How couples appraise and communicate about their fertility problems:
A study using Interpretative Phenomenological Analysis

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ABSTRACT

The focus of this study is the impact of fertility problems on couples as a unit. The meaning of fertility problems and how couples reported they communicated were the main areas of interest. A cross-sectional semi-structured interview study was employed. Ten couples were recruited via the Hull IVF unit and interviewed by the primary researcher. The interview transcripts were analysed using Interpretative Phenomenological Analysis. Two super-ordinate themes emerged: *Expectations of life* —“What's it all about?” highlighted the lifecycle expectations people have; how when our expectations are not met one considers one's commitments and goals in life; and the impact of fertility treatment on all of these factors. *Dealing with ongoing fertility problems* —“When it doesn't happen how we expect” presented the differing responses to ongoing infertility with feelings of resentment and acceptance emerging. Communication was revealed to play an important, yet complex, role in the experience of continued fertility problems. Women seemed to have a greater need for communicating, both with their partner and with others. The couples that reported effective communication were also more likely to report successfully managing any differences as well as satisfaction with their relationship. The themes were discussed in relation to previous theory and research; the stress and coping model was found to be helpful for guiding the research process, but did not seem sufficient to fully explain the depth of meaning the fertility problems had for the couples. Further research on couple communication is recommended. The main clinical implications of the study pointed to couples needing time out from treatment to process their experiences and for counselling to be offered more regularly at different points in time.
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1. INTRODUCTION

1.1 Overview

This study is interested in how fertility problems impact on couples and how the couples manage and communicate about these problems. This is considered important because, although the fertility problem may only lie in one of the partners, both partners potentially face the prospect of childlessness. How each individual appraises and copes with the fertility problem is in turn going to impact on their partner, and how this affects both the relationship and the level of distress is of interest to the clinician working in this field.

This chapter will consider the different interacting factors and theories that are important in the overall understanding of fertility problems. Firstly, the social context of infertility is presented considering the differences between the genders in terms of parenthood. Psychological theories are then described to provide a model of understanding for the different psychological reactions individuals have to their fertility problem. The literature focusing on the psychological responses to fertility problems is then examined briefly followed by a closer look at investigations that have gender as their major focus. This research highlights the need for studies to examine the processes between the couples, specifically looking at communication and thus providing the justification for this study. Finally, the rationale for using the qualitative method of Interpretative Phenomenological Analysis is given.

1.2 Social context of fertility problems

The social systems within which people live impart cultural ideals and norms. One of these norms is to have children; this is unaltered by racial, sexual, religious, ethnic or social class divisions (Veevers, 1980). In a Canadian study, over 80% of respondents
rated motherhood and fatherhood as being important, and over 75% rated it was important that parenthood was biological (Miall, 1994). The views and beliefs held by members of society about infertility are likely to impact on the individual and couple who experience fertility problems.

It has been argued that infertility is a stigma violating the norms of acceptable behaviour (Pfeffer, 1987; Veevers, 1980). The notion that infertility has a psychological cause, that individuals are ‘trying too hard,’ ‘just need to relax’ or ‘need to be told about the facts of life’ can also cause feelings of stigma (Miall, 1994). In fact, for unexplained infertility, the dominant model through to the mid-1980’s was the psychogenic model, which assumed the cause of infertility was the woman’s unconscious resistance to motherhood (e.g. Fischer, 1953; Rothman Kaplan Nettles, 1962). This model has now been largely refuted as the evidence for its development was weak and biased (Greil, 1997); also systematic studies have demonstrated there are no personality differences between the fertile and non-fertile (Greil, 1997). Recent research has implicated stress as a contributing factor to fertility problems (e.g. Boivin & Takefman, 1995; Domar, Zuttermeister, Seibel, Benson, 1992), although further research is needed in this area.

Involuntarily-childless women viewed infertility as representing failure, and experienced feelings of anxiety, conflict and isolation (Miall, 1986). These women frequently excluded themselves from social situations that involved children. In an earlier study, Miall (1985) had described how childless women often felt more isolated as they were treated as second-class citizens by women with children as they could not contribute to child-centred conversations. Abbey, Andrews & Halman (1991) found
that support offered to infertile couples by friends and family often exacerbates their negative feelings due to well-meaning but misguided advice.

Despite the increasing equality between men and women in western society during the last century, it remains that a woman's reproductive capacity defines them (Genevie & Margolis, 1987; Stanworth, 1987). Although the cause of infertility is equally distributed between men and women, women are regarded most often as being responsible for infertility (Miall, 1986; Griel, Leitko, Porter, 1988).

Furthermore, the genders are seen differently in terms of the biological and social pressures to reproduce. Miall (1994) conducted a study in Canada that explored attitudes towards infertility. A random sample of participants was recruited using a city directory. This method yielded a 63% response rate made up of 71 males and 79 females. The sample was predominantly Caucasian with a high educational and occupational status. The participants were interviewed using a standardised interview schedule that combined fixed alternative and extensive open-ended questions to elicit meanings.

The results of the study indicated that motherhood was seen as an innate desire for women, with significantly more men holding this view. On the other hand, the desire for fatherhood was seen as a learned behaviour, with more women than men holding this view. The men of this study viewed their career as significantly more important than the women, and significantly more women rated motherhood as more important than a career. Almost all the men and women (96% and 91% respectively) rated that women want children more than men. The reasons given for this concerned females having an innate drive towards motherhood as well as social conditioning.
In this study there was also a perceived gender difference in how society views infertility. Specifically, it was felt that infertile men were more likely to be ridiculed whereas infertile women were more likely to be offered sympathy (Miall, 1994). In fact, studies have shown that women frequently take the blame for infertility even when the problem lies with the male (McEwan, Costello & Taylor 1987). A reason for this seems to be that male infertility is seen as somehow linked to sexual identity and masculinity; infertility results in a tarnished male ego (Miall, 1986; 1994).

The importance of children and the differing parental roles for men and women is reflected in UK society. The recent government census (2001) reveals that across England and Wales 48% of married couples have dependent children, showing that having children is the norm for our society. The figure of 48% is probably an underestimate of the number of married couples with children as it only represents dependent children. Nine out of ten single parents are women. Nearly half of female single parents work, whereas nearly two thirds of male single parents work (National Statistics website) which fits in with Miall’s (1994) finding that men view their career as more important, whereas women view motherhood as more important. The statistics regarding single parents perhaps shows that in the UK women are seen by society as the more important parent. This is also reflected in our child custodial laws in that women tend to be favoured.

1.3 Theories to explain the psychological responses to fertility problems

*Lifecycle*

In Erik Erikson’s immensely influential chapter ‘Eight Ages of Man’, he details eight psychosocial stages that an individual goes through from childhood to old age.
Satisfactory development is achieved if the individual resolves the dilemma presented by each stage of life. Procreation is a central feature of two of the stages in adulthood. Young adults face the task of intimacy versus isolation. The goal of intimacy is achieved through commitment to a partner “with whom one is able and willing to share mutual trust and with whom one is able to regulate cycle of work, procreation, recreation, so as to secure the offspring, too, all the stages of satisfactory development.” (Erikson, 1950 p.257). The dilemma of middle adulthood is generativity versus stagnation; generativity is achieved through establishing and guiding the next generation. Erikson suggests children are neither necessary nor sufficient to move successfully through these stages, yet, the emphasis is that children are a biological, social and cultural expectation and usually inherent in the satisfactory development of the self.

The stages of the family lifecycle proposed by Carter and McGoldrick (1980) also places emphasis on the importance of children. Children are a consideration in the last four stages of this eight-stage model. Adjusting relationships with one’s partner to accommodate children; adjusting relationships with children once they reach adolescence; launching children; and adjusting to children taking a more central role in family maintenance.

The expectation and desire for procreation is documented throughout history and across cultures (Burns & Covington 1999) and, arguably, this is ultimately driven by the selfish gene as described by Dawkins (1976). Therefore, when these stages of the lifecycle are essentially blocked by fertility problems, psychological problems may ensue.
Life-crisis theory

The life-crisis theory was proposed by Menning (1977) and views infertility as a major negative event that is unexpected. Scholssberg, Waters & Goodman (1995) argue that the lack of an expected transition can also be viewed as a crisis. As emphasised in the previous section procreation is an expectation that most people hold, and is inherent in the normal expected development of the individual and the family. Parenthood fulfils personal and societal goals so the inability to achieve these can cause a life crisis (Berk & Shapiro, 1984; Forrest & Gilbert, 1992; Menning 1977; Williams, Bischoff & Ludes 1992).

Grief models

Menning (1980) applied the Kübler-Ross model of grief to the explanation of the reactions to fertility problems. The model delineates five stages of grief: shock, denial, anger, bargaining and acceptance. Couples may experience a number of losses perhaps largely in terms of the loss of potential to have a child. They may also experience failed treatment as a loss, as often the involved process of IVF can lead to a perceived bond with the embryo, so if treatment fails it can feel like the loss of a child. Menning argued that this predictable pattern of feelings is evoked by the losses experienced by individuals with fertility problems.

Other models of grief and bereavement have also been applied to the experience of infertile couples. Based on information-processing theory and attachment theory, Bowlby (1980) suggested a model in which the phases of grief are: numbing, yearning and searching, disorganisation and despair, and reorganisation. Bowlby's model provided the foundation for further models (e.g. Sanders, 1989) that recognize the
active and dynamic participation of the individual as well as acknowledging the typical responses in grief.

Burns and Covington (1999) describe the 'keening syndrome' that refers to an Irish custom of grieving where the men sit around the edges of the room whilst the women prepare the body, weeping and wailing. They reflect this is how couples often grieve infertility with the male being the 'forgotten mourner'. This gender difference in response to loss could ultimately impact on the emotional well-being of the individuals involved as well as the relationship-satisfaction of the couple. It has been suggested that loss is more salient for women than for men, with men feeling threat more powerfully than loss (Glover, Gannon, Sher, & Abel, 1996).

Although some argue that grief models do not take into account the enduring nature of infertility (Unruh & McGrath, 1985), grief models have been very influential in guiding therapeutic interventions used by fertility counsellors.

**Biopsychosocial theory**

This theory takes into account the many biological, psychological and social factors that can influence the individual's response to fertility problems. Gerrity (2001) discusses the different stressors that fertility problems present, namely, existential, physical, emotional and relationship stressors. She argues that this biopsychosocial theory accounts for the effect of fertility problems on family relationships and across time. This theory has led to the development of stage models of infertility. For example, Blenner (1990), based on a qualitative study of 25 couples, proposed eight psychological stages that fell under three categories. The first category was engagement and included: the dawning of awareness, facing a new reality and having
hope and determination. Immersion was the second category including the stages of intensifying treatment and spiralling down. The final category was disengagement which involved: letting go, quitting and moving out, and shifting the focus. In a study across five stages of infertility, examining individuals and couples, Gerrity (2001) found that gender and stage of infertility influenced differences in anxiety and coping techniques.

It was argued by Pasch and Dunkel-Schetter (1997) that the effect of infertility fits with a stress and coping model and needs to be addressed at the level of the couple.

**Stress and coping**

The stress and coping theory described by Folkman (1984) provides a good framework for understanding the impact of fertility problems on the couple. One of the main facets of this theory is the interplay between the individual and their environment. Stress occurs when an individual appraises the environment as taxing or exceeding his or her resources and as endangering his or her well-being. The theory emphasises that the person and the environment are in a bi-directional dynamic relationship that constantly changes. The stress and coping model can apply to the other theories presented in this section and will therefore be explored in more depth.

**Appraisal**

When a person evaluates the significance of a specific transaction with respect to well-being, they are engaging in the ‘primary appraisal’ of that transaction. After determining the significance, the person then evaluates their coping options and resources; this is secondary appraisal. These cognitive appraisal processes determine
the meaning of an event to an individual. Appraisals are shaped by personal and situational factors, namely their beliefs and commitments.

People’s beliefs, referred to by cognitive psychologists as schemas (e.g. Beck, 1976), are shaped by their life experiences. Beliefs serve as a perceptual lens from which the world is viewed. Rotter (1966) explored the generalised beliefs people have about control and presents two polarities for a person’s locus of control namely internal and external. People with an internal locus of control believe events are dependent on one’s own behaviour, whereas those with an external locus of control believe events depend on luck, fate or powerful others, not on one’s own actions. When a person is faced with a novel or ambiguous situation, such beliefs have their greatest influence. The more ambiguous a situation is, the more influence personal factors have in determining the meaning of the environment (Lazarus, Eriksen, & Fonda 1951; Schank & Abelson, 1977). Issues of control have particular relevance to the experience of fertility problems in terms of the appraisal and coping. Unexplained infertility is especially ambiguous, therefore the meaning couples attribute to the fertility problem will be more influenced by personal factors.

Commitments can be a person’s values, ideals, or specific goals that they have in life. As is seen in the life cycle models parenthood is a personal and societal ideal for most people. Therefore, people tend to have specific goals, or values and ideals about parenthood and raising a family. Folkman (1984) argues that a situation will be appraised as significant when it involves the potential threat or harm of a strongly held commitment. The extent of the commitment can also affect the significance of beliefs about control on a specific encounter. So, controllability becomes more important when
there is more at stake. In addition to a person's beliefs and commitments the situational factors can also influence primary appraisal.

Secondary appraisal involves the evaluations of coping resources – physical, social, financial, psychological and material; and the options available to the person. Part of this secondary appraisal is the situational appraisal of control.

*Coping*

Folkman and Lazarus (1980) defined coping as “cognitive and behavioural efforts to master, reduce or tolerate the internal and or external demands that are created by the stressful transaction”. This definition of coping is independent of its outcome. Coping may serve the function of managing the problem (problem-focused), or it may serve the function of regulating emotions or distress (emotion-focused). Emotion-focused coping can be used to enhance a person’s sense of control by altering the meaning of a situation. Strategies may include focusing on the positive aspects of negative outcomes (‘the fertility problems have brought us closer together’), or engaging in positive comparisons (‘I’m a lot better off than...’). It is recognised that emotion-focused coping can be difficult to distinguish from appraisal; in fact, many forms of appraisal have a coping function and can help regulate distress.

Folkman (1984) argued that successful coping and adaptation to chronic long term stressors, which fertility problems often are, may require both active coping as well as periods of denial or escape during which psychological resources and positive affect can be restored.
The theories and models considered here are not necessarily in opposition, but perhaps focus more closely on one particular element of the infertility experience. For example, the stress and coping model can fit with a number of the other models as the primary appraisal an individual makes is determined by their life expectations, or what they expect to happen in their lifecycle. The secondary appraisal, or the coping response, may fit with the grief model of infertility as a person’s coping may well reflect the stages of grief. It is useful to bear in mind the theoretical models when considering the literature as some models may better explain the findings than others.

In order to understand couples’ experiences more clearly it is important to consider the medical aspects of fertility problems and some of the treatment options that may be available to couples. This will provide some insight into the decisions that couples may face.

1.4 Medical aspects of fertility problems

Over the years, fertility problems have become increasingly medicalised. Although this has improved couples’ chances of conceiving a child that is biologically theirs, it can also prolong the infertility experience. Couples can feel pressured into pursuing a medical solution and any ambivalent feelings may be denied as they might suggest a baby is not really wanted (Jones & Hunter, 1996).

**Diagnostic**

Couples who have been trying to conceive for 12 months or more without success are medically defined as infertile. It is estimated that one in six couples in the UK experience fertility problems at some time in their lives (Human Fertilization and Embryology Authority [HFEA], 2002).
Location of cause

Both men and women are equally affected by sub-fertility. In men, problems are commonly due to poor sperm quality, whereas in women causes include tubal disease and endometriosis (HFEA, 2003). The cause of fertility problems is estimated to be one third male factor, one third female factor and one third unexplained.

