if it doesn't happen...I don't grieve about the thought of it not happening. It's like somehow through all this I have found myself, that in a way that I have never had an opportunity to find myself...I have the opportunity now to help others find themselves".

Most of the participants talked of feeling positive about their lives and reaching acceptance of their situations.

Martin and Caroline said they always kept a very positive outlook and never doubted that they would conceive. Fortunately, they did and are very happy with their children. It is not possible to know how they would have fared long term should things have turned out differently. The experience of having a long period of trying to conceive has made them very appreciative of their child (and now children). They felt angry when they saw people not taking proper care of their children, for example, not using safety measures around the home. Caroline also became angry about people who:

> "carry on with sports every night of the week and the kid never sees them. It still makes us feel so angry. It still makes us feel they don't appreciate them. You know, why couldn't that have been ours? Even though we've got Susie".

Wendy and Jim both adopted a very positive approach to their lives and ensured that they still had a rewarding life. As noted earlier, they have since conceived and report they are both very happy.

It was not until she finally left her husband that Agapanthus truly felt happy. Over the years, she said she experienced growth and change and, although sad at times about not having children, she describes herself as happy.

Kate does not appear to have reached a stage of acceptance with respect to not having children, unlike Steve who does not seem as concerned:

> "it was important to me, but it was more important to her".

Kate does seem to have retained a fairly optimistic view of the future, even if they remain childless.

Anna has adopted a very optimistic and positive outlook, taking on new challenges and finding fulfilment both in her business and in her personal growth work.

Most of the participants have moved through various dimensions of sorrow, continued with interests or developed new ones, to reach acceptance of their situation and, for most, to experience growth.

## CONTEXTUAL FACTORS

When looking at relationships between categories, primary consideration must be given to the context in which they are set. "Conditions have to be given specificity by identifying them as causal, contextual, or intervening, in order to give them meaning in terms of what is being studied" (Corbin & Strauss, 1990, p.167). However, certain conditions can assume different properties, depending upon what relationship is being examined. Some contextual factors function as antecedents and others as consequences. To use the example of Bill's alcoholism, this can be viewed as a consequence of both his sterility and negative experience with the medical profession. In another relationship, it could be seen as an antecedent to coming to terms with not having children and pursuing alternative life goals. It is also part of the contextual setting of his marriage over a five year period. Such flexibility of contextual factors enables the analysis to adopt a broader view of the story emerging from the data, rather than limiting a factor to a single relationship.

### Gender

As discussed in the introduction, there are gender differences in the ways people react to fertility difficulties. Such differences include, among others, coping styles and psychological well-being. However the reasons for these differences are not purely because women have different coping styles, for example, than men. When looking at infertility issues, it is important to remember that it is often the women who are subjected to drawn-out investigations and interventions. If a man's sperm count is normal, then the focus of exploratory procedures is then directed towards the woman. She therefore has numerous encounters with the medical profession, more time off work and possible physical effects from procedures. Her life can then become more focussed, than her partner's, on the couple's fertility difficulties. It is understandable that there will be differences in the couple's reactions.

Wendy's experience exemplifies this point. When she was going through the IVF procedure, she felt quite isolated:

"...with the physical side of the artificial insemination on the IVF programme, the blood tests, were the main times that I felt really lonely...that it was something only I could do...it wasn't OK for him to be there...I guess that was sort of a lonely time".

**Age**

My study has not been able to address adequately age and/or generational differences owing to the lack of variation in age groups. Most of the participants were in their mid-thirties. Agapanthus, at 68, was the oldest participant. Agapanthus did remark that when she was younger, one tended to stay in a marriage because of the marriage vows and the old-fashioned idea of loyalty. There is the possibility also, that the younger generation talk to each other more about their feelings, their expectations and their difficulties. I referred earlier to a 92 year old woman that I spoke to, but was not able to tape our conversation. She told me that when she got married, the subject of children was never discussed between her and her husband. When she did not conceive, it was never mentioned. She also said that she just got on with her life and did not get distressed about being childless. She said she had a happy marriage and led a fulfilling life. However, Anna and her husband also did not communicate well about their not being able to conceive, unlike the other younger participants.

There may be differences in people who are nearing the end of their childbearing years, compared to those who have several years left. Speaking from personal experience, I know that as I approached 40, there was a strong sense of dismay that I would probably never conceive. Yet, on the other hand, I also felt a sense of relief that I would no longer be able to think 'maybe, you just never know..'. It was a welcome sense of finality to the long years of fertility problems. As previously stated, my study is not able to address this concept of age.