The cause of the fertility problem may lie in only one of the partners, yet the prospect of childlessness is confronted by both partners. This makes infertility a couple’s problem presenting a distinctive challenge that could potentially impact on the quality and satisfaction of a relationship (Pasch and Christensen, 2000).

Treatment options

Over the past thirty years, there have been significant medical and technological advances in reproductive health. The probability of people with fertility problems having their own biological child has improved. These advances have numerous implications on the psychological consequences of fertility problems, namely although they offer hope they can also extend uncertainty and thus distress. In addition, the increased knowledge regarding the causes of fertility problems have been instrumental in refuting psychogenic explanations for infertility that theorised that infertility was due to the female’s unconscious fears of motherhood thus implying psychological problems were the cause rather than the consequence of infertility.

Assisted Reproductive Technology (ART) is a collective term used to describe a number of treatment options available. Perhaps the most widely known is In Vitro Fertilisation (IVF). This technique involves the use of hormones to stimulate the
maturation of the female eggs; mature eggs are then removed and fertilised in the laboratory by the man's sperm. The embryos are then transferred back into the uterus. Approximately one in three couples achieve pregnancy with this technique.

A more recent development that has improved prospects for male-factor infertility is Intra Cytoplasmic Sperm Injection (ICSI). This is where a single sperm is injected into the egg for fertilisation to occur.

Other treatment options include the use of donor eggs or sperm, which for at least one of the partners results in biological childlessness. Other alternatives that people have are adoption or remaining childfree.

After a diagnosis of infertility, there are many difficult decisions about the way forward for the couple. For some it may be a matter of pursuing available treatment options, for others it may be adoption, or remaining childless, and for some couples it may lead to the break down of the relationship and each partner going their separate ways. The impact of fertility problems and the numerous issues it raises for a couple have been the source of investigation for much research.

1.5 Psychological responses to fertility problems

Factors to consider

Numerous factors influence a person's psychological response to an event. The factors specific to the experience of fertility problems include: where the problem lies (i.e. male/female factor, or unexplained); the nature of treatment, if any; the stage of treatment; and the financial implications of having treatment.
A characteristic of the infertility literature is that the type of methodology used seems to determine the findings, thus presenting apparently different stories about the impact that fertility problems have on people. Although some studies use both qualitative and quantitative methods the following literature has been divided in order to consider with greater ease what it is about the methodology used that impacts on findings and the reasons for the differences.

**Qualitative research**

An advantage of the qualitative literature is that it allows the experience of fertility problems to be examined within the social context, therefore taking into consideration the various influences that contribute to the meaning of fertility problems to different people. The research in this area includes semi-structured interview studies with women and couples, descriptive questionnaires, and clinical-anecdotal reports. By and large the descriptive literature depicts the experience of having fertility problems as devastating, particularly for women.

Dunkel-Schetter and Lobel (1991) reviewed the clinical-anecdotal and qualitative literature and divided effect of infertility into four areas: emotional effects, loss of control, effects on self-esteem, identity, beliefs, and social effects. Themes that recur in terms of the emotional response to infertility are grief and depression, anger, guilt, shock or denial, and anxiety.

Overall, qualitative research has found infertility to have a negative impact on the couple’s relationship. Partners have reported feelings of hostility, anger and blame as well as anxiety about their relationship (Cook, 1987; Dunkel-Schetter & Lobel, 1991; Mahlstead, 1985). Nevertheless, it is important to point out that the descriptive
literature does not make comparisons to other couples, but attempts to characterise the situation of having fertility problems. Thus, simply because infertility presents couples with a crisis, it does not necessarily follow that these couples’ relationships are any worse off than presumed fertile couples. In fact, infertile couples also report that their fertility problems have brought them together (e.g. Greil, 1991).

In a more recent review by Greil (1997) a number of themes emerge from this literature, some of which are presented below.

1. Infertility as a central focus for identity especially for women (Olshansky, 1987; Greil, 1991; Greil, 1989).

2. *Feelings of loss of control* and attempts to regain control (Becker, 1994; Woollett, 1985; Mahlstedt, MacDuff, & Bernstein, 1987).

3. *Feelings of defectiveness and reduced competence,* especially for women (Valentine, 1986; Mahlstedt et al., 1987).


5. *Stress on marital and sexual relations* at the same time there exists a counter-tendency for infertility to “pull couples together” (Freeman, Boxer, Rickels, Turek, & Mastroianni, 1985; Lalos, Lalos, Jacobson, & von Schoulzt, 1985; Greil, 1991; Lorber & Bandlamudi, 1993; Valentine, 1986; Sabatelli, Meth, & Gavazzi, 1988).


There are limitations with the qualitative research, namely, the small sample sizes, overemphasis on women, as well as it being weakened by its retrospective nature. A point highlighted by Dunkle-Schetter and Lobel (1991) is that the clinical-anecdotal literature that makes up some of the qualitative research represents problems experienced by a small number of patients that had sought psychological help and this had been over-generalised to the rest of the infertility population giving a negatively-biased view. However, despite these limitations, Berg, Wilson and Weingartner (1991) argued that the qualitative research has been the most insightful.

Quantitative research

Quantitative research sets out to test the hypothesis that fertility problems cause negative psychological consequences. Certain psychological characteristics of infertile participants are compared to the general population either by the use of control groups or the norms of standardized measures.

The results of numerous studies have been equivocal. A review by Dunkel-Schetter and Lobel (1991) concluded that there was no consistent empirical evidence that infertility caused a strong negative psychological reaction; whereas Wright, Allard, Lecours, and Sabourin (1989) concluded that infertile individuals are more psychologically distressed than the general population. One reason for such opposing conclusions seems to be the authors’ interpretations of what should be counted as ‘more distressed’. Wright et al. (1989) concluded that the psychological consequence hypothesis was supported if infertile participants scored higher than norms or controls on just one of six subscales.
on a psychological measure, whereas, Dunkle-Schetter and Lobel (1991) concluded it was not.

Stanton and Danoff-Burg (1995) reviewed studies published since 1982. The studies reviewed used psychometrically established self-report measures of distress and psychopathology, sexual satisfaction/functioning, and marital satisfaction/quality. Comparisons to control groups or available norms were made. Thirty-one studies were reviewed. There were mixed findings regarding the psychological distress and symptomatology. Seven studies indicated greater levels of distress in infertile women compared to norms, 12 studies indicated levels of distress were comparable to norms, and 9 studies produced mixed results. There was considerable variability in the infertile women's scores, and even when they reported significantly greater distress on average, the differences compared to the control groups were not that extreme.

The most consistent findings were in the research regarding sexual and marital satisfaction, revealing no difference between infertile women and controls, or yielding satisfaction scores within the normal range. The authors concluded that people with fertility problems do not experience clinically significant psychological reactions or adverse marital and sexual consequences.

To sum up, perhaps the best way to understand the conclusions from the quantitative literature comes from Greil's (1997) statement:

Although the psychological distress literature does not speak with one voice, it may be safe to assert that the infertile seem to be distressed compared to other individuals but not in a clinically significant way. (pp. 1683)
It should be noted that in the studies reviewed there were numerous different measures used; there was variation in terms of the time at which measures were administered and in the sample size. In addition, as with most research in the area of infertility, the majority of the research was conducted on females only.

A conceptual shortcoming of the quantitative literature is that it has seemingly overlooked the social construction of infertility, transforming what should be understood as a characteristic of a social situation into an individual trait (Greil, 1997).

Explanations for discrepancy in the research

Studies examining the impact of infertility on relationship satisfaction remain divided. Dunkel-Schetter and Lobel (1991) suggest the variability in reactions to infertility is the factor that best explains the discrepancy between the qualitative and the quantitative research. The variability in reactions can be explained by the stress and coping model presented earlier. How an individual appraises their fertility problem is determined by the beliefs and commitments they hold regarding having children. This is shaped by the social context, and the psychological models that describe lifecycles. The person's appraisal of their fertility problems will determine how they respond and the level of distress they feel. This highlights the possibility that within a couple infertility may have a different meaning and consequence for one partner than for the other. How this affects the couple and how couples manage the differences have yet to be explored in depth.
1.6 The impact of gender on the experience of fertility problems

In most societies, men and women are socialized to have different roles. Although in Western society these roles are becoming more similar, traditionally women were wives and mothers and men provided the financial or material support. The biological reproductive difference between men and women also impacts on the socialisation of the genders. It is the woman who experiences the nine-month pregnancy and the birth, presumably thinking a lot more about the whole reproductive process. These differences between men and women are hypothesised to impact on the responses they have to infertility, and given that infertility is experienced within a couple-context, it is important to consider possible differences and how these may interact. Although differences may not always fall along gendered lines, a potential mismatch in the reaction to infertility could lead to difficulties within a couple’s relationship.

To date, the literature that has explored gender differences has found that infertility is a more stressful experience for women than it is for men; this is particularly apparent in the studies that have used specific infertility measures.

In brief, compared to men, women are more likely to have lower self esteem (Wright et al. 1991; Beaupaire et al. 1994; Pasch. 1994), be more depressed (Beaupaire et al. 1994; Berg et al 1991; Abbey et al. 1991), report lower life satisfaction (Abbey et al. 1991; Link et al. 1986), blame themselves for the infertility (Berg et al. 1991; Dunkel-Schetter & Lobel, 1991; Abbey et al. 1991; Abbey et al. 1995), regard childlessness as unacceptable (Berg et al. 1991; Ulbrich et al. 1990), avoid children and pregnant women (Berg et al. 1991), initiate treatment (Becker & Nachtigall, 1994; McGrade & Tolor, 1981), seek out information about infertility (Berg et al. 1991), find that achieving parenthood provides a remedy for the negative consequences of infertility.

The research that considers differences between the genders per se, does not always translate to clinical application in that the knowledge that women are more distressed than men does not provide directions on how to support the couple. Men with fertility problems are not without distress. The more useful research has considered the context of the stress experienced by the genders and examined more closely the meaning of the infertility problem to each member of the couple.

The Abbey, Andrews and Halman (1991,1992) research team conducted a study that compared infertile couples with presumed fertile couples and explored whether fertility-problem stress was different from other sources of stress. Couples completed various measures of stress, perceptions of meaning, attributions of control, and life satisfaction. The presumed fertile couples rated these measures with their ‘biggest problem’ in mind, whereas the infertile couples rated them with respect to their fertility problems.

For both groups higher levels of stress were related to reduced marital functioning and decreased life quality. However, the genders differed in terms of the meaning they attributed to the stress source. For women, fertility problems stress had some distinctive features compared with other problem stress. The negative impact on sexual self-esteem, sexual dissatisfaction and sense of self-efficacy was significantly greater for women experiencing fertility problems, than for women experiencing other problems. This contrasts with the reports of the men in this study. For men, the dynamics of the fertility problems stress are very similar to the dynamics of other problems (Andrews, Abbey & Halman, 1992). The researchers argue that the impact of
stress is both direct and indirect via marriage factors. They found that for both groups stress has a greater and more global impact on wives than husbands, but this does not mean that husbands are unaffected.

Abbey, Andrews and Halman (1991) reported that compared to their wives, infertile husbands reported more home life stress, lower home life performance, more interpersonal conflict and less perceived control. This is in line with Greil (1991) who argued that husbands are affected indirectly by fertility problems through changes in their relationship with their wives, whereas wives are affected more directly.

Berg, Wilson and Weingartner (1991) considered both gender and sex role identification in their study of 104 married couples with primary infertility. Previous research on sex role identification found that femininity was associated with greater levels of distress for both genders, and higher levels of guilt and blame for women (Van Balen et al. 1989). Masculinity and androgyny is associated with better self-esteem and body image (Adler & Boxley, 1985). Berg et al. found that feminine sex role identification was associated with greater marital and sexual satisfaction, and masculine sex role identification was associated with less emotional distress for both genders and greater sexual satisfaction for men only. Regardless of who possessed the fertility problem nearly half of all the women in this study reported feeling less feminine due to their fertility problem, with only 19% of men feeling less masculine. This study also found the genders differed in terms of the context of their distress. Having a child was more important to women than men, and women reported the desire to nurture and care for a child more than men. A proportion of the men stated their motivations for parenthood were to satisfy their wife’s desire, whereas no women had their husband’s desire for a child as a motivation for parenthood.
Berg et al. concluded that a key factor in the adjustment of both men and women with fertility problems was their relationship. They suggest therefore that interventions that seek to improve the relationship, particularly spousal communication, will be useful in this area. However, further research is needed in order to gain a better understanding of the interactions between couples and how they communicate about their joint problem.

Recently studies have examined the notion that appraisal and coping differences between partners are associated with relationship problems. Levin, Sher and Theodos (1997) conducted a questionnaire study examining whether having similar coping styles impacted on individual and relationship distress. The results indicated that high marital satisfaction was associated with both partners using task-oriented coping. For women, marital satisfaction was high when men were using low levels of emotion-oriented coping and low when men were using high levels of emotion-oriented coping. If both partners engaged in emotion oriented coping, men felt more psychologically distressed. This latter finding suggests it is not simply a matter of partners using similar coping strategies. The relationship between the way each partner copes and the individual and relationship distress experienced is clearly a complex one.

Based on the literature describing the gender differences in response to fertility problems, Pasch, Dunkel-Schetter and Christensen (2002) proposed a theoretical model that suggested that the individual partner’s approach to infertility would affect the relationship by affecting the quality of communication. They tested their model by using self-designed scales and questionnaires that aimed to measure the individual’s approach to infertility, their self-esteem and the effects of infertility on marriage. The
researchers then rated each couple's conversation about a difficult topic related to their fertility problem on one behavioural dimension (negative affect towards partner).

Pasch et al. (2002) found that marital communication was less negative if husbands showed more involvement, talked more to their wives and saw having children as important. When communication was less negative, infertility was perceived, by wives, to have a more positive effect on their marriage.

This study highlights that communication plays an important role in relationships of couples experiencing fertility problems. However, Pasch et al.'s study took quite a narrow focus by testing a theoretical model before further work had been done on the possible gender differences in appraisal and how couples communicate and manage any differences. In addition, communication was only assessed using one behavioural dimension, which may not reflect the complexity of this process.

So far, the research that has considered differences between the genders has revealed that men and women seem to attribute different meanings to the fertility problem, and this is probably influenced by societal values and traditions, as well as perhaps biological differences. Most of the research on gender differences has separated couples out into gender groups rather than studying couple units. This loses the interaction between the couple and how they may influence each other's view about fertility. Very little research has been done on how couples manage as a unit. Research has indicated women draw on more social support more frequently than husbands (Berg et al. 1991) reflecting general gender norms that women are more expressive than men (e.g. Cozby, 1973). Men report more interpersonal conflict and the effect of infertility on men seems to be mediated through their relationship with their wives (Greil, 1991).
Thus, the marital relationship and communication between partners are important topics for consideration.

1.7 Qualitative methodology and Interpretative Phenomenological Analysis

Qualitative methodology is the most suitable approach to take to uncover, describe and explain the quality and meaning of the experience of fertility problems to couples both individually and as a unit. How they view the role of communication and their experience of communication is also of interest in this study.

It was felt that the qualitative method of Interpretative Phenomenological Analysis (IPA; Smith, 1995) was particularly appropriate for the research aims of this study as IPA is concerned with the participant’s view of the topic under investigation and attempts to report the participant’s personal perceptions and meanings they have about that topic. IPA also takes into account the dynamic process of research and that the insights gained are the product of interpretation; thus IPA requires a reflexive attitude from the researcher.