**Relationship**

Happiness, contentment, satisfaction are just a few descriptors which can portray a person's feeling about their marital relationship. Although I did not specifically inquire of each participant about the state of their marriage, most gave an impression throughout the interview. For some people it was overt, like Agapanthus and Anna, while for others, it was implied. When interviewing the couples, I could also watch and listen to their interaction. The people who fared more adversely in their experience were also dissatisfied with their relationships. Those who had steady, contented marriages with good communication seemed to weather their adverse times with minimum distress.

**Concurrent Activities**

For some of the participants, their lives were centred around trying to conceive while, for others, they still enjoyed other interests along with developing their careers. Agapanthus loved her job as a dental nurse and, in her leisure time, spent many hours doing embroidery. She is excellent at her craft and it appears that this creative outlet has helped give her an added dimension to her life. Martin and Caroline played sport, Wendy and Jim enjoyed outdoor activities in the weekends. Like Kate and Steve, they also continued with their career plans. Later, Anna started developing her own business and pursuing her own interests. As noted earlier, Kate found it easier to cope with the disappointment around menstruation when she was working, compared to when she had more time to think about it when she was a student.

There appears to be a greater sense of equilibrium in the lives of people who have outside interests and who foster the growth of their career. A narrow focus of continually trying to conceive appears to place extra stress on people wanting to have a child.

**Duration of Trying to Conceive**

Over time, the participants seemed to become accepting of and adapted to their situation. The longer they tried to conceive, the more likely they were to develop alternative life plans. The effects of failing to conceive in the short term appear to strengthen people's resolve to keep trying. Longer term consequences include the negative feelings discussed earlier, while in the very long term, most participants found the experience had both added to and detracted from their lives. For example, Bill and Shirley still feel bitterness but state that their marriage has been strengthened by what they have both been through together. Toni eventually overcame her depression, still feels sad about not having children but is really appreciating a loving relationship. Kate and Steve seem to be still experiencing a certain degree of distress through their efforts to conceive, but they acknowledge the advantages of being childfree. They have also developed plans for the future that do not include children.

**Support**

The presence or absence of support has emerged an important factor as to how people have coped with their fertility difficulties. Bill, Shirley and Toni, in particular, received little support and found coping with their situation very difficult. Agapanthus received support when she lost her pregnancies which helped her through a painful time. However, because she chose not to talk about the reason for those losses, she never gained the support which may have eased the distress of living in a destructive marriage. Both Martin and Caroline received support. Caroline had a couple of good friends, one in particular, she recalls:

> "became my second mum with my mum living in another town, and she was really good".

Knowing how important the support was to her, Caroline was also able to offer support and help to other friends going through a similar experience. Toni, also recognising the importance of support, would like to offer hers to other infertile people. Wendy and Jim were of strong support to one another, particularly for Wendy when she was going through the IVF

programme. Jim felt that generally their family and friends had also been supportive but felt sometimes their friends' sympathetic comments were "a wee bit sort of superficial". This may characterise the isolation people can feel; other people just do not really understand what it is like to go through this experience.

The support that is offered by friends is not always appropriate. It is difficult for people with infertility problems to know which friends to confide in, and therefore who is likely to offer the most appropriate support. I consider that contact with an infertility support group may provide that missing link. Some people may be better helped by talking to a professional counsellor who has a thorough knowledge and understanding of the emotional difficulties associated with trying to conceive.

Social support research has found that significant others may try to be supportive but their comments or actions are perceived as unhelpful by the recipients (Abbey et al, 1991). In this study, I have found this has been the case for most of the participants. With respect to conceiving children, those who have been able to conceive often adopt an authoritative role on the matter and give advice on how to conceive. Such advice is often grounded in their own unique experiences, coloured by hearsay and mostly inappropriate to the recipient.

As the experience of trying to conceive is often of lengthy duration, it can sometimes be difficult to receive consistent, ongoing support from friends and family. People can feel helpless and frustrated as their efforts to be supportive appear ineffective (Abbey et al, 1991). It is often left to the two individuals to give support to one another, sometimes difficult to do when both are feeling burdened by their difficulties.

**Beliefs and Attitudes**

I was interested to learn how people's beliefs and attitudes might affect their reactions to infertility. The belief that it is our role to grow up, get married and have children is particularly strong. Toni felt she was not a real woman because:

> "when you're a child, you have dollies and things like that, in a pram, and sort of brought up with women having babies, and...mother will say...you'll have a baby one day".

Bill, as noted earlier, also felt a failure. Other people's beliefs and attitudes about "being a real man", helped shaped his own ideas. He was able to reflect on these attitudes:

> "I had been trying to make other people happy, make my parents happy, make the society I live, says I should have children; 2.4 I think the average is. So I've tried to be part of the law so to speak".

He added it was wrong to try and be the same as everybody else. Certainly, until recently, most people grew up believing that to have children was just part of life; a societal and cultural belief. Carter and Carter (1989) note that society accuse voluntarily childless people of selfishness which, in effect, has no substance. This attitude can make it very difficult for those trying to conceive as they are made to feel different. "Pronatalism has been a part of human custom and law for thousands of years...it serves an important function for us all" (Carter & Carter, 1989 pp.95-96).

## COMPARISON WITH PRIOR RESEARCH

The following discussion addresses my findings in relation to other research and the theoretical models presented in the introduction.

The feelings and experiences which my participants have described, reinforce mostly what previous research has found, as outlined in the introduction. They endured similar adverse psychosocial consequences, reached acceptance, developed new goals and experienced growth.

### Gender Differences

The women tended to experience more stress and disappointment than their partners. As noted earlier, the reasons may lie in the dynamics of attempting to conceive, with more investigations and interventions being female-oriented. Perhaps, too, the women who have grown up believing that rearing children will be their adult role, have more invested in trying to conceive. They are preparing for their life purpose and any blocks to that goal will carry disappointment, frustration and anger. Men, on the other hand, are more likely to be continuing on with developing their careers and not having children is less likely to affect their long-term goals. However, the study has also shown that men have been conditioned to become fathers and, in some cases, experience a sense of role failure. Women's greater propensity to express their feelings of distress than men, may account partially for gender differences.

### Grief Model

In some respects, the grief model is similar to the process described by the participants. For example, the feelings of sadness and, for some, depression, followed by later stages of resolution and growth certainly hold true. However, not all experienced feelings of shock,

disbelief and denial. For most participants, it was a gradual realisation over a long period of time that they may not be able to conceive. The only person who experienced shock was Bill. This was undoubtedly because he found out at an early stage about his sterility and in a very blunt way.

Participants did not use the term 'grief' which is associated with a loss. Feelings of loss were related to that of control, power, sense of purpose in life and having one's own family. Several people changed medical practitioners to ones who demonstrated a better understanding of their difficulties and who communicated well. This helped empower them to regain a degree of control over their lives. These dimensions of loss relate to Mahlstedt's (1985) discussion of a collective loss as a response to being unable to conceive.

The participants did share that sense of sadness that those who have reached resolution over a loss can feel. In my own experience, it was a relief to have reached a stage where I had accepted my infertility, but knowing it was natural to also feel sad at times over not having a child. For me, there was a sense of importance attached to those moments of sadness; it reminded me of what I had endured, of my growth and consequent, major lifestyle changes.

Overall, the grief model is not an adequate paradigm within which to understand the process of trying to conceive. At best, it partially describes the feelings and experiences of some participants.

**Situational Crisis Model**

The situational crisis model relates to an event of brief duration. Except for Bill, the participants' experiences were not illustrative of the situational crisis model. When Bill found out about his sterility, it was a shock and so constituted a situational crisis. The other participants went through several years of fertility difficulties, the span of which is not indicative of a situational crisis.

### Developmental Crisis

Once again, this model does not explain all the participants' experiences. It does serve as a good interpretation of Agapanthus' experience. In developmental terms, she resolved her crisis by continuing her career working with children, using her leisure time by creating exquisite needlework and by also taking a great interest in other people's children. She was able to achieve her 'task of generativity' by alternative ways than raising children. The developmental crisis model serves as a partial interpretation of the childlessness experience, but only if one conceptualises infertility as one of many dimensions of generativity. If rearing children is viewed as the only adulthood task of generativity, then this model does not explain all my participants' experiences.

### Medical Model

The medical model offers an incomplete and inadequate explanation. For some people, their infertility has a pathological origin, but for others it is unexplained. The stories related by the participants in this study speak of psychological effects, social consequences and are imbued with contextual factors. With respect to the 'medical' side of their experiences, it was their often, negative encounters with medical professionals which was the problem, rather than physical or 'medical' problems.