IPA sits in the philosophical movement of phenomenology. The central assumptions of phenomenology are that perception is viewed as the primary psychological activity; understanding is considered the true end of science; multiple-perspectives are equally valid as they represent different self-worlds; and that individuals’ perceptions of their self worlds are based on their own hidden assumptions which phenomenologists also try to understand (Willig, 2001). A method that also sits within a phenomenological framework is Grounded Theory. This method was not as suited to the present study as it is more concerned with the social processes that account for phenomena, whereas IPA is interested in the nature or essence of the phenomena. Willig (2001) argues that ‘IPA
is specifically a psychological research method', whereas Grounded Theory may be better suited to sociological research questions.

The process of IPA involves interviewing participants about their view on the topic under investigation. The phenomenology is their personal perception, rather than an objective entity. The assumption that IPA makes is that people's accounts reflect their underlying feelings and thoughts, thus analytic interpretation of the phenomenology, aims to get close to the participant’s personal world as the researcher attempts to uncover what people think and believe about the topic. As mentioned above, IPA recognises that research is a dynamic process and that the access to the participant’s personal world is complicated by the researcher's own conceptions; therefore it is acknowledged that the results produced by IPA are influenced by the researcher's own standpoint which is described alongside the results.

1.8 Rationale for current study

Fertility problems present a unique challenge for couples and their ability to manage individually will impact on how they manage as a couple. If each partner is in crisis, it could be difficult for them to meet each other’s needs. In addition, if they are each at different points on their adjustment what is helpful to one partner may be harmful to the other (Andrews, 1984). Partners are likely to influence each other’s appraisal of their fertility problem; therefore it seems important to study couples as an interacting and dynamic unit so as not to lose the complexity of their experiences.

Gaining a broad understanding into the ways couples manage their fertility problems may offer some insight into how some relationships suffer significant distress and others report improvements as a consequence of being infertile. Such knowledge could
be used to aid future couples who encounter fertility problems, possibly helping them to understand their difficulties and circumvent unnecessary distress.

In order to develop our understanding about what is important and helpful for couples it is necessary to discover the ways couples experience their fertility problems and how they report that they communicate about the issues involved. Imposing theory too early may narrow the focus of the research area and lead to key variables being missed.

1.9 Research aims

The aim of this research is to explore individual partner’s and couples’ appraisal of their fertility problems and the way in which they communicate about them. The specific research questions are: In what way do couples’ appraisal of infertility (a) differ, and (b) impact on their relationship? What role does communication play in aiding couples to deal with any differences? There are no hypotheses due to the exploratory nature of this study.
2. METHOD

2.1 Overview
The study was a qualitative piece of research regarding the impact of fertility problems on couples. The couples in this study were interviewed together by the primary researcher about the meaning of fertility problems and the way in which they communicated about them.

2.2 Design
This was a cross-sectional semi-structured interview study of couples who experience fertility problems. Quantitative data on appraisal was collected for descriptive purposes. The aim of the study was to explore the couples’ appraisal of their fertility problems as individuals and as a couple. How the couples communicate about these topics, and how they deal with differences within the couple regarding their fertility problems were also of interest. The interview transcripts were analysed using the qualitative method of Interpretative Phenomenological Analysis (Smith, 1995).

2.3 Setting
The IVF Unit from which the research participants were recruited was based at Princess Royal Hospital in Hull, East Yorkshire, UK. The clinic is in the catchment area of four Primary Care Trusts on the North Bank (the geographical area extends up to Bridlington, east of York, down to Goole and along the Humber to Spurn Point).

The clinic offers a number of fertility treatments; approximately 350 patients for IVF and ICSI per year. Approximately 60% of patients are self-funded, and 40% are funded by the NHS, although the treatment received is identical.
2.3 Participants

Couples who were attending or had attended the IVF Unit were invited to take part in the study. Couples were recruited and interviewed over a period of eight months. The nature and stage of any treatment which couples were receiving varied. Couples with primary infertility were approached first; then, due to a poor response rate, recruitment extended to those with secondary infertility.

Couples who were on the IVF unit database and had received treatment 18 months ago or less were sent a letter to invite them to participate. In total, 120 couples were sent a letter about the study and 16 replies were received (13% response rate). Two of these replies were from women interested in participating but their partners were unwilling, two couples had very recently had a child, and one couple replied to say they did not wish to participate and felt they should not have been asked as they had ceased treatment a year previously. Eleven couples were interviewed, but one of the tapes had too much background noise for the speech to be deciphered and transcribed. Ten couples were included in the study (8% of those approached).

2.4 Measures

*Information about participants and their fertility history (Appendix 1)*

Participants were asked to report details about their age, ethnic origins, education, occupation, and the length of their relationship. Information regarding the fertility problems was also gathered including the time trying to conceive, the time they first consulted their GP, when the nature of the fertility problem was diagnosed and any previous and current treatment they were receiving.
Semi-structured Interview (Appendix 2)

A semi-structured interview schedule was designed by the primary researcher following the guidelines set out by Smith (1995). The interview schedule represented the overall areas that the research was concerned with: meaning of fertility problems to each individual partner, meaning of fertility problems to the partners as a couple, and process of communication regarding fertility problems. Care was taken to make questions neutral and open, in language familiar to the participants. The interview schedule was used to guide interviews rather than dictate them so that the interviewer could respond to participants’ interest or concerns and probe any interesting areas that arose.

Questionnaire 1 (Appendix 3)

Primary Appraisal

Threat and challenge. A measure used in Stanton’s (1991) study was employed with the addition of one item that measured perceived harm to emotional well-being. Threat and challenge were measured using a seven-point Likert scales with eleven items, three for challenge and eight for threat. Scores ranged from 1 (low threat/challenge) to 7 (high threat/challenge). Participants evaluated threat appraisals by rating the extent to which their fertility problems had the potential for harm to such areas as physical health, health, important career goals, and financial security. To assess the possibility for challenge, participants were asked to what extent their fertility problems had provided them with the potential for personal growth, the strengthening of a relationship or a personal challenge.

Loss. A brief measure that was developed by Buttler (1999) consisting of items derived from qualitative studies on infertility. The measure was tested on a pilot group and the internal consistency of the loss scale was found to be high (α = .88), indicating good
reliability. The ten items of the questionnaire ask participants to rate on a seven point Likert scale, the extent to which their fertility problems had provoked feelings of loss to such areas as feelings of masculinity/femininity, potential role of being a father/mother, sense of being normal, and important life goals. The original measure was used for males only, whereas this measure was for both genders and so slight changes or additions to the wording were made.

Secondary Appraisal

*Perceived infertility control.* This was measured by a slight variation of an adapted version (Glover, 1996) of Miller Campbell et al.’s (1991) scale for infertile women. High internal consistency was reported for both versions Miller Campbell (Cronbach α = 0.76) and Glover (Cronbach α = 0.81).

The measure used in this study changed the wording of the Glover version slightly to apply to couples rather than just an individual. The measure comprises seven items, each item being scored from 1 (not at all) to 5 (completely). Higher scores indicate high perceived control over infertility and low scores represent little perceived control over infertility. Examples of items are:

“How much can you control the negative feelings you have about your fertility problems by the things you do and the actions you take?”; “How much can you control the type of treatment you receive by the things you do or the actions you take?”

2.5 Procedure

Ethical approval was obtained from the IVF Unit’s Ethics Committee and the Local Research Ethics Committee (see Appendix 4).
One hundred and twenty couples who were on the IVF unit’s database were sent a letter from the Scientific Director inviting them to participate in the research. In addition, the primary researcher made an announcement at a number of monthly meetings for new couples, as well placing posters and leaflets regarding the study in the IVF unit waiting room. If couples were willing to volunteer, they provided their names and contact details to the primary researcher by returning a form in a freepost envelope. The primary researcher then telephoned the couples to provide further information and if they were willing to participate, an interview was arranged.

Couples were interviewed together by the primary researcher either in their own homes (8 of the couples) or in a counselling room at the IVF unit (2 of the couples). Firstly, the couples completed consent forms and the questionnaires detailed above. Each partner completed the appraisal questionnaires independently of the other. The participant details were given verbally to the researcher. The semi-structured interview then began and this was audio recorded using a dictaphone. The whole process lasted approximately one and a half to two hours, depending on the couple. The interview was transcribed by the primary researcher and all identifiers were omitted.

2.5 Data analysis

The interviews were analysed using Interpretative Phenomenological Analysis as described by Smith (1995). The transcripts were read and re-read in order to get a general sense of the nature of the participants’ accounts as well as being informed by the interviewer’s experience of the interview itself. Notes were made of emergent themes for all transcripts. Attention was focused on the themes that came up for all
interviews and themes that, although may not have been present in all interviews, seemed particularly pertinent. These themes were defined and developed in more detail focusing on the interrelationships. In short, the data analysis was a process of identifying, defining and redefining themes, and linking them back to the participants’ accounts. Two super-ordinate themes, each with four sub themes, were generated. The final themes attempted to capture the essence of the experience of couples with fertility problems grounded in their own words. The detailed analysis was conducted by the primary researcher and a second researcher read a number of the transcripts in order to ensure important themes were not missed and there was adequate support to in the data for the identified themes.

For the purpose of quality, the researcher engaged in personal and epistemological reflexivity throughout the processes of interviewing, transcribing and analysing. This involved considering the interview as an interaction in which gender, age and style of interviewing may have come to bear on the respondents story. Also, the investigator’s conceptions and preconceptions are considered when understanding the results. The reflexivity of the primary researcher is detailed further in the results section.

The personal details of the participants and the appraisal questionnaire results were collated and are presented in the results section.
3. RESULTS

3.1 Overview of results

This chapter presents the analysis of the data collected from the couples’ interviews. Firstly, the characteristics of the couples are presented in order to describe the sample of participants interviewed. The sample is further described using the quantitative data from the appraisal questionnaires. Partners have been shown together to illustrate any similarities or differences within the couple. The themes of the study are then described in detail with illustrative quotes.

3.2 Characteristics of the participants

As ten couples were included in the study, it was felt appropriate to present their individual details (Table 1). All participants described their ethnic origins as White and British apart from one female who was White and Spanish.

Table 2 presents the results of the appraisal questionnaire. The means indicate that the males and females of this study have similar appraisals of their fertility problems. On average, women scored slightly higher on the harm and loss scale. There seemed to be a trend that the partner who had the identified fertility problem tended to have rated the items higher.
<table>
<thead>
<tr>
<th>Interview</th>
<th>Male Occupation</th>
<th>Female Occupation</th>
<th>Male age</th>
<th>Female age</th>
<th>Length of relationship</th>
<th>Time trying to conceive</th>
<th>Nature of the problem</th>
<th>Current Treatment</th>
<th>Treatment History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Electrician</td>
<td>Health care Manager</td>
<td>31</td>
<td>35</td>
<td>5 yrs 5 m</td>
<td>3 yrs</td>
<td>Unexplained</td>
<td>IVF</td>
<td>1 x IVF: unsuccessful Female - operations</td>
</tr>
<tr>
<td>2</td>
<td>Health care professional</td>
<td>Health care professional</td>
<td>26</td>
<td>29</td>
<td>6 yrs 4 yrs</td>
<td>6 yrs</td>
<td>Male factor</td>
<td>ICSI</td>
<td>1 x ICSI: unsuccessful 1x ICSI: abandoned</td>
</tr>
<tr>
<td>3</td>
<td>Manager</td>
<td>Teacher</td>
<td>36</td>
<td>32</td>
<td>6 yrs 2 yrs</td>
<td>6 m</td>
<td>Unexplained</td>
<td>IVF</td>
<td>None</td>
</tr>
<tr>
<td>4</td>
<td>Emergency services</td>
<td>Estate agent</td>
<td>39</td>
<td>36</td>
<td>18 yrs 10 m</td>
<td>6 yrs 6 m</td>
<td>Unexplained</td>
<td>IVF</td>
<td>IVF: successful, miscarried at 7 weeks IVF: successful, lost twins 5 months into pregnancy</td>
</tr>
<tr>
<td>5</td>
<td>Scientist</td>
<td>Hairdresser</td>
<td>30</td>
<td>31</td>
<td>4 yrs 2 yrs</td>
<td>6 yrs</td>
<td>Male factor</td>
<td>Pregnant</td>
<td>3 x IUI (DI): unsuccessful 1 x IVF (DI): successful</td>
</tr>
<tr>
<td>6</td>
<td>Manager</td>
<td>Secretary</td>
<td>30</td>
<td>30</td>
<td>11 yrs 4 yrs</td>
<td>6 yrs</td>
<td>Female factor</td>
<td>None</td>
<td>2 x IVF: unsuccessful Female - operations</td>
</tr>
<tr>
<td>7</td>
<td>Manager</td>
<td>Manager</td>
<td>37</td>
<td>34</td>
<td>12 yrs 3 yrs</td>
<td>6 yrs</td>
<td>Male Factor</td>
<td>None</td>
<td>2 x IVF: unsuccessful</td>
</tr>
<tr>
<td>8</td>
<td>Engineer</td>
<td>Health care professional</td>
<td>38</td>
<td>38</td>
<td>12 yrs 5 yrs</td>
<td>6 yrs</td>
<td>Female factor</td>
<td>None (awaiting donor)</td>
<td>IVF: successful, miscarried at 7 weeks IVF: abandoned; IVF: unsuccessful</td>
</tr>
<tr>
<td>9</td>
<td>Driver</td>
<td>Manager</td>
<td>30</td>
<td>38</td>
<td>4 yrs 3 yrs</td>
<td>6 yrs</td>
<td>Female factor</td>
<td>None (awaiting donor)</td>
<td>3 x IVF: unsuccessful</td>
</tr>
<tr>
<td>10</td>
<td>Driver</td>
<td>Customer services</td>
<td>28</td>
<td>30</td>
<td>7 yrs 5 yrs</td>
<td>6 yrs</td>
<td>Female factor (Secondary infertility)</td>
<td>Pregnant</td>
<td>Female - operations IVF: successful</td>
</tr>
</tbody>
</table>

(* Health care professionals included nurses, speech therapists, occupational therapists and physiotherapists).
<table>
<thead>
<tr>
<th>Appraisal</th>
<th>Harm (30)</th>
<th>Threat (21)</th>
<th>Challenge (21)</th>
<th>Loss (70)</th>
<th>Control (35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview 1</td>
<td>Female 30</td>
<td>11</td>
<td>16</td>
<td>67</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Male 25</td>
<td>12</td>
<td>15</td>
<td>57</td>
<td>10</td>
</tr>
<tr>
<td>Interview 2</td>
<td>Female 19</td>
<td>11</td>
<td>10</td>
<td>29</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Male* 14</td>
<td>9</td>
<td>12</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td>Interview 3</td>
<td>Female 13</td>
<td>6</td>
<td>14</td>
<td>38</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Male 10</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Interview 4</td>
<td>Female 16</td>
<td>8</td>
<td>18</td>
<td>19</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Male 18</td>
<td>11</td>
<td>17</td>
<td>35</td>
<td>20</td>
</tr>
<tr>
<td>Interview 5</td>
<td>Female 6</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Male* 7</td>
<td>3</td>
<td>18</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Interview 6</td>
<td>Female* 23</td>
<td>9</td>
<td>19</td>
<td>54</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Male 15</td>
<td>10</td>
<td>19</td>
<td>38</td>
<td>17</td>
</tr>
<tr>
<td>Interview 7</td>
<td>Female 13</td>
<td>13</td>
<td>8</td>
<td>36</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Male* 11</td>
<td>10</td>
<td>17</td>
<td>33</td>
<td>25</td>
</tr>
<tr>
<td>Interview 8</td>
<td>Female* 11</td>
<td>8</td>
<td>11</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Male 15</td>
<td>12</td>
<td>7</td>
<td>27</td>
<td>16</td>
</tr>
<tr>
<td>Interview 9</td>
<td>Female* 5</td>
<td>3</td>
<td>17</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Male 5</td>
<td>3</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Interview 10</td>
<td>Female* 16</td>
<td>9</td>
<td>18</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Male 17</td>
<td>9</td>
<td>12</td>
<td>27</td>
<td>22</td>
</tr>
<tr>
<td>Mean value</td>
<td>Female 15.2</td>
<td>8.4</td>
<td>12.4</td>
<td>31.9</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Male 13.7</td>
<td>8.4</td>
<td>13.2</td>
<td>27.9</td>
<td>17.8</td>
</tr>
</tbody>
</table>

* Partner with the identified fertility problem
3.3 Overview of themes

Eight themes emerged from the IPA analysis of the couples’ interviews. These were organised into two super-ordinate themes: ‘Expectations of life – “What’s it all about?”’ and ‘Dealing with ongoing fertility problems – “When it doesn’t happen how we expected”’. An overview of the super-ordinate themes is given, followed by a description of the four sub-themes within them. The themes are presented using direct quotes from the interviews to illustrate the participants’ experiences in their own words. At the end of each quote is the interview number and page number from which the quote was taken. Throughout the descriptions of the themes any variations within and between the couples are discussed. An overview of the themes is presented in Table 3.

Table 3: Summary of themes

<table>
<thead>
<tr>
<th>Super-ordinate theme 1:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectations of life – “What is it all about?”</td>
<td></td>
</tr>
<tr>
<td>Theme 1: Life plans</td>
<td></td>
</tr>
<tr>
<td>Theme 2: The meaning and importance of parenthood</td>
<td></td>
</tr>
<tr>
<td>Theme 3: Commitment to the relationship</td>
<td></td>
</tr>
<tr>
<td>Theme 4: Fertility treatment takes over your life</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Super-ordinate theme 2:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with ongoing fertility problems – “When it doesn’t happen how we expect.”</td>
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3.4 Super-ordinate theme one: “Expectations of life – “What’s it all about?”

Overview of super-ordinate theme

The couples in this study talked about the expectations they had in life for having a family and “completing the circle” (Int 7, p1). For almost all of the participants there was an assumption that they would be able to have a child when they chose to, and many had imagined themselves as a parent, thinking it was an inevitable part of their lives. When faced with the prospect of biological childlessness their life plans were altered, even shattered. Fertility treatment was seen by some as a solution to their problems and offered couples hope and optimism, and when treatment failed, it seemed like a second blow.

When their expectations were not met, many of the individuals found themselves contemplating what their life was about. The inability to do something that they felt was natural and would be easy led to a number of emotions. It forced couples to contemplate and reflect on the commitment they had to parenthood and to their relationship, especially in some of the cases where only one of the partners had an identified fertility problem. All the couples in this study were sufficiently committed to having children to undergo fertility treatment. Although treatment was seen as a chance and an opportunity to reach their goals, it was also seen as a threat, as something that could take over their life and increase their feelings of powerlessness.

Theme 1: Life plans

Many of the couples talked about the expectations they had in life of meeting the right person, getting married, settling down and having children; this was both their own expectation, and, in their eyes, the expectation of their families and of society. Having
children seemed to be viewed by many couples as a natural progression, part of what life is about.

M: ...for me personally its all about having a child, or, children, and completing that circle, so to speak.
F: Yeah, I think it's a natural step that we always knew, I always knew I was going to take, and its, you can't fill that step with anything else... (Int 7, p1)

Some individuals had more explicit life plans than others; some couples had unspoken life plans perhaps reflecting the expectations of society and what is viewed as being the normal progress of things.

F: ...it changes all your, sort of, aspirations for the future 'cos you expect to get married and have children. And then it all changes.(Int 2, p1)

F:... and once you’ve decided to have children, it was suddenly like the life plan wasn't going to map out as I had sort of hoped it would. (Int 3, p2)

Fertility problems and fertility treatment were not included in the life plans of these couples; it was not something they expected to happen to them. Many of the couples talked about it being something that happens to others.

F: ....I think its just that, again in your life plan you didn't you don't expect, its always something that happens to other people, and its probably because there is no reason, there's nothing, you know there's nothing wrong, ..........also feeling that IVF was something that I didn't really need, it was strange really. I suppose it's the fear factor as well, its not a very nice thing to go through, its not natural. (Int 3, p 13)

The strength or degree of an individual’s expectation tended to have influenced how they responded to their fertility problems. Some individuals had never thought much about having children; it wasn’t a priority in their life and those people seemed less affected by their fertility problems.

M: So I've never had a life plan ever........... if its not been an expectation, and its not been a goal, therefore I've had nothing to fail. ‘Cos I’d never really thought about it. (Int 3, p9)
On the other hand, there were couples that had explicit and detailed life plans mapped out over years and the set-back that their fertility problem had caused led to disappointment.

F: ...And we’re like two years over that plan, and it it’s terrible, ...but it was our goal 10 years ago, or 12 years ago, and now we aren’t where we wanna be you don’t know how to get there. Everything else we did din’t we?
M: Yeah (Int 7, p16)

Some of the couples reflected that they had felt fertility treatment was going to provide the solution to their problem. Their belief in medical technology led them to think that it would be easy to accomplish their goal of having children and complete their life plan. For these couples it was not until treatment failed that they began to consider they might never have children. Treatment failure meant the nature and severity of their fertility problem started to sink in.

F: Erm, well, when I first found out I didn’t, I thought, oh, they’ll be able to sort it. You don’t think straight away, oh they’re not going to be able to sort it, because you think oh medical things nowadays, you know........and then, it never really hit me properly until I started going to IVF (Int 6, p3)

F: ...I thought the first cycle was a done deal. I never went in, I never thought there was going to be any way it was never going to work, and when it didn’t it absolutely crushed me, don’t you think? (Int 7, p1)

The impact of fertility problems on life plans caused uncertainty and lack of control that were felt acutely by some of the couples.

F: I hate it, I hate the not knowing, I’m,...I can’t, I like to know where I’m going and what I’m doing and I can’t stand the not knowing whether it will work or not, I think it’s awful........ I can’t do anything about it, it’s all in the lap of the Gods. There’s nothing I can do, other than do the treatment......... I can’t see a future because I don’t know where my future’s gonna go, and that’s the bit I really just don’t like. (Int 7, p1,2)

F: You, I feel almost in the lap of the Gods again, and I don’t like that, I like being in control. (Int 1, p2)
It seemed the couples whose life plans were geared towards having children found it hard to do anything else in life but focus on the fertility treatment.

\[ M: \ldots I \text{ mean, it wasn't a particularly stressful time between 1 and 2 was it, it was just, it was a nothing time, we did nothing, we never we, particularly went anywhere, did we?} \ldots \text{we just never really did a great deal of anything did we, and I think we just got totally wrapped up in it didn't we? Completely 100\% 110\%, and that's why after the second time didn't we, we sat down and talked about it.} (\text{Int 7, p5}) \]

Some individuals seemed to feel that their self-concept was in part based on being a parent; it was something they always just assumed and imagined would happen.

\[ F:\ldots \text{I wanted to be like a an earth mother, you know with five children, I always wanted five children. And I can't even have the one.} (\text{Int 1, p2}) \]

\[ M: \text{ I mean its frustrating more than anything. You know, I want children, I've always wanted children, I'd make a perfect father I know I would, I'm good with kids...}(\text{Int 8, p5}) \]

There was also a feeling of having failed; this seemed to be more prevalent amongst women, particularly those with female factor problems.

\[ F: \ldots \text{It was like, something that's so natural, not being able to have it, is, you feel, you don't feel feminine, you feel like a failure...} (\text{Int 10, p 3}) \]

They described how they felt guilt and responsibility for their partner's childlessness and talked about the desire to "give" their partner a child and the experiences that go with it.

\[ F: \text{Erm, I feel like I've let everybody down. Erm, definitely let M down, and my parents (Int 6, p2)..... I know that I can't give M children...}(\text{Int 6, p4}) \]

\[ F: \ldots \text{its quite...like you're not a woman, a complete woman really. Not that it don't make like that, but its like you're not quite all there complete, and that will be a bit imperfect, to be the perfect person is to be able to conceive and go through the pregnancy and see my belly and stroke it, all these moments, I'm taking away from him all these experiences, down to me he's not having them.} (\text{Int 8, p16}) \]
The life plans of the couples in this study reflect people's expectations, which in turn reflect what they describe as the norm. The inability to have children when they wanted to left some of the couples feeling abnormal.

F: ... like when you start the IVF, because it's like it's not like normal couple, like, nobody knows that a normal couple are trying to have babies, or anything like that, but, everybody knows every step of the way, when you're going through IVF... (Int 6, p2)

The following quote highlights feelings of abnormality during treatment; it is from a couple who were describing a time when they had taken a break from IVF treatment.

F: I think that six weeks we've just had we felt, well I felt like a normal couple without awaiting without awaiting for something to happen.
M: You'd come off the tablets that made you feel strange so we could enjoy a drink
F: We could do things as a normal couple and live life
M: Yeah and live life
F: for about six weeks, and now its [IVF] back again and we're not normal anymore
M: and then we got on with other things and we all started college and got really busy, to try and er not block it out but fill your life again get on life...and then its come back again
F: Just feels like life's not not full (Int 1, p4)

When the expectations of the couples in this study were not met due to their inability to have children naturally, they had to step back and consider the options available to them. In this sample, all couples opted to seek treatment of some kind; in some of the couples one of the partners was more driven towards that solution than the other partner.

M: ......it sounds like I'm always putting the ball in F's court, I would rather see F happy and its something that I think F wants more than I want it and if medicine's the way forward and its going to help I'd rather er that that was the way that we went ......I suppose, it sounds really awful, I'm pushing the buck here, but as I said it will make F, it will fulfil F's or overall well being and if that's what she wants then that's what she'll get. (Int 3, p9)

The couples had to consider their commitments in life, and as one couple put it they essentially felt they had to consider the meaning of life.
M: It is hard to get back on with life because you feel like saying well what the hell are we bothering for.
F: Yeah, you feel there's no purpose
M: You feel like your life's just stopped
F: You feel there's no purpose to anything (Int 1, p17)

Theme 2: The meaning and importance of parenthood

Faced with the prospect of childlessness individuals found themselves evaluating how important parenthood was to them. Some found themselves evaluating whether parenthood was about reproducing their genes, or perhaps nurturing a child. The couples in this study described having to face some difficult decisions, talk about complex issues, and consider options that may not ordinarily arise within a couple without fertility problems.

F: ........we know each other a bit more in what we feel about certain things in life, that you don't normally discuss that when you get together and you know you love each other, and yeah you know you want a family sometimes, but you don't discuss how important it is for you, and now we know what degrees of importance it is for him and for me. (Int 8, p12)

For many of the couples an important element of parenthood was that their child was biologically theirs. The notion that they would see themselves or family members in their child seemed an important reason for people, whether it be the way the child looks or how they may behave.

M:........ everybody wants their own child. Ern, so the same reasons, you've created this thing, it grows up with same looks, same mannerisms and so on and so forth, you can see your old man in them you know that sort of thing, for sure. (Int 8, p19)

The women in the study talked about how the prospect of going through the process of pregnancy and birth was an important element of being a mother.

F: Yeah, I I want to have the experience of going through birth, that that process, and that's what I want to experience. (Int 9, p12)
A few of the women had experienced a pregnancy but had lost the child, yet they reflected on how they felt during that time, highlighting the importance this biological experience was for them and how it was associated with feeling feminine.

\[ F: \ldots I \text{ was at my proud, most proud when I was pregnant \ldots that was just lovely, the lovely feeling, and you feel, you feel like a woman I suppose.} \text{(Int 4, p7)} \]

\[ F: \text{Well, I can only say when I was pregnant, you know, it was like 7 weeks but I felt out of this world, it was like the bestest feeling up till then, can you imagine if you continue with that you're going to feel like nothing else matters, you're like relaxed and er you know nothing else matters, feeling of mother nature and er really powerful, powerful, you know like something very powerful. I think, very good.} \text{(Int 8, p17)} \]

Many of the women in this study demonstrated a strong commitment to having biological children with their partner. Some of these women did not personally have a fertility problem yet were still willing to go to great lengths and undergo invasive medical procedures in order to have the chance of having a child.

\[ M: \text{But then we'd have to worry about treatment for those (F: Laughs), it's a bit scary.} \]
\[ F: \text{Oh, its scary but I wouldn't mind, yeah. I don't think I'd have anymore if I have twins though (laughs). Yeah, its quite scary isn't it? (Int 2, p7)} \]

\[ F: \ldots I'll probably have to have another operation. But I would still go through the operation and still go through the pain, I mean...dunt matter how much pain I'm in. The last operation was painful, and I did have to stop in and what have you, but its just sommat that you go through. You don't care how much pain you go through, just as long as there's this slim chance that it might make things easier. Which I've always thought. So you go through anything really. (Int 6, p27) \]

However, it seemed that many of the women wanted some assurance that they would have a child even if it were not genetically theirs. So, although in general their preference was to have their own biological child, they seemed more prepared than some of the men to explore the other options, such as adoption.

\[ F: \text{Erm, we, we, when the DI didn't work, erm, I actually started to have a bit of a panic on thinking that maybe maybe we should just have a child whatever, from anyone. So, went into, well I looked into adoption... (Int 5, p8)} \]
The women appeared to have a desire to nurture a child, not just create one. They seemed to consider what would happen should their medical treatment fail and for a number of the couples the women had sought out information regarding adoption, highlighting their desire to have a child in their life.

*F: ... I felt that it would ruin my life if we didn't have children, you didn't think it would ruin yours, and you were, you, you still feel that if you don't have children you won't look back and wish, whereas, I would and I would consider adoption and you definitely won't will you?  
M: No (Int 3, p3)*

The men who were committed to having biological children were, in some cases, reluctant to consider the thought of biological childlessness. They tended to avoid or dismiss exploring that possibility, and instead talked positively about the outcome of the fertility treatment. In some cases, the men seemed to have more hope and optimism than their partner.

*M: I'm very much an enu burying my head in the sand, erm (laughter)........ I'm quite, actually I'm normally quite upbeat about it and I think that it will, it will work, or, so I've not really let those thoughts enter into my mind to be honest with ya. Erm, but not, I'll be perfectly honest, I've not thought well what we gonna do if it doesn't work because, I reckon I am very upbeat that it won't, so, I've not really gone there if I'm being honest. (Int 7, p9)*

These men preferred to postpone making those decisions, attempting to maintain their hope that they would have their own child.

*M: ........you want your own child and you don't want to give up the hope of ever having your own child I mean ... adoption's the other option we've got, but to give up all hope of having you own child is a big decision to make and you don't want to make it ever. It's a big decision. (Int 1, p3)*

*F: 'Cos it wouldn't be yours would it?  
M: No it wouldn't be mine  
F: We wouldn't have made it.  
M: No, that's it.  
F: .......But because we haven't made this baby and it's not ours and, you know.  
M: That that's how I feel at the moment. (Int 6, p27)*
Although both the sexes said they would prefer their own biological children, it seemed that the women were more open to 'non-biological parenthood' than the men. This may suggest women have a greater need to nurture than men, or it may simply be that men want to consider their options one at a time, and will not move on to the option of 'non-biological parenthood' until they are sure that they have exhausted every avenue.