### Cultural Paradigm

The cultural paradigm is the most appropriate model as it takes into account contextual factors, particularly those of a personal and sociocultural nature. The social and cultural pressure to become parents can be quite strong and, for people like Toni, Bill and, to a certain degree, Wendy, not being able to conceive resulted in a feeling of role failure. Childlessness can attract stigmatisation and isolation (Miall, 1985; Sandelowski, 1988) and both Toni and Bill reacted very strongly to other people's hurtful comments. Although the cultural paradigm

explains infertility or childlessness quite well, it does not conceptualise it as a process. Like the other models, the experience is observed more as a passive or fixed event.

## GENERAL DISCUSSION

Repeated readings of the transcripts left me with the question: 'Why did some people experience deep distress while others seemed to just touch on sorrow?' Analysis of the transcripts did reveal some psychosocial differences between the participants. Factors seemed to emerge which reflected my own experiences of trying to conceive. I later realised that perhaps this knowledge had always been there, but I had never actually organised it into a cogent form. My own personal experience has, undoubtedly, influenced the way I have examined the data. For example, my knowledge of the importance of support, prompted me to look closely at this factor. Nevertheless, by staying close to the data, that is, asking questions, checking them out by re-reading transcripts, I was able to recognise other key factors and assemble my ideas into a model (Figure 1).

The factors which were germane to a less distressing process of trying to conceive were:

* Support

* Empathic Medical Practitioner

* Knowledge and Control
  - possible reasons for infertility
  - investigations and interventions

* Concurrent Activities
  - career development
  - leisure interests

* Alternative Plans for the Future

* Marital Relationship
  - good communication
  - feeling of happiness with partner

**Support**

The receipt of ongoing support is an integral part of coping with the infertility process. Often the participants appeared to be receiving support which, though well-meaning, was not always appropriate to their needs. Ideally, friends and family can be supportive by becoming informed about infertility and developing an understanding of what the individual or couple is experiencing. Often, all that a person needs is someone who will listen to them, be non-judgmental and show care and concern. At times, more concrete assistance may be required. Perhaps a significant other could say 'I'd like to be of help in some way. What would you like me to do?'. For example, a woman may appreciate the company of a close friend to accompany her to a clinic, particularly if her partner is not always able to attend. It can be a very lonely and distressing time straight after a consultation, especially when one has just been told 'just keep on trying, there's nothing wrong with you'.

Many people require more than support from friends and families and may well benefit from counselling. An appropriate counsellor could help the individual or couple learn to manage the stresses of trying to conceive and thus alleviate symptoms of distress. Contact names and numbers of counsellors or agencies could be made available to people at their doctor's surgery. It may be worthwhile for people to talk to a counsellor before they start experiencing problems, so that they learn appropriate skills to deal with any difficulties associated with not being able to conceive.

**Empathic Medical Practitioner**

Consultations with medical practitioners have been characterised by insensitivity, patronage and ignorance. These adverse encounters reinforce the necessity for medical professionals to have a greater understanding of the process of trying to conceive. It is not purely a physical procedure, rather one typified by psychological and social elements. Some of the participants spoke about GP's or gynaecologists they consulted in the early days of their fertility investigations and, consequently changed doctors. There is the possibility that doctors trained many years ago have not acquired a basic understanding of the psychological symptoms and needs of their patients. Hopefully, today's medical schools are redressing this aspect of practice.

Ideally the following should occur when an individual or couple consult a GP or gynaecologist when they find they are not conceiving. The doctor should have sufficient knowledge of, not only the physical side, but also the psychosocial aspects of infertility. He or she should be able to discuss with the couple their difficulties in a sensitive, caring manner. Sufficient information should be communicated to the people in a simple, clear fashion and, at the same time, inviting queries to ensure they fully understand. It would also be appropriate, at this stage, for the doctor to briefly inform the couple of common stresses associated with infertility and let them know there is counselling available if they would like to use it.

I consider that a pamphlet should be drawn up which outlines basic facts and figures about infertility. For example, statistics could be presented on how long it takes most people to conceive and how many couples do not ever conceive. Also, information should be provided on the different types of investigations and interventions involved. Further, common experiences could be shared, relating to effects on relationships, sexual relationships as well as feelings often associated with difficulties in conceiving. Knowing that they are not on their own can alleviate feelings of isolation for infertile people. Names and phone numbers of appropriate agencies where people could refer for counselling should also be included. The pamphlet could be handed to the couple at their consultation and could also be made available to any patients in the waiting room. The benefit of a pamphlet is that it can be taken away

and read at any time, it can be referred to and be also passed on to other people. People can forget everything they are told in a doctor's room, particularly if they are feeling upset at the time. A leaflet could be a useful source of information.