The latter suggestion is illustrated by the following quotes:

M: I'd rather exhaust all other possibilities, and when I know that they're exhausted, and that there's basically no, no chance of that. If we went through surrogacy and it didn't work I wouldn't have another go. One, because it's emotionally, emotionally it's too much, and financially, I'm not adverse to paying, but we're not getting any younger. (Int 8, p25)

Theme 3: Commitment to the relationship

The couples in this study reflected on their commitment to the relationship with their partner and the importance of that relationship in their lives. It seems most of the couples expected children to be a part of their family and when having children became difficult the couples were forced to consider the future together without children. For some couples this was a prospect that they felt comfortable with and they reflected on the strength of their relationship.

F: I think as a couple it's put strain on us at times... ultimately we have a very very strong relationship so you know, we have a very nice and very full life, so that if, if we don't have children, you know our relationship is still full enough, for us to want to carry on being married (M: mmm) and stay together.

M: And ern, yeah I think there is support there, our relationship is very strong, and we didn't get married to, ern, to er, procreate really. Er, you know, we got married because we loved each other and er, that's how it always is. (Int 3, p4)

A number of the couples talked about that if it came down to it, as long as they had each other that was the main thing. They talked about being able to imagine themselves in the future together without children.

F: I think what, for me, ern, I I don't, I believe that I've found somebody that I want to spend the rest of my life with, and I don't want it to break the relationship
up, ern, so I think for me as a couple that's the main thing. I'd love children but if it's not going to happen its not going to happen.

M: Mmmm, I, yeah I mean we discussed this obviously, and I totally agree with what F said, .......... as much as I would love to have a family, if it doesn't happen, as long as F and I stay together, which I'm sure we will do, then that's important. (Int 7, p7)

F: We've said this haven't we, you know we've got each other, we can do anything because we've got each other, we can get through anything, which you know from what we've been through, you know it's proof that you know we can get through and we're just there for each other and we've got each other, and as I say, we could live just us couldn't we? (Int 4, p12)

Other couples seemed to feel life would be “OK” without having children – their relationship would be enough – although this seemed less preferable for them.

F:.....we know when enough's enough and we're together. Whereas we know people who have split up from IVF, and we know we're together, and there is life after IVF and we can be content even if we're not ecstatically happy we can be OK can't we. (Int 1, p13)

For at least one couple the man gave the impression that he would feel dissatisfied that all they would be left with was their relationship.

M:.................... You know your plans change because, you're you're focused and sort of tunnel vision towards children or whatever, and then all of a sudden you can't and you're like right (laugh), what do I do now? Sort of thing. This this is it. Its just me and you, so (laugh). (Int 6, p2)

Where only one member of the couple has a fertility problem that member showed an awareness that their partner has the potential to have a child with someone else should they wish, yet it is the commitment to the relationship that keeps them together. Two of the men with male factor fertility problems highlighted this in interview.

M: Don't know, although she says she's got a choice in it (F: mmm) I think she has – It's more of a choice between having kids with me or having kids with somebody else. (p13, 14)

M: ......yeah, it did er certainly make me realise how lucky I was, in that other women might have just told me to pack my bags and clear off, and you know, F: Oh no, I knew that you were right for me. (Int 5, p19)
One of the men in the study had quite a radical change of view towards parenthood. There was no chance he could biologically father a child yet he had had the belief that a biological link was necessary to bond with a child. Initially, he had felt that a child that was not biologically his would not "believe in me as a father". This man's commitment to his partner was instrumental in his change of view.

_M_:......_when I sort of initially rejected the idea [of donor insemination], but, it was certainly from a selfish perspective and when over that next couple of weeks, it was a realisation that a) it wouldn't be as bad as I thought, b) it wasn't fair of me, because I was infertile, to impose childlessness upon F, and, that I also wanted us to be together... (Int 5, p8)

For one of the couples in the study having children was about consolidating their relationship; the female wished to share a part of herself with her husband in creating a child. For this woman it was about having a piece of him, not just about having a baby; this was something that was appreciated by her partner.

_M_: _It is, it is a compliment, that she'd actually put herself through that, I know it's something she wanted more than anything, but she wanted it with me. It's not something that she'd have just took any other, any other Tom Dick and Harry sperm out the sperm bank and had a baby, it it was the fact that it was me who she wanted it with, so._(Int 10, p24)

**Theme 4: Fertility treatment takes over your life**

Many of the couples reported that going through fertility treatment had a big impact on their lives both in practical and emotional terms. Couples felt unable to control their lives due to the treatment being reliant on biological processes, often making it difficult to plan their lives around it - an issue that was particularly prominent for two of the couples in this study.

_M_: ....... _there's a lot of practical problems as well like getting time of work, appointments and things._

_F_: _Yeah, that's the worst part about it_ (laughs).

_M_: _Especially, when we can't plan it advance you going to come on exactly these days or these times._ (Int 2, p4)
M: the last time it was an absolute nightmare sort of juggling time at work and things like that... (Int 7, p19)

Some couples also felt that in some ways they had no choice but to have treatment; they were being offered a chance, a window of opportunity and it was too big a decision to turn it down.

M: to give up all hope of having you own child is a big decision to make and you don’t want to make it ever. It’s a big decision. (Int 1, p3)

Also, for a lot of the couples time pressure seemed an issue due to of the age of the women being a central feature of fertility, so couples seemed to feel they had no choice but to go ahead with treatment.

F: Yeah. Erm, yeah. I mean to be honest with...I mean you you don’t have a choice do ya? It’s like I mean we’re going to have to have it now, I mean we’re young. We didn’t really have a choice did we? (Int 2, p6)

F: I think my problem was is we had seen the Dr, ern, about how many times you should try, but also the statistics say that, I think it runs, I was in with the peak age group, so I wanted to be pushed into getting pregnant before 34 because I fall into the next category then. So, in my head, if we could do it really quickly and get it sorted I was still in my peak to do what I should be doing, whereas now I feel I’ve dropped down one. (M: mmm) Which is quite bizarre really because there’s only two weeks in it (laughs)(Int 8, p6).......I think for me though one of the major things that is actually, it has made me more and more aware of is my age.(Int 7, p19)

A number of the women in the study felt they rushed through treatment; if the first IVF cycle was unsuccessful they went for another one straight away, again reflecting the feeling that time was running out. The women that had experienced this reported that rushing into the next treatment cycle had had a detrimental effect on them emotionally.

F: you do think you’re invincible though, going from one cycle straight into another one, without having a breather in between, because emotionally, it’s just the worse thing I have ever done. (Int 7, p5)

F: ...my second cycle, I wasn’t even ready for that I was really unstable psychologically and I shouldn’t have done it.......they called me to go through and everything and I just went along with it, but I wasn’t ready was I? (M: No) I really wasn’t ready and I just don’t, it didn’t work, it was a disaster they had to
On the whole it was the women who talked more about the difficulty of treatment and the experience of it as a threat. For some couples it also seemed to reinforce their sense of failure and not being able to conceive naturally. Many couples talked about feeling as if their lives were on hold, as if they were in limbo when waiting for treatment. It seemed that having treatment gave people hope but perhaps having the chance of conception prevented some people from moving on to other options, possibly extending their distress about their fertility status.

F: ......but the IVF almost goes like that with blinkers, and it’s just there and you can’t see anything beyond it at all. It’s like a blindfold.
M: It is hard to get back on with life because you feel like saying well what the hell are we bothering for. (Int 1, p17)

3.4 Super-ordinate theme two: Dealing with ongoing fertility problems – “When it doesn’t happen how we expected”.

Overview of super-ordinate theme

The couples in this study dealt with their fertility problems in varying ways. Some people responded in a consistent way, while others moved between resentment and acceptance. Many of the participants felt that it was unfair they had fertility problems and searched for reasons and explanations as to why it had happened to them. Other participants were able to accept that they had difficulties conceiving and were able to adjust more easily. Many felt both resentment and acceptance and although they felt what was happening to them was unfair, they knew that ultimately they could accept it. Some couples showed ambivalence about whether they would ultimately accept their problem; they knew that at some point they would stop having that treatment, but seemed to think that they would know instinctively when this time arrived.
Communication played a role in how couples dealt with their problems. This theme includes communication between the partners and with other people outside the couple. There was variation in the frequency and nature of the discussions couples had, with some couples not talking at all about their difficulties. It was here that gender differences were more apparent, with females having a greater need to talk to others than the males.

**Theme 1: Resentment of an unjust world – “It’s just so unfair”**

Many of the couples in the study seemed to search for explanations as to why they had fertility problems. They reflected on what they could have done wrong to deserve this perceived injustice. Why was it them? The inability to have children made some of the couples feel abnormal; they felt they did not understand the reasons for their difficulties conceiving; this was especially prominent in those couples who had unexplained infertility.

*M: Not being the same as everyone else. Not being able to do the things everyone else does...and not feeling part of things.*

*M: Feeling, yeah, out on a limb – a bit different to everyone else...* (Int 1, p1)

*M:...try and ignore it to some extent. Try and be as normal as I can but sometimes you sit and you can’t be, it creeps back in that you might never have kids* (Int 1, p1)

Some couples were of the opinion that it was just not fair: they did everything right, led ‘pure’ lives, but were still unable to conceive. A sense of anger and resentment of their difficulties came across from some of the couples that they could not do something that is so natural and normal. One woman felt that even if they did eventually have a child she would still resent the pain she has suffered.

*F: I think that that even if we have a child then I I’ll grieve that I’ve not been able to have a child naturally normally... and even if I have a natural child in five years time I’ve been through this pain* (Int 1, p7)
In their search for an explanation, some of the couples felt at times as if they were being punished by being unable to conceive, and that they had suffered enough.

\[ F: \text{... what have we done wrong, have we not, sort of, done our time now sort of thing. (Int 3, p6) } \]

Couples also talked about their annoyance at other people’s insensitive comments. Many couples reported that people had advised them to relax, have a holiday, just forget about it, and even to try giving up their vegetarianism and eat meat as this might help them conceive.

\[ F: \text{If we’d got a pound for every time someone has said to us ‘just forget about it, go have a holiday, just relax, just forget about it’} \]
\[ M: \text{yeah, go on holiday and relax! You know, get drunk, you might just lose your inhibitions a bit more (tut) (Int 4, p8)} \]

Couples felt that others generally did not understand their predicament, reflecting how for other people it is so easy.

\[ F: \text{...I'd be thinking you've got no bloody idea how I feel, you know try try two years of this. (Int 3, p6) } \]
\[ M: \text{I mean to some people it's just the easiest thing in the world, but when you can’t it’s the hardest thing, there’s no, there’s no in between. You know, you’re at one extreme or the other (Int 6, p8)} \]

Most of the couples interviewed talked about feeling angry and resentful towards some parents whom they perceived as being inadequate. They talked about people not caring for their children properly or neglecting them. They spoke of pregnant women smoking and parents smoking with their children in the car, or shouting at their child in the supermarket. A number of the couples talked about teenage pregnancies and how they felt the children born in those circumstances were less likely to have a good life. Couples felt frustrated as they believed that they would love their children and be able to offer them a comfortable life, nice home and opportunities.
In their search for an explanation, some of the couples felt at times as if they were being punished by being unable to conceive, and that they had suffered enough.

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Couples felt that others generally did not understand their predicament, reflecting how for other people it is so easy.

\[ F: \text{...I'd be thinking you've got no bloody idea how I feel, you know try try two years of this. (Int 3, p6) } \]
\[ M: \text{I mean to some people it's just the easiest thing in the world, but when you can't it's the hardest thing, there's no, there's no in between. You know, you're at one extreme or the other (Int 6, p8) } \]

Most of the couples interviewed talked about feeling angry and resentful towards some parents whom they perceived as being inadequate. They talked about people not caring for their children properly or neglecting them. They spoke of pregnant women smoking and parents smoking with their children in the car, or shouting at their child in the supermarket. A number of the couples talked about teenage pregnancies and how they felt the children born in those circumstances were less likely to have a good life. Couples felt frustrated as they believed that they would love their children and be able to offer them a comfortable life, nice home and opportunities.
M: ...it really annoys you when you’re sat in the car and the parents in the front smoking two kids in the back no windows open or anything, you know......You feel like jumping out and getting the kids out......Don’t know how lucky they are. (Int 1, p29)

F: But you know things like that I just think god you know we’re fighting for that to be in that position and there you are you’re in that position and you’re abusing it. (Int 4, p2)

M: Er it’s, not, yeah, it’s quite upsetting sometimes, it’s, the kids are all sat there, scruffy, dirty, smelly you think goodness me, I could give them kids a beautiful upbringing and so on and so forth, but, yeah it’s, you come out some houses and you think what’s it all about, but life’s like that, you know. (Int 8, p5)

Some of the couples reported feelings of jealousy towards other people with children. They were faced with difficult mixed feelings when friends fell pregnant, feeling happy for their friend but also upset that it wasn’t them. Women seemed to have stronger feelings of jealousy, and were occasionally caught by surprise at their reactions as normally they would consider themselves to be level-headed.

F: ......erm, the unfairness, of friends who seem to have it all, and you know, they’ve wanted two years between the second children and they’ve got it, and it just seems unfair when they’ve always got money, they get everything they want they’ve never had to work, you know and all this sort of stuff, erm... Just probably that, the un, sort of, (M: mmm) unfairness of it... ...you know even when friends have just sort of made the effort to come and say 'look I’m pregnant I want to tell you before you hear from somebody else' I’ve been pleased for them but half sort of pissed off as well ... ... ... yeah I went through that when there was a bad patch I was very, sort of, jealous and a bit bitter really yeah. (Int 3, p 6)

F: ... I haven’t seen her since [I found out she was pregnant], and I don’t think I can. I will one day...... it’s affected my quite deeply. And it’s taken me by surprise really because I’m a person who can celebrate children, who can get babies, anything, I really don’t mind, you know, ...and that surprised me so much. (Int 8, p11)

Some of the women also reported avoidance of pregnant women or looking at babies as it was too painful for them. For one couple in particular the woman told how she reacted “hysterically” to the news a family member was pregnant and refused to see or speak to them. She had very strong feelings of resentment and was unable to cope with others having what she felt she and her husband should have.
F: Just because they would have been happy with the new baby. And with it being so close, I know that I would never be able to give M a baby. So I don’t really want to see them... happy. (Int 6, p12)

Theme 2: Acceptance – “They were the cards that were dealt”

Some individuals were more able to accept their fertility problems and not let it have such a major impact on how they felt in comparison. There were couples where both partners had similar attitudes to each other, feeling there was nothing that you could do so you just had to accept it. They had a common goal of having their own children and their way of coping with it was to just get on with it.

F: I'd say we cope with it quite well really we’ve both got the same ‘well we can’t do anything about it attitude’ really ‘ant we?
M: Yeah. (Int 2, p13)

F: ..........it’s dust yourself down and carry on.
M: Yeah, just get on with it with the next, that’s just our attitude towards life, whatever is that basically it didn’t work, obviously it was upsetting, it was very upsetting, but then after a couple of days, or a day or two, it’s like right, where do we go from here... (Int 7, p7)

A few of the men in the study took the attitude “if it happens it happens”. They did not feel they had control over the problems and therefore took a fatalistic approach.

M: I’m at the other end of the spectrum [from my wife] really, ‘cos, we said we’d have, like to start a family, and I was of the attitude if it happens it happens. And I was never, what’s the word, not so much bothered, but er, I was going to let nature take its course, and if it didn’t take its course so be it. And I hadn’t even the thought of IVF treatment at all. So, for me, I was, I accepted the fact that it hadn’t happened therefore it didn’t and it wasn’t going to happen, and I’ve left it at that really. (Int 3, p2)

M: .........I just feel fairly relaxed about it all now. Yeah, they were the cards that were dealt and that was that........ and it’s just things happen that way, and that was it. (Int 5, p1)

M: I think we pretty much take it as if; in the grand scheme of things I think we pretty much take it in our stride to be honest with you.
F: Yeah. (Int 7, p22)
The men in this study were less likely to talk about feeling jealous or resentful of other people’s children, and they didn’t report feeling affected by seeing babies or pregnant women as a number of the females in this study had.

**Theme 3: Talking with each other**

Intra-couple communication seemed necessary for these couples for both decision-making and support. There are a number of difficult decisions to be made including whether or not to pursue treatment (and the type of treatment), how long to keep trying and all the issues that arise around donor treatment. Some of the couples in this study had differing views from their partner about the importance of children to their lives and whether biological parenthood was a necessary part of being a parent. Not surprisingly, the couples varied considerably in the extent and nature of their communication. Some couples had numerous discussions around what the next step was, and explored a number of possible avenues, whereas others consciously did not talk about their fertility problems and were aware they were avoiding the topics.

*M: Mmm. But, I don’t know, we still haven’t really (nervous laugh) sat down and discussed, I don’t know, the next move, so to speak, really. (Int 6, p9)*

*F: Yeah, we just don’t talk about it.*

*M: We won’t talk about it, because I suspect if we’d talk about it we would argue.(Int 6, p5)*

*F: The future is something that we’re avoiding, which we know we’re going to have to talk about sooner or later. (Int 6, p22)*

Asking the couples about their communication did seem to elicit themes that reflected a gender difference in the need to talk. The women seemed to be the partner that initiated discussions around fertility and had a greater desire to talk things through.

[Interviewer: But you’re the one who initiates the conversation about it?]  
*F: Yeah, I think so.*  
*M: Oh, for sure, well 90% of the time, yeah  
F: Yeah, most of the time  
M: If it’s not brought up I probably wouldn’t...  
F: ..........I wish we talk a bit more about it (M: mmm) I could go on and on forever, and erm
M: I'm the opposite
F: He's the opposite, he don't don't like to talk a lot in depth, it's a little bit of a problem with us. (Int 8, p2,3)

F: Er, sometimes a bit frustrated because he has not got an open mind like me, he sometimes dismisses things before he has even discussed it. You're very black-and-white aren't you? There are no shades of grey with you (M: mm) And I found it a bit frustrating ...(Int 3, p3)

Some of the men in this study were taking a more optimistic stance about the success of treatment, so dismissed or postponed talking about the future; it's unclear whether this was because they felt unable to discuss beyond the next step, or chose to take one thing at a time, but it was often to the frustration of the female.

M: When we first started we discussed it a little bit, just when we were sorting out what treatment then. But since then we've not really discussed it much at all. We're just waiting to see what happens.
F: I don't (laughs) I don't know what will happen if it comes to that (laughs)
M: I don't think we will anyway, so. (Int 2, p5)

M: We've not discussed, we've not discussed. And like F would say well what if it won't work, what if it dunt work this time, and I would just, my reply will be, well it's gonna work and it solves the problem, and that's just the way that its been int it.
F: Yeah (Int 7, p10)

One man found it very difficult to accept that treatment had not worked. In his mind he remained optimistic until the date of the end of treatment indicated by the IVF unit, and would deny any evidence his wife presented to him that the cycle might have failed.

M: Yeah well, you know, from from my point of view, you know, half way through the treatment you know you said it int working, and I was like, well, let's just wait until the end, don't say it hasn't work, 'cos it might, there's al..., you know while you're still doing the treatment there's always a glimmer of hope, you know, you've got to sort of cling on to that hope. You know like F's saying, you know she did know it hadn't worked, but, for god sake don't tell me that because we're still only half way through. You know we've got another week or so to go yet or whatever. You know, it still might work. And I could understand what F's trying to prepare me for when it doesn't work, because it hadn't worked, because she knows her body, and you know etc etc. Erm, you know and that's what she was trying to do, but I was like saying look, I don't wanna know, there's still hope, whatever you say, you're not right, it's gonna work. And then it doesn't, and you like um. (Int 6, p30)
Some of the men also seemed to prefer to think things through in their own mind before entering into a discussion, whereas it seemed women used discussion to help them think.

F: But he wouldn't talk about it either.
M: No, so for about a couple of weeks I didn't say anything did I?
F: No, so I was left wondering what I was going to do (M: yeah) with my life.
M: F didn't feel particularly as though you wanted to bring it up with me did you?
F: No because you were just so (M: yeah that's right) adamant that you didn't like the idea (M: yeah) at first
M: That's it. So but when I, as I was left to, you know, when I was left to my own devices for a couple of weeks I could think about it a bit clearer, and then just sort of said one day, you know, that I didn't mind. (Int 5, p2)

Couples also used each other to talk things through for support and reassurance. It tended to be the women who felt they needed more support. In some cases, partners helped a lot, but in others they actually ended up making their wives feel worse.

F: He seems to be more philosophical, and he always reassures me that no matter what he loves me, and you know, because I always say I'm the guilty one, it's my fault, and he says, don't be silly and he tries to reassure me and everything, and that helps me a lot. (Int 8, p2)

M: Don't know try and support each other (F: mmm) try and cheer her up if I can, .....  
F: Mmmm. But then it makes me feel worse if he says ern, 'it's all my fault that you're upset and I feel guilty' (laughs) and that makes me feel worse because he starts feeling guilty. (Int 2, p13)

Theme 4: Talking with others – Limits, secrets and taboo

Couples with fertility problems are faced with the dilemma of whether or not they should tell other people about their problems. There was variation both within and between couples in this study in terms of whether or not they told others, whom they told, and how much they would tell about having fertility problems. Additionally it seemed that people’s motivations for telling, or not, also varied.
Many of the couples initially kept their problems to themselves; for some this reflected their belief that the fertility treatment would be successful.

M: Yeah. I know I think at first, the very first one we thought well what's the point of telling everybody (F: laughs) we thought it all gonna be done and sorted and then we'll just tell them that we're having a baby and then that will be all done and finished with won't it you know, you know. (Int 7, p6)

For some couples it was not until the stress accumulated over time that they began to tell people. Continued fertility problems were more difficult to keep secret for many couples, for both emotional reasons and the practical implications of the treatment.

F: I didn't like it I said that I would tell everyone the next time it was just really sort of isolated, it's it's, I mean they're really supportive at work and they ask me how I am and......... No, that wasn't very nice, it's a lot better now people know, I can talk to people. (Int 2 p14)

The couples who did talk about their problems did place limits on how much they would talk about; this seemed to be related to the nature of the problem, but also a reflection of their personality traits. It came to light that it was usually the men who seemed less likely to talk to others about their fertility problems.

M: I don't know but I don't feel sort of threatened masculinity with just F knowing it. Erm. If everybody knew I maybe would more so, definitely, but I don't mind people knowing that we're having fertility treatment, but I don't like discussing that it's a problem with me, with a lot of people, I don't mind one person knowing. (Int 2, p2)

M: I haven't spoken to any friends about it, 'cos it's, I'm not a private private person, but er, I don't really feel it's any of their business really, so I've not wanted to ask or tell anybody. (Int 3, p5)

Couples seemed to feel that telling people could be both a positive and a negative experience. Many of the women in the study found that talking to others provided them with social support and enabled them to express some of their feelings and thoughts. They talked to friends and work colleagues; some women turned to professionals – in two cases this was a reflexologist – but felt they just needed anyone to listen.
F: Not everybody, but certain friends that I'm close to, I feel I'm a very open, I probably wear my heart on my sleeve a little bit, but I'm very open about things and I feel that talking about things makes me feel better sometimes just, sometimes just getting it off your chest, having a bit of a rant when you're walking the dog with somebody and really like getting it... Or just sometimes talking to somebody and getting some, just some sort of reassurance, or some sort of support that you know that you're not, there's somebody there who's sort of there, just to sort of like care and to understand where you're coming from, that you're not going completely mad (laughs) and yeah. (Int 3, p6)

F: I go, I still go to reflexology, and that lady does help me a lot, I do talk to her endlessly, and I think she's not just my reflexologist, she's my counsellor, and that helps a lot (Int 8, p28)

Some of the couples felt that by telling people there would be more pressure due to being continually asked and essentially monitored by family and friends. In one case, the couple did not tell anyone which in itself placed a burden due to the difficulty of keeping it secret, yet they viewed this as “the lesser of two evils” (Int 7, p.18). Another couple who were unable to maintain their secret perceived a number of pressures and obligations from their family, but felt unable to voice these and consequently they experienced added stress.

F: Erm, I feel like I’ve let everybody down. Erm, definitely let M down, and my parents, because in the first instance, when I found out there was something wrong, erm, we didn’t let anyone know, but because I had to keep going into hospital for some operations, people got to know, and then, you don’t feel pressurised, well, you do feel pressurised, like when you start the IVF, because it’s like it’s not like normal couple, like, nobody knows that a normal couple are trying to have babies, or anything like that, but, everybody knows every step of the way, when you’re going through IVF, they know that the first day you start your injections, everybody phones up and says ‘how’s your injections gone?’. So everybody knows, and like, obviously, because our families are so close, when you have your eggs taken out it’s ‘oh, you’ve had your eggs taken out, are you OK?’ And, yeah, it’s lovely having close family (M: mmm), but to a certain degree you want to keep it to yourself ‘cos you don’t want (M: puts more pressure on) all the pressure, but... Then you have to look at it in their way, like they’re not gonna get any grandchildren or anything like that, so. You can’t really turn around and say ‘look can you just leave it alone’, because obviously, it’s part of their, you know, their not gonna get grandchildren, so. You have to bite your tongue a lot. (Int 6, p2)
Couples also reported finding fertility problems a difficult topic to raise, that there was a feeling of taboo surrounding it. This perception seems to have limited the amount that couples were willing to talk about their issues.

F: I think the problem is that, it's not something you talk about, you don't sort of stand in a bar and 'By the way, did you know I'm infertile?' you know you just don't (Int 3, p19)

M: It's one of those things you'd rather somebody else went and told people for you. (Int 2, p14)

F: Yeah. Less people understand, less people talk about infertility treatment, they just don't talk about it....
F: They won't talk about it, it's a secret, taboo, and you're not allowed to talk about it. Which makes, we sort of don't understand, but in some ways you almost feel like that it must be a failing if everyone's got to be so quiet about it. (Int 1, p9)

Finally, couples also showed an awareness that other people either make assumptions if they don't know about the couple's fertility problem, or they may be afraid to ask. Some couples found that their friends who did not know about their fertility problems would comment on how it was a good decision not to have children, and how they could have their career and do many other things in life. The couples concerned found this quite hurtful at times and reinforced feelings of isolation. For others they were aware that family and friends stopped asking for fear of upsetting them, and they stopped telling the women news of other people successfully conceiving or having their child.

M: It's just that I didn't want to upset her and, er, it wasn't anything I didn't think it was the right thing to say in a conversation or tell her the new news that another friend had just come out and er just got pregnant. (Int 3, p7)

F: I think a lot of them don't want to upset you, I know my best friend, because she's got three kids, which maybe maybe I feel worse, I'm not quite sure but like she she didn't want to, you know, keep asking me, she kept saying to me. I'm always here you know, you can always talk to me and, but it's hard talking to people because they don't they don't understand, like, our feelings. (Int 6 p8)
F: And my friends, or the people I worked with, they were frightened to tell me about babies as well. And frightened because they didn’t want me to get upset, not because I was gonna go mental or anything like that, but they knew it used to upset me. (Int 10, p5)

**Reflexivity**

Smith (1995) suggests it is important to take into account some of the researcher’s own conceptions and experiences of the research process when reflecting on the results presented above. The most pertinent elements of the researcher’s reflections are presented below.

**The interview as an interaction**

All of the interviews were conducted by the primary researcher, a white British 23 year old female, who was in her second and final year of training as a Clinical Psychologist. The researcher had clinical interviewing experience and the principles of good interview practice suggested by Smith (1995) were followed as closely as possible. The interview itself perhaps set a limit for the partners as they were interviewed together; it could be that if interviewed on their own, partners may have presented a slightly different standpoint.

An observation made by the primary researcher was that those couples who reported not talking together as much (Interviews 2 & 6) seemed much less comfortable with the interview situation. There were at times moments of awkwardness and tension within the couple, and they left an impression that there were many things that were unspoken, or unspeakable. In contrast, the couples that appeared very open with each other and seemed to have a sense of humour when reflecting on their relationship, despite major differences in viewpoints (i.e. Interview 3), left the interviewer feeling much more positive about their relationship and their adjustment to their fertility problem. In short
those couples that did ultimately sit down, work through and discuss their situation, seemed to be more relaxed and at ease with each other. This process appeared to come more naturally for some individuals than others. Having stated these impressions, it is worth highlighting the researcher's belief in the advantages of communicating within a relationship.

The investigator's conceptions and preconceptions

As mentioned, as a Trainee Clinical Psychologist various psychological models are likely to have guided my analysis of the interviews. From a stress and coping framework, and a Cognitive Behavioural perspective, the meaning the participants attributed to their fertility problems was my main interest. It came to my attention that in the initial interviews I was allowing my own assumptions, about lifecycle and the evolutionary drive to pass our gene on, to limit my questioning, and from then on I attempted to probe for deeper meanings, which led to eliciting people's fundamental views on life. Over the course of the research my views towards the phenomenon of infertility have developed in that the complexities of the decisions faced by couples in this situation do seem overwhelming and I have perhaps been left with more questions than answers.
4. DISCUSSION

4.1 Overview

Couples were interviewed about what they considered having fertility problems meant to them, and how they communicated about it. This chapter discusses each of the super-ordinate themes that emerged from the data linking them to the relevant literature. The stress-coping model and research questions are reflected on in the light of the findings within the discussion of the second super-ordinate theme. Finally, the strengths and limitations for this research are presented, suggestions for further research made, and the clinical implications considered.

4.2 Super-ordinate theme 1:

Expectations of life – “What’s it all about?”

A significant theme that emerged from the couples interviewed for this study was that of life plans. Couples had an expectation of having children, and conception is something that is seen as controllable, given the means of contraception available in today’s society. Many couples had postponed having children until they felt they were ready, whether it be financially, professionally, or emotionally. When couples had taken the decision to start trying to have children they expected it to be easy. The expectation and belief about having children reflects society’s norms. Clark, Henry & Taylor (1991) argue that having children is a goal-inherited from society; there is an assumption that procreation is a natural part of adulthood (Daniluk, 1988). This notion of life plans links directly with the lifecycle models such as that of Erikson’s ‘Eight Ages of Man’. Many of the couples in this study anticipated that they would have children and complete their family when they so wished, and when they were unable to have children they could not progress to the next stage of the lifecycle. This led some of the individuals in this study to question their life goals.
As suggested by lifecycle models people are guided by goals: the desired outcomes they wish to achieve in their lifetime (Carver & Scheier, 1981; Martin & Tesser, 1989). Higgins (1987) argues that goals ultimately represent who we ideally wish to become. It has been suggested that goals are represented in hierarchical form. People may have some major life goals, but in order to achieve those they must complete a number of sub-goals that lead to accomplishing the major goal (Vallacher & Wegner, 1987). As conception and birth and raising a child are considered by society as normal (Veevers, 1973), individuals may not question their reasons for having children, they simply assume that they will. The themes from this study revealed this process of questioning occurred for a number of the individuals as their infertility continued and their assumptions were not being met.