**Knowledge and Control**

As shown in the study, people feel more in control of their lives when they know what is happening and, if possible, know what is causing their infertility. Unfortunately, for a minority of people, they never find a reason. However, it is important they are kept fully informed about investigations and possible interventions worth trying.

There may come a stage for people when they realise that they may never conceive, or, if they do, it may take many years. It is a painful and difficult process to keep trying for years and years and, it may be helpful for people to consider the alternative of being child-free. They may not be ready to examine this option in the early days of trying to conceive, but it may take the guidance of a counsellor to help them explore this alternative. Carter and Carter (1989) talk about "ending your infertility" (p.56). It gives back the issue of choice to the individual or couple, when they choose to stop trying to conceive and live child-free.

> "To be childfree though, demands a choice. The transformation from acceptance of childlessness to childfree occurs through the process of making a life decision. It is not simply resigning yourself to your fate. It is not the stoic acceptance of what you can't change. No, it is the act of making a decision to create a positive change". (Carter & Carter, 1989; pp 59-60).

With respect to trying to conceive, I contend, therefore, that a sense of control over one's life can be facilitated by sufficient knowledge of possible reasons for non-conception, interventions, investigations and alternative options for the future.

### Concurrent Activities

So often the process of trying to conceive takes over a couple's lives. The people who continued to build up their careers, that is, further education, promotion, changing to a better job, along with enjoying leisure activities tended to cope with their fertility problems and suffer less distress than those whose whole focus centred on trying to conceive. It appears that a balanced lifestyle helps keep other issues in perspective. Sporting interests and hobbies may help to relieve tension as well as bringing a sense of achievement and pleasure. If employed, it may be important to continue developing a career. If the child does not eventuate, then the career is still there and has not been retarded.

### Alternative Plans for the Future

Alternative plans for the future emerged as another factor which can help people deal with the disappointment over a blocked goal. For example, Wendy and Jim planned to shift to another town and develop a small block of land, whether they conceived or not. It gave them an added dimension to their lives; something else to focus on and to look forward to. To find that we cannot have something that we have longed and waited for, can lead to great sorrow and emptiness. Most of the participants, at the time of the interview, had developed plans for the future, but, for some, these plans had not transpired until after they had endured much suffering.

This is an aspect which could be conveyed to couples when they first present with fertility difficulties. The future plans need not be alternative ones to raising a family; they could run concurrent. However, the point is that there is something else in the future to work towards and look forward to, should the couple remain childless. Concurrent with alternative plans for the future, I recommend placing a time limit on trying to conceive. For some couples, setting a date to review their situation would assist them in keeping their efforts in perspective.

## Marital Relationship

The individuals who appeared to communicate well with their partners and who were happy in their relationship, seemed to fare better than those who had less satisfactory relationships. It is difficult to say whether that was the case with Bill and Shirley. They did not mention what their early relationship was like, except that Bill said his alcoholism nearly broke up their marriage, yet, in the end, Shirley stood by him. Overall, the pressures of trying to conceive and, in some cases, learning that an individual is not fertile, can place great stress upon the marital relationship.

A couple of further points are worth examining. Women tend to respond differently from men to the infertility experience. This may be due to their differing expectations of what parenthood will bring them. For example, to many women, leaving a career to become the primary caregiver for the first few years is a greater lifestyle change to prepare for than remaining at work while the partner cares for the child. Another feature is that women tend to be more expressive in nature of their feelings, while men are more reserved. My participants' reports certainly indicate this view, also reflecting the women's observations that the men do not seem to be as concerned over not conceiving a child.

As pointed out earlier, if couples are able to talk over their concerns with a counsellor, they may learn ways to communicate better with each other and adopt ways of dealing with their stress. Preparation for the rigours ahead could diminish marital discord. It is important to remember that, for some people, their experiences have helped strengthen their relationship. Perhaps this could happen for other people too if they are given adequate support and counselling.

## Support for Grounded Theory

My study has disclosed certain factors which help explain differences between those people who experienced a greater degree of distress than other participants. These relationships may be difficult to uncover in a quantitative approach to analysis. Grounded theory has provided the framework from which to build a model of the process of wanting a child. From the

model, the relationships between different factors or categories are brought more clearly into focus. The theory derived from my research supports the choice of grounded theory for this study.

## LIMITATIONS OF THE STUDY & RECOMMENDATIONS FOR FUTURE RESEARCH

As with other studies of this nature, the participants do not constitute a representative sample. Nevertheless, the research has yielded several factors worthy of subsequent examination. A quantitative study could examine the relationships drawn from my research on a larger population sample.

This study has focussed on the mid-thirties age group, thereby precluding conclusions to be drawn on age and generational issues. A further study could examine and compare different age groups.

Another group of people that have had little research are those who are no longer trying to conceive and have remained childless, particularly in the older age group. A study on this group gives rise to the following questions :

* What were their experiences?

* 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 and disappointed?

There certainly seems to be a positive side to trying to conceive for some people, thus constituting an area worthy of examination.

In a larger sample, comparisons could be made between those that have received counselling, particularly in the initial stages, and those who have not.

A longitudinal study, as opposed to the more retrospective nature of the present one, could reveal richer information about the process. There would be value in employing both qualitative and quantitative data.

## SUMMARY

An examination of the process of trying to conceive must take into account many contextual factors. The reasons people want a child can have some impact upon their feelings, particularly those feelings related to a sense of role failure. The state of the marital relationship, the presence or absence of support, encounters with the medical profession, as well as concurrent activities, are all strong contextual factors which interact with the experience.

The participants in this study experienced wanting a child in terms of a long process. Essentially, it was typified by their efforts to conceive, investigations and interventions, experiences with the medical profession and consequent effects upon self, intimate and other relationships.

There was a negative impact upon affect, with most people experiencing a degree of sorrow. The model illustrates this dimension showing how all categories lead to sorrow and then move on to acceptance/resolution, new goals and, finally, growth. Some participants stayed longer at the stage of sorrow, experiencing further adverse effects such as ill health, one case of depression and suicide attempt and one instance of alcoholism. They all reached a stage of acceptance of their situation and most developed new goals or alternative future plans if they were to lead a childfree life. At the time of the interview, most people stated they felt happy and positive about their lives. However, for those participants who had not conceived, there was a sense of underlying sadness.

Certain factors emerged from this study which appear to make the experience of trying to conceive less distressful. These include:

* support
* empathic medical practitioner
* knowledge and control
* concurrent activities
* alternative future plans

* satisfactory marital relationship

Previous research has largely focussed upon specific features of infertility; the psychological effects of and adjustment to infertility having been well documented. Various paradigms have been used by other researchers to explain the experience of trying to conceive, but my research suggests that they only relate partially and also to only some people's experiences. My study has examined the overall picture of people's experiences, leaving them in the context of their lives. I have found that while people have experienced various negative psychological effects, they have also been able to work through their difficulties.

Trying to conceive a child over a long duration is characterised by interrelated physical, psychological and social stresses. Similar to other ordeals we may encounter in life, these stresses can be ameliorated with preparation, knowledge, support and a sense of control. For those currently suffering anguish over not being able to conceive, a more positive outlook to the future could be gently fostered. The alternative of living a child free life could be explored. Some people could benefit from spending time with a counsellor with in-depth knowledge of infertility issues; particularly those issues relating to psychosocial distress. There is also merit in people attending an infertility support group. Such groups can encourage discussion about trying to conceive, promote sharing of problems in a supportive atmosphere and lead to an exchange of ideas. A support group also diminishes the sense of isolation people often feel with respect to their fertility difficulties.

Society tends to view childlessness as an aberration, or a role failure, making it difficult for couples to accept that living child free is a positive alternative. On the other hand, if society became more accepting of childless couples, hopefully these people would suffer less distress and be able to move on with their lives. Both infertile people, in particular, and society, in general, could gain by having greater knowledge of the process of infertility. The group trying to conceive would benefit by maintaining or regaining a sense of control over their lives. The community would be better able to offer appropriate support and understanding to those trying to conceive.

While acknowledging certain limitations, the discovery of those factors which may lessen the distress people may endure while trying to conceive, has made the study a valuable contribution to research. The application of these findings could provide a good grounding for further research. They can also help both professional people and people with fertility difficulties adopt a better understanding of the infertility process.

**Appendix 1**

**MASSEY UNIVERSITY**

**Human Ethics Committee**

**Name of Applicant:** Ruth Mortimer

**Department:** Psychology

**Project Status:** Masters thesis

**Name of Supervisor:** Dr Ross Flett

**Funding Sources for the Project:** N/A

**Title of Project:** The psychosocial effects of infertility: a qualitative study

**Description of Project:**

**(a) Justification**

Infertility can exert major adverse effects upon the quality of people's lives. The psychosocial effects can lead to deterioration in physical and mental health, disrupted careers, social interactions and marital functioning. Ten percent of couples are infertile, but recent studies suggest that this figure is rising which may well lead to a greater incidence of both individual and marital problems. Prior quantitative research has produced much data about infertility, but has not been able to capture fully the diversity of individuals' experiences. Earlier research has also concentrated on the female account of infertility. The present study will help redress the imbalance be incorporating both males' and females' experiences.