A number of the couples commented on how easy they thought having children should be and felt it was unfair that they were not able to achieve their goal. It seemed that couples had an assumption that if they engaged in the ‘appropriate behaviours’ they would achieve pregnancy. These ‘appropriate behaviours’ seemed to represent sub-goals; these involved adopting a healthy lifestyle, monitoring their menstrual cycle, following advice from experts, and finally engaging in fertility treatment. For almost all the couples in this study, despite engaging in these ‘appropriate behaviours’ they did not attain their goal. For some, the sense of unfairness was overwhelming. Couples seemed to have a belief in a “just world”; that good behaviours were deserving of reward. They felt that if they took the appropriate actions and took control over their fertility then they would achieve their desired outcome. When they did not achieve their desired outcome they were left feeling that the world was unjust.
The themes of this study described how some of the couples had concrete, detailed life plans. These couples had previously felt in control of their destiny and their fertility problems had caused them to feel out of control, something which some individuals found difficult. Their life had been planned, they had imagined their future, women had thought about what it would be like to be pregnant, they had thought what it would be like being a parent. They had wondered about what the child would be like, if they would look like them or have their mannerisms. All of these thoughts about being a mother or father seemed to have heightened their desire for a child. Despite taking actions to try and fulfil their goal the couples still did not reach their desired outcome. Couples, especially those with unexplained infertility, talked about how they did everything right and therefore just could not understand why they were unable to conceive.

This lack of control seemed to impact on individuals in varying ways. Folkman (1984) argues that when more serious commitments or goals are at stake it may be more important to the person to control these. For the couples in this study having a child was a major life goal, so there was a lot at stake for them. Beliefs that individuals have about control influence the meaning of a transaction, and can be particularly pertinent in individuals faced with fertility problems. Rotter’s (1966) concept of internal and external locus of control was outlined in the introduction; in brief, it describes the conviction a person has about whether they can control events, or whether they believe that events are uncontrollable and contingent on factors such as fate. It has been argued that generalised control expectancies have the most influence in novel or ambiguous situations, something which is frequently a characteristic of fertility problems.
The principle that ambiguous or novel situations are appraised in line with the person's beliefs about control can be used to understand some of the interviews. A number of individuals in this study seemed to have an internal locus of control and reported how they had believed that having fertility treatment gave them control over their problem and provided them with a solution. Their belief in medical solutions meant that, initially at least, their fertility problems were not that significant; they felt that medicine would ‘solve it', and they would have a baby. Couples reported assuming that they would be the one out of three treatments that were successful; when treatments were unsuccessful these individuals were forced to re-evaluate their appraisal of their fertility problems and their beliefs about medicine.

It seemed for some of the individuals that having generalised beliefs that they were in control of events led them to feel particularly threatened by their fertility problems. Folkman (1984) describes how appraisals of control can heighten threat. She argues the reason for this is the interrelated nature of events that means there can be pay-offs to control. Although for many individuals fertility treatment may feel like one is taking control over the fertility problems, there are costs in terms of physical well-being, time, money and emotional well-being. Furthermore, there is only approximately a 30% chance of the outcome being successful. Fertility treatment may be seen as an option to controlling their fertility problem, but inherent in the treatment is a loss of control. Also, it seemed from this study that the strength of belief in medicine as having the solution meant that couples felt like that they had little option to take the treatment being offered to them when it was offered.

Control can also be stress-inducing when it opposes a preferred style such as avoidance, as one can be forced to confront issues they might normally prefer to deny or avoid. A
number of individuals in this study talked about how the severity of their fertility problems did not ‘hit them’ until they began fertility treatment; the treatment made them confront their inability to conceive naturally. Fertility treatment creates a heightened awareness of the conception process, which can act as a further confrontation and reminder of the couple’s inability to conceive naturally. Fertility treatment can also lead to a ‘public awareness’ of conception, in that family and friends know, or ask about details of the treatment. A number of the couples in the study talked about the additional pressure this created, and how it reinforces feelings of abnormality, as generally others do not know that a couple is trying for a baby until the woman is pregnant. It seemed this acted to challenge couples’ beliefs about their normalcy. When these beliefs were challenged, many individuals began to ask themselves questions about what it meant to them to have a child. This is a finding that has been reported previously. Daniluk (1988) described infertility as a blockage to major life goals, and in response to a blockage of goals individuals find themselves evaluating the meaning of those goals (Horowitz, 1982; Mandler, 1982; Martin & Tesser, 1989).

When the couples in this study were evaluating their individual commitment to children, the issue of nature and nurture seemed to be important with couples expressing a preference for biological children. However, as this possibility was called into question, and couples were unable to easily achieve a biological child, then a gender difference seemed to arise. The issue of adoption seemed to separate the genders; females seemed more willing to consider this as an option than did the males. The men in this study were reluctant to ‘give up’ the possibility of having a biological child and felt they would like to continue pursuing fertility treatment until they had ‘exhausted every avenue’; they did not want to consider the alternative such as adoption until they had reached that point. However, there seemed to be a degree of ambivalence
about when one would know they had reached that point; for many of the couples the point was not defined in concrete terms; they were going to rely on knowing instinctively when they should stop.

There could be a number of reasons as to why, compared to the women, the men did not want to consider biological childlessness. It may be that for men that genetic link with their child is more important; if they are going to invest time in nurturing and raising a child they want to be genetically related to that child, which makes evolutionary sense when viewing it from the perspective of the selfish gene (Dawkins 1976). Another reason could be that fathering a child is tied up with the notion of masculinity. Biologically, men have the potential to father a great number of children; it may be that when a man is unable to father a child they may feel that they are not masculine. Glover et al. (1996) found that 27% of men reported feeling less of a man as a result of having fertility problems. This is also linked with society's perceptions as illustrated in the Miall studies presented in the introduction.

A further reason for this is likely to be related to fertility treatment: the investment required by women is far greater compared to men. On a practical level men only play a small role in the fertility treatment; unlike the women, they do not have to undergo invasive medical procedures. So, simply from a cost-benefit perspective men do not have as much to lose, and a lot to gain by going ahead with fertility treatment. However, the men in this study did show an awareness of the costs of fertility treatment to their partners and this is likely to have an impact on their decisions also as they may not wish to see their partner suffer.
For women on the other hand, the costs of going through the fertility treatment are much higher. Not only do they relinquish control over their bodies when undergoing IVF by having their hormones artificially controlled and their eggs retrieved, there are also the emotional costs. Many women in this study described the experience treatment as quite threatening and some described being quite traumatised by it. Not only did they experience treatment as physically difficult, but also emotionally, it could be “devastating”. Women are inevitably more involved in the process of conception when it is achieved through IVF. Women talked about feeling responsible for the potential pregnancy as on leaving the IVF clinic after the embryo transfer they were technically pregnant, so it felt like it was up to them from then on. One couple spoke about the bond they felt with their embryos due to the involvement and knowledge that is associated with fertility treatment. When treatment was unsuccessful they experienced a sense of failure and loss which was much more acute than they had felt at the arrival of her period every month.

So, for some it seemed like treatment was like a double-edged sword; although it offered people hope and a chance of their own baby, it could also create feelings of loss of control, failure and trauma. Women were putting themselves physically and emotionally under great pressure and, at times, through pain despite feeling that the treatment was not going to work. For some, especially women, IVF heightened the sense of failure they felt. One woman described that even if she had a baby naturally, the damage done by the treatment was irreparable. One woman was ready to adopt children and did not want the trauma of going through IVF again, but because her husband had such strong feelings about having a biological child they had gone forward for further treatment. This woman described IVF as “a blindfold”. She highlights the power of medicine, in that the chance it offers, despite its low success rate, meant that
no other options were seen. The chance offered by medicine, and the belief people have in medicine as well as people's instinctive desire for a biological child meant alternatives were less likely to be considered. Previous research has suggested that continued treatment-seeking may impede the necessary processing individuals need to engage in for them to make the cognitive, emotional and behavioural shifts associated with adjustment (Glover, Hunter, Richards, Katz & Abel, 1999).

It seemed that it was not just the desire for a biological child, it was the major life goal of having children that meant the couples of this study were unable to consider other ways of life. Although women were more likely to look into adoption, ultimately, they were seeking ways to reach their life goal of being a mother. It may be argued then that for women, being a mother is important for their sense of self. Many women in this study spoke of their fertility problems making them feel a failure and unfeminine. It may be that there is something more fundamental than just having a child; it may be about the development of the person, or self-actualisation, and women may feel this cannot be achieve if they do not experience motherhood. From her clinical work with clients who have unexpected infertility Raphael-Leff (1998) documented how prolonged failure to conceive led women to feel their body is deficient. She argues that infertility threatens the epistemological centre of a woman's world. Similarly, qualitative research conducted on patients with chronic lower back pain suggested that the pain was more than just physically unpleasant; it emerged as a source of significant threat to the maintenance of self. The experience of this pain prevented the patients' attempts to establish a stable or coherent understanding either of the pain or their self-concept (Osborn, 2002).
When people are continually seeking a way to achieve their goal of having a child, whether it be through fertility treatment or adoption, not only can the process of this pursuit be quite stressful and disappointing, they may continue to deny the possibility of eventual childlessness. Whilst hope of having a child is ongoing it may prove difficult to make any shifts in thinking. This can be explained by Rachman’s (1980) Emotional Processing Theory. Rachman highlighted a number of factors that may cause difficulties in emotional processing. The stimulus factors of uncontrollability and unpredictability are relevant to fertility problems; in addition to this, for couples undergoing treatment there may also be an element of high arousal and danger. Whilst couples are undergoing fertility treatment or seeking ways to achieve their goal they may experience difficulties in successfully processing the negative events that are occurring in their lives. It could be argued that treatment may be a way of avoiding the final conclusion that they cannot have biological children; although, in addition to this the treatment itself has been described as stressful and traumatising. Rachman suggests that successful emotional processing involves breaking down the incoming stimulation (i.e. repeated failure to conceive) into manageable proportions, and that these are processed over an optimal period; the breakdown and absorption of material is impeded by excessively intense or complex situations. Arguably, fertility treatment, especially when it is unsuccessful, represents both an intense and complex situation that creates high arousal. Thus, for some people, fertility treatment prevents psychological adjustment. A number of the couples in this study, especially those who had been through two IVF treatment cycles, seemed to show an awareness of needing a time to process what had happened to them. Many women said they had continued on the “conveyor-belt” of treatment and felt psychologically damaged by rushing into a second cycle of IVF after failing the first.
Investigators have recognised two functions of coping: emotions-focused coping aims to regulate emotions, and problems-focused aims to manage the problems causing distress (e.g., Kahn, et al., 1964; Mechanic, 1962). A popular conceptualisation of coping implies that a person is managing or succeeding; however, Folkman (1980) has argued that coping is defined independently of its outcome. Furthermore, successful coping can involve periods of denial or escape in order for the person’s psychological resources and positive affect to be restored. The latter is something many of the couples talked about. Some couples took 'time out' from their fertility problems; they had breaks in treatment so that they did not have to think about it for a while and “be normal”, thus allowing them to restore their psychological resources. Couples also talked about the practical solutions that were available to them (problem-focused) as well as how they dealt with their distress by expressing some of the emotions or seeking out alternative treatments such as reflexology to help with their distress (emotion-focused). In this study, one way the couples coped was to reappraise their situations, and when it had a different meaning it was often more manageable and created less distress. The process of reappraisal also included the dynamic between the couple, and the beliefs and reactions of the two partners.
4.3 Super-ordinate theme 2:

*Dealing with ongoing fertility problems – "When it doesn’t happen how we expect."*

The ongoing nature of the fertility problems for the couples in this sample could lead to strong feelings of resentment. These feelings seemed to be more prevalent in the women than the men of this study. Women described that they felt unable to look at pregnant women and babies because it was too upsetting. They felt jealous of friends who announced their pregnancies and bitter that it was not them. They described finding it hard to make sense of the people they saw as being inadequate parents and felt it was unfair that those people could have children and treat them badly. They felt they would be a good parent yet they could not have children and to them this seemed unfair.

This sub-theme of resentment seems to reflect some stages of the Kubler-Ross grief model. The model proposed that people move through five stages of grief: shock, denial, anger, bargaining and acceptance. When describing their resentment of an unjust world, people described the avoidance/denial of pregnant women and babies, or situations that reminded them of their difference. Anger was felt towards other parents, even friends who achieved pregnancy. The bargaining seemed to occur when couples were seeking to explain and move on to accepting their fertility problems.

The second sub-theme was that of acceptance. There were some individuals who seemed to be able to accept their fertility problems more easily. One of the males of this study stands out as representing acceptance; he reported that he did not have any life plans, just took each day as it came, and hence, if having a child is not a major life goal, then when it doesn’t happen it is not experienced as a failing. People who seemed to have life plans which were not as rigid were more able to incorporate the fertility problems. It could be argued that for these people being a parent was not necessary for
them to feel complete as a person; they had other things in their life that were sufficient for them to feel whole.

Acceptance did seem to operate on different levels; some people just seemed to feel powerless acceptance, as if they really did not have any control over what happens so they felt there was no point in getting upset over it. Whereas for others, like the man described above, having children was not a life goal for him, therefore his acceptance seemed almost more genuine.

This stress and coping model described by Folkman (1984) was the research framework used to guide this study. The themes elicited from the data do all reflect primary and secondary appraisals, and this model can provide a useful framework for understanding some of the data. However, it seemed that what the themes revealed went deeper than the appraisals of threat, loss and challenge, and reflected something more fundamental about the impact of infertility on the self and the assumptions and goals that guide us. Although the stress-coping model does discuss these as commitments and beliefs that guide appraisal, the focus on appraisal per se may not be as useful when trying to help these individuals in a clinical setting. It could be suggested that the questionnaires based on this model only touch on surface aspects of fertility problems. Perhaps the more important questions to ask individuals and couples are about their beliefs, commitments and goals, and it seems these core beliefs may be better predictors of adjustment. This could explain in part the discrepancy between the qualitative and quantitative literature. A reason previously cited for the discrepancy was that the measures used in quantitative research are too global, that they are not sensitive enough to the minutiae of the infertility experience.
In terms of appraisals, couples in this study did not show many differences. Where differences did occur it seemed that couples were able to manage this. Also, this study revealed that people seem to expect difference; many couples commented on various reactions simply being down to gender; ‘it’s a man-woman thing’. It may be that because difference is expected it is not necessarily a problem. It seemed that it was not the differences per se that caused the problems, it was how they were dealt with. Those couples that had differences and did not communicate a great deal gave the interviewer the impression of being less well-adjusted than those who communicated effectively. Those that did report good communication also reported they were happy with their relationship. It may be argued that the differences that would cause relationship problems would not necessarily be about appraisal, but would be about the beliefs and commitments underlying that appraisal.

A number of couples talked about the strength of their relationship and the commitment they had to their relationship. Some felt their problems had made them pull together and that their relationship and knowledge of each other had deepened. Most seemed to feel that they already had a very strong relationship anyway. The relationship seemed to be a determining factor in how the couples dealt and coped with their problems. It did not seem to matter as much if the partners had differing ideas about life plans, and what children meant to them; if they were committed enough to each other they were able to deal with problems. The couples who seemed to be the most well-adjusted had been able to address many issues and discuss them in order to fall in line with each other and move forward.

Couples talked about the expectation they had that a relationship has its ‘ups and downs’, and that they took the ‘rough with the smooth’. Almost all partners showed a
willingness to talk with each other. Only two of the couples in this study stand out as not talking a great deal, and they seemed to be the ones who were more difficult to interview and gave an impression of being less well-adjusted.

The results suggest that male-female differences are expected by people, and therefore, when the male does not talk as much, or is not very understanding of his wife's feelings, this is not unexpected and hence couples are able to cope with it. Overall, women seemed to take the responsibility for talking and would initiate discussion, and men engage in this process, even though they may be less likely to initiate it. However, in some cases it was apparent that the men could have been more successful in how they had engaged in the communication process, as females talked about how the man made them feel worse. One couple was able to manage this using their support network, and a family member helped the couple get through and communicate more. This man was willing to accept help and guidance and the couple were able to move forward.

There was also a sense of partners trying to protect each other from distress. Men would sometimes withhold information about a friend's pregnancy. The motivation for this seemed to be so as not to upset their wife, but at times it also seemed self-protecting, i.e. the husband found it difficult to cope with his wife's distress. Some women also seemed to try and protect their husbands by preparing them for treatment failure or breaking news about treatment failure to them gently and remaining strong for them.

The gender difference was also apparent when couples described talking to others. Females were much more likely to discuss their fertility issues outside of the couple
with friends or work colleagues. This may reflect the communication pattern that men tend not to discuss personal information with others. It could again be linked to the notion of masculinity. Even if men do not have the identified problem, their inability to have a child with their partner could represent them not feeling like a complete man. Again, some of the comments made to these men by the work colleagues reflect society’s view of married childless men.

One of the aims of this study was to highlight and understand the role of communication between the partners and also with others outside of the relationship. Pasch, Dunkle-Schetter and Christensen (2002) first illustrated the importance of communication in the couples’ experience of fertility, suggesting that the quality of communication would be affected by the individual’s appraisal of their fertility problem. The conclusions drawn from this study were that it was the husbands’ approach to infertility that played a pivotal role in determining marital outcomes. Pasch et al. argued that it was the husbands’ level of involvement that impacted on communication and thus marital satisfaction. Pasch et al. imposed a theoretical model and the researchers, not the couples themselves, rated the communication. The present study took a broader look at how couples perceived their own communication and illustrated some of the many factors that seem to influence relationship satisfaction. The present study seems to suggest that if couples are able to communicate effectively any differences in the appraisal of fertility problems do not seem to be of greatest importance. It could be argued that many other factors within a couple’s relationship influence how they interact and communicate with one another.

Communication serves numerous purposes including decision-making and support within the couple. The themes revealed the complexity and variability between the
couples. Communication could be experienced both positively and negatively. One woman described how her partner made her feel worse; she felt unable to express her feelings of distress about their fertility problem because if she did the male would express his feelings of guilt and blame as it was a male factor problem. One couple described how the female would somehow turn every conversation round to be about their fertility issue, and this was perceived by both of them, but the man especially, to be unhelpful. Previous research has consistently shown gender differences in terms of communication (e.g. Cozby, 1973). Women tend to self-disclose more than do men, and their disclosures tend to be material that is personal and feelings-oriented. Men on the other hand disclose more readily when the information is relatively neutral or factual. This gender difference is apparent in this study's theme 'Talking to others'; women were much more likely to talk to others about their fertility problems than were men.

As mentioned in the reflexive section of the results, some of the couples that did not talk gave the impression of greater distress than those that did talk. This perhaps highlights communication as a mediator between the couples. If each partner is clear about each other's beliefs and commitments and appraisals, and these are discussed and explored together through talking, then it is possible for the relationship to stay positive. This is illustrated nicely by interview three, where the couples had quite different beliefs and commitments about having children. Because this couple did communicate, and the female used support outside of the couple, they were able to remain positive and happy in their relationship, and reflected on the strength of their relationship.

The literature that deals with couples' problems tends to have communication training as one a main focus of helping relationships. Communication within the relationship
seems to be an important mediator of appraisal. This study has begun to reveal some of
the complexities of the dynamic between the partners but further research examining
the specifics of communication within couples with fertility problems is important.

4.4 Strengths of the study

The aim of this study was to gain insight into how fertility problems impact on couples
as a unit. The study explored in depth the meaning fertility problems had for the
couples, and captured how the couples talked about their problems. By taking a
qualitative approach the complexity of the couples' interaction and influence on each
other was not lost, and what was described by some couples was a process of joining
together their individual appraisals and coping strategies, or accepting their differences.
Ultimately this study revealed that if a couple were committed enough to each other
they could overcome the difficulties posed by their fertility problems.

4.5 Limitations of the study

Generalisation

A significant problem in conducting this research was recruiting participants; the
response rate in the present study was very poor (19%) and highlights the difficulties in
attaining a representative sample of couples experiencing fertility problems. Thus, one
of the limitations of this study is that the sample of participants are self-selecting and
are likely to represent couples that are committed enough to both each other and to
having fertility treatment. This perhaps says something about the nature of their
relationship as other couples faced with similar difficulties may have gone their
separate ways, or decided not to have children, or to adopt children rather than embark
on fertility treatment. Therefore the results of this study must be interpreted with the
knowledge that the couples in this study may have had particularly strong relationships.
One of the features of this study is that couples were interviewed together; this may have prevented some couples coming forward, especially those that may not communicate openly with each other. This point may be supported by the fact that the primary researcher was contacted by three females that wished to participate but their partners were not willing to volunteer. In addition, within this study it is important to be aware that couples may have told a slightly different story had their partner not been present during the interview. Another factor that may have influenced the story couples reported was that the interviews were all conducted by a female; had the interviewer been male couples may have reported their story differently.

The participants in this study were made up of white middle class individuals, as is most of the infertility psychological literature. From a social constructionist viewpoint this is significant as the experiences are mediated historically, culturally and linguistically (Willig, 2002). The role of men and women in these kind of societies are more equal. The women in this study all worked, with the majority having careers; whereas, in other cultures women’s primary role may be to have children, and this would inevitably impact on their appraisal of their problems. The couples in the study talked about life not being full, or having a purpose without children, and this was something felt by couples who both had careers. It could be inferred therefore that, for individuals who did not have a career and were more ‘family-focused’, fertility problems would have a more detrimental impact.

**Quality**

As discussed in the method section, steps were taken to ensure the quality of the themes that emerged from the data. This included analysis by two researchers and considerable
reflexivity throughout the process, a summary of which was presented in the results section. However, ultimately with qualitative work the data may have been interpreted in an alternative way had it been analysed by other researchers with different backgrounds.

4.6 Suggestions for further research

When people experience problems or emotional distress, they turn to family and friends, for informal help, rather than to mental health professionals (Barker, Pistrang & Shapiro & Shaw, 1990; Wade, Howell & Wells, 1994; Willis & DePaulo, 1991). Thus, everyday relationships with family and friends provide informal psychological helping, and may play an important part in the prevention of more serious psychological problems (Milne, 1999). As demonstrated in this research very few of the individuals sought professional help, but many talked about the importance of talking and seeking support informally. Research has found that the person used most frequently for this informal help is the spouse or partner (Barker, et al., 1990; Veroff, Kilka, & Douvan, 1981). This highlights the importance of couples' relationships and there is evidence to suggest that the quality of helping from each partner may be crucial to well-being at times of stress (Pistrang & Barker, 1995).

This study highlighted some of the complexities of communicating as for some couples the communication was perceived as being negative or unhelpful. This study relied on each partner's reports of the communication within the couple. In order to understand the communication processes more fully alternative research methods would be necessary. A method used by Pistrang, Picciotto and Barker (2001) was tape-assisted recall. The emphasis of this method is the moment-by-moment interactions between the partners rather than retrospective reports of their communication. The method was
borne out of the concepts and methods used to analyse the process of formal helping, such as counselling, and Barker, Pistrang and Rutter (1997) argued that these methods can be usefully applied to informal helping.

Tape-assisted recall involves taping participants' conversation and then playing it back to the couple in order to elicit their perceptions of specific parts of the conversation. This procedure was derived from the psychotherapy process research (Elliott, 1986; Elliot & Shapiro, 1988).

As discussed throughout this report, a particular characteristic of fertility problems is the direct impact it has on both partners; thus both partners have an investment and are emotionally involved. In depth, single-case studies have revealed that personal involvement in the problem can cause difficulties in the ability to help, despite good intentions (Pistrang, et al., 1997; Pistrang, Clare & Barker, 1999). Further research in the area of fertility problems could employ this method to focus more closely on communication between the partners and provide some insight into how couples may be advised to help each other through the stresses of infertility.

In addition to research looking at communicating between couples with fertility problems, it may be useful to extend the research to those couples who have fertility problems but do not pursue treatment, or couples who simply never want children. Uncovering the reasons for this may provide some insight into how to help couples with fertility problems perhaps reframe this experience.
4.7 Clinical implications

A finding that seems to have an important implication for practice is that fertility treatment may impede a person’s ability to emotionally process their experiences. When IVF treatment is unsuccessful couples need time to process that information; not only will couples need to reflect on their goals, but they may also need time to ‘recover’ from the demands of the treatment. A number of the couples felt they had rushed into second IVF cycles, without having this processing time. Not only is this potentially damaging psychologically, but the stress is also likely to have a detrimental effect to the outcome of the fertility treatment. It may be advisable to enforce couples to take a break before embarking on a second cycle of treatment. During this break the couples could be offered further counselling to make sense of their experiences and to potentially adjust their goals, and perhaps look at ways they could communicate more effectively.

Some couples felt that when embarking upon their first IVF cycle, they had not felt it necessary to go for counselling; it was seen as just another hassle. However, a number of the couples in this study did in fact comment that they felt counselling should be re-offered, especially after treatment failure. This seems to highlight the importance of timing, and could suggest that counselling should be re-offered on a number of occasions, so that should the couples feel ready to talk the opportunity is there for them.

A further comment that many of the couples made was that they felt they should receive more information and general advice on factors such as nutrition and alternative therapies such as reflexology. It may be useful for couples to be given advice on taking care of themselves in a psychological sense. There is perhaps scope for developing
workshops for couples to learn about factors such as healthy living and stress management.

4.8 Summary

The two super-ordinate themes that emerged from the data described how fertility problems could lead couples to consider their expectations in life; on a surface and a more fundamental level. It seems that continued fertility treatment could potentially interfere with the emotional processing of their experience, thus, a break in treatment would be recommended for their psychological health. The participants had differing reactions to their ongoing problems and communication seemed to play a key role in those reactions. Further research on this process of communication has been recommended. What is highlighted is the resilience of the couples in this study. It is important to recognise the help they give each other and the resources they draw upon from within themselves and their social support system. It is perhaps the couples who adjust well to their problems that can offer the most useful knowledge which could then be applied to others in similar circumstances.


Human Fertilization and Embryology Authority. www.hfea.gov.uk


6. APPENDICES

Appendix 1: Participant details

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<td>How long have you been together as a couple? (Married?)</td>
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<td>How long have you been trying to conceive?</td>
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<td>When did you first consult your GP about your fertility problem?</td>
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<td>When did you find out the nature of your fertility problem?</td>
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<td>What type of treatments are you currently having?</td>
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<td>Have you had treatments before? – What were they &amp; when did you have them?</td>
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Appendix 2. Interview: Questions and prompts

**Appraisal**
I’d first like to ask each of you to answer
1) What does infertility mean to you personally as an individual?
2) How do you feel about having fertility problems?
Prompt: Can you give me an example of when you felt like that?
Some couples report feeling like they’re grieving or that their man/womanhood has been threatened – have you ever felt anything similar?
*After each partner has answered:*

3) What does infertility mean to you as a couple?
4) Were you aware that is how your partner felt?

-----------------------------------------------------------------

**Differences between partners**
1) Can you tell me about any differences between you and your partner in terms of what infertility means to you and how you feel about it?
Prompt: Have there been particular issues you tend have disagreements about?

-----------------------------------------------------------------

**Management of differences**
*If there are differences:*
1) How do those differences impact on your relationship?
2) How do you manage those differences?
Prompt: How do you react to disagreements? How do you feel, what do you say or do?

*If there are no differences:*
1) To what extent have you always been similar in terms of how you feel and what infertility means to you?
2) In what other aspects of your life are you similar?
3) How would you explain your similarities/differences?
4) Do your similarities/differences affect the way you deal with your fertility problems?
Appendix 3. Questionnaire – The meaning of fertility problems

1) Please state what the nature of your fertility problem is and where the problem lies:

2) Please circle a number for each item below to indicate how much the fertility problems you are experiencing have:

- harmed your partner’s physical health
  
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- threatened an important career goal

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- threatened an important life goal

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- threatened your financial security

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- harmed your partner’s emotional well-being

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- harmed an important relationship

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- provided the potential for personal growth

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- harmed your physical health

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provided the potential for strengthening a relationship

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provided personal challenge

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harmed your emotional well being

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3) Please circle each item to reflect the extent to which you feel you have:

- lost your ability to be a successful partner

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- lost the potential role of being a father/mother

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- lost your hopes for the future

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- lost your feelings of masculinity/femininity

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- lost a sense of being normal

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- lost the closeness in your relationship

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lost an important life goal

1 2 3 4 5 6 7
Not at all A great deal

lost the potential for having a biological child

1 2 3 4 5 6 7
Not at all A great deal

lost sexual spontaneity

1 2 3 4 5 6 7
Not at all A great deal

lost the ability to achieve what you want

1 2 3 4 5 6 7
Not at all A great deal

4) Please answer the following questions by circling the answer which most applies to you.

How much can you control the likelihood that as a couple, you will get pregnant by the things you do or the actions you take (diet, exercise etc.)?

1 2 3 4 5 6 7
Not at all A Little Somewhat Very Much Completely

How much can you control the likelihood that you will eventually achieve pregnancy by your mental attitude and the way you look at your situation?

1 2 3 4 5 6 7
Not at all A Little Somewhat Very Much Completely

How much can you control the type of treatment you receive by the things you do or the actions you take?

1 2 3 4 5 6 7
Not at all A Little Somewhat Very Much Completely

How much can you control the negative feelings you have about your fertility problems by the things you do and the actions you take?

1 2 3 4 5 6 7
Not at all A Little Somewhat Very Much Completely
How much can you control the negative feelings you have about your fertility problems by your mental attitude and the way you look at your situation?

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<td>Somewhat</td>
<td>Very Much</td>
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How much can you control the negative feelings your partner has about your fertility problems by the things you do and the actions you take?

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How much can you control the negative feelings your partner has about your fertility problems by your mental attitude and the way you look at your situation?

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Appendix 4 - Ethical approval letter

HULL AND EAST RIDING LOCAL RESEARCH ETHICS COMMITTEE

Ms A Kilbride
Trainee Psychologist, Dept of Clinical Psychology
University of Hull
Cottingham Road
Hull
HU6 7RX

5 August 2002

Dear Ms Kilbride,

LREC/06/02/101

How couples appraise and communicate about fertility problems

The Chair of the Hull and East Riding REC has considered the amendments submitted in response to the Committee's earlier review of your application on 17th June 2002 as set out in our letter dated 20th June 2002. The documents considered were as follows:

Participants Information Sheet version 1 dated July 2002

The Chair, acting under delegated authority, is satisfied that these accord with the decision of the Committee and has agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you the favourable opinion of the committee on the understanding that you will follow the conditions set out below.

Conditions

- You do not undertake this research in an NHS organisation until the relevant NHS management approval has been gained as set out in the Framework for Research Governance in Health and Social Care.

- You do not deviate from, or make changes to, the protocol without prior written approval of the REC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases the REC should be informed within seven days of the implementation of the change.

- You complete and return the standard progress report form to the REC one year from the date of this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within three months of completion.

Hull and East Riding Local Research Ethics Committee Members

Prof. Sir Killick (Chair) – Dr M Davidson – Dr Cath Hoyle – Dr F Calvert
Mrs G Davison – Cllr K Wastell – Mrs H Thornton-Hayes – Dr F Beasley
Mrs L Shepherd – Mrs H Williams – Mr F Asher – Mrs J Wild
Mrs N Mockbee – Mr D Henton – Mrs A McLean
• If you decide to terminate this research prematurely you send a report to this REC within 15 days, indicating the reason for the early termination.

• You advise the REC of any unusual or unexpected results that raise questions about the safety of the research.

Yours sincerely,

Prof S R Killick
Chair of the Hull and East Riding REC

TREC/ 06/02/101 Please quote this number on all correspondence
Appendix 5: Recruitment letter

Dear Sir