The present study, outlined below, will comprise multiple-case studies of couples' experiences to examine existing theory and, if appropriate, develop an alternative theory. The identification and examination of both short and long-term negative and possible positive effects, can be fruitfully employed in the counselling and support of infertile people.

**(b) Objectives**

The broad objective of the present study is to employ a qualitative approach to collecting information on the psychological and social effects of infertility upon people's lives. The

study proposes to reveal fresh slants and illuminate prior quantitative research. A further objective is to examine gender differences in the experience of infertility.

**(c) Procedure for recruiting participants and obtaining informed consent**

Subjects will comprise six infertile couples from the Manawatu area, derived from the local Infertility Support Group. The researcher will attend a group support meeting to explain the nature of the study and invite couples' participation. If not enough couples are obtained through the Support Group, advertisements will be placed in The Tribune and The Guardian to invite volunteers to take part in the study.

Volunteers will be given an information sheet (Appendix 1), a consent form (Appendix 2) and an appointment will be made for the first meeting. The initial meeting is designed to familiarise the couple with the procedure of the main interview and allow the opportunity for questions to be asked. Ruth Mortimer will tell prospective participants that she is working on her thesis as a requirement of her Masters degree in psychology and that she is also training to be a clinical psychologist. She will disclose a little of her background relating to her experiences of infertility in order to develop rapport and show that she has a genuine interest in and understanding of infertility. The fact that she is a mature woman should also serve to enhance her role in this study.

**(d) Procedures in which research participants will be involved**

Participants will be involved in three stages of the study. The initial stage is the first meeting where the researcher explains the nature of the study. The second stage is the main interview where the couple is interviewed individually and then together. The last meeting is for the couple to read over the transcript of their accounts and make any amendments or additions.

**(e) Procedures for handling information and materials**

All tapes and tape transcripts will be stored securely and will only be accessible to the researcher. All participants will receive a summary of the research at the completion of the study.

## ETHICAL CONCERNS

The study will be conducted within the ethical guidelines of Massey University and the New Zealand Psychological Society.

### (a) Access to participants

There is no problem with gaining access to participants.

### (b) Informed consent

Potential participants will be fully informed about the study and their rights, both orally and in writing, and will have the opportunity to raise questions with the researcher. Both the participant and the researcher will sign and retain copies of the consent forms. These forms are attached in the Appendices.

### (c) Confidentiality

All materials produced in the course of the research will be stored securely. Fictitious names will be used in the transcripts to ensure confidentiality, while the results of the study will be written in a form that precludes the identification of particular participant.

### (d) Potential harm to participants

When discussing marital relationships, some people may experience discomfort or distress, or conflict between partners may arise. Participants will be advised of this possibility and that should any problems result from the interview, the researcher can advise the names of an appropriate counsellor agency if they require guidance. The first interview will serve to stimulate discussion between the people in the interim period before the main interview. Prior discussion between the couple should minimise possible distress and foster communication.

However, for the majority of couples, the opportunity to share experiences of infertility with an informed and empathic researcher, can have liberating effects. Such disclosure can also clarify issues and promote understanding between partners as they communicate their personal experiences of infertility.

**(e) Participants' rights to decline**

Participants will be advised orally and in writing that their participation is purely voluntary and that they may withdraw from the study at any stage. The researcher will telephone each couple after the first meeting to confirm the date of the main interview. At this stage, the researcher will remind the participants of their right to decline to participate in the study. A further telephone call will be made a few days after the main interview to thank them for their co-operation and time and to allow further opportunity to withdraw if they so desire.

**(f) Arrangement for participants to receive information**

At the third meeting, the researcher will discuss with the participants their transcripts and provide the opportunity for further questions and discussion. Each participant will receive a summary of the research.

**(g) Use of the information**

The main objective of the study is to produce a masters' thesis in the area of psychology of a publishable standard.

**(h) Conflicts of interest**

There are no conflicts of interests in the research. The research will not interview participants personally known to her. The issue of research funding is not applicable.

**LEGAL ISSUES**

No legal issues are foreseen with respect to copyright, ownership of data or materials, or any conflicts of interest arising from the research.

**OTHER ETHICAL COMMITTEE SUBMISSIONS**

No submissions will be made to other ethical committees.

**MATTERS TO BE DISCUSSED WITH THE ETHICS COMMITTEE**

There are no other specific matters which we wish to raise with the Ethics Committee for discussion.

**Appendix 2**

## The Psychosocial Effects of Infertility: A Qualitative Study

### Information Sheet

My name is Ruth Mortimer and I am completing an MA in psychology. My thesis topic is studying the psychosocial effects of infertility on individuals and couples. I am working under the supervision of Dr Ross Flett and Dr Mandy Morgan from the Massey University Psychology Department.

I am seeking volunteers who would like to participate in my study.

First of all, I would like to give you some personal background. Several years ago, my former husband and I tried to conceive over a five year period, but to no avail. I was diagnosed as having endometriosis which seemed to be the only possible factor preventing conception. After several years of emotional distress and disappointment, we gave up trying to conceive.

With the support and encouragement of my husband, I undertook extramural university study and, a couple of years later after my marriage broke up, I moved to Palmerston north to attend university full-time. I finally came to terms with being childless, although still felt quite sad about it at times. I had gained strength and confidence from those painful earlier years and found fulfilment in my studies and training towards a career as a clinical psychologist.

I decided that infertility would be an interesting topic to research for my thesis and commenced research early this year. However, incredibly, a few months later, I became

pregnant and appeared to conceive on my 40th birthday. My partner and I were totally surprised, but very thrilled.

I then became concerned about my research. Would it be insensitive to interview people while I was pregnant? I grappled with this issue until I decided to change my focus and only interview people who are no longer trying to conceive and, in particular, the older age group. Unfortunately, I have found it extremely difficult to get participants for my study. I have now decided to also include those who are currently trying to conceive and hope that my personal disclosure on this information sheet will enable people to decide whether they would like to participate or not.

**What is involved?**

I will discuss with you, either by phone, or in person, details of the study. If you are willing to participate I would require 30 - 45 minutes of your time for a taped interview.

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 that occur to you during your participation;
* provide information on the understanding that it is completely confidential to the researchers; you will be asked to provide a fictitious name to ensure that you will not be identified in the write-up of the study;
* be given a summary of the findings from the study when it is concluded.

I will not be acting in the role of specialist in the field of infertility, nor as a clinical or counselling psychologist. If you have any concerns arising from the study, the attached sheet lists names of agencies which can provide guidance.

If you are interested in taking part, please complete the enclosed form and mail it back in the stamped, addressed envelope provided. I will then get in touch with you to discuss any further details.

You are very welcome to phone me at Massey, 3569099 X 7187, or leave a message for me at the psychology department, or at my home, 3554173 if you require information.

Thank you for taking the time to read this sheet and I look forward to possibly hearing from you.

**Ruth Mortimer**

**Infertility Study**

**Name**.....

**Address**.....

.....

**Telephone**.....

This is not a consent form. It is only indicating possible interest in participating in the study.

Thank you for your interest and I will contact you shortly.

**Ruth Mortimer**

**Appendix 3** **The Psychological Effects of Infertility**

## Consent Form

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 am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researchers on the understanding that it is completely confidential.

I wish to participate in this study under the conditions set out on the Information Sheet.

**Signed:** .....

**Name:** .....

**Date:** .....

**Researcher:** .....

**Appendix 4**

**Interview Schedule**

1 Discuss expectations, if any, of having children.

2 Did trying to conceive have any effects on marriage.
- sexual relationship
- other areas of the relationship

3 Effects on other relationships
- family, friends, others.

4 Effects on career plans.

5 Did you reach a stage where you realised you may remain childless? Discuss.

6 Experiences with medical profession.

7 Any alternative plans if remaining childless.

8 General comments or reflections on the whole experience.

**Note**

Other areas, for example, people's feelings, attitudes, ways of coping and support were also brought up if the participant had not already discussed them.

**Appendix 5**

**Sample Letter**

Dear Bill and Shirley

Thank you both for giving up your time last Saturday morning to talk to me about your experiences of infertility. I found your story, though sad, most interesting and it will be of great help to my study. I appreciate your candour in discussing quite intimate and painful details. However, I am pleased for you both that you are now able to get on with your lives by making plans and enjoying yourselves.

I have enclosed a transcript of the interview and would ask you to read it through, correcting any errors, and noting any areas you may like omitted. You are free to add anything as well. There is no urgency for this, so take your time. I have enclosed a freepost envelope for you to return the transcript.

I did enjoy meeting you both and found I learned a lot from listening to your experiences. Once again thank you for your participation.

Yours sincerely

Ruth Mortimer

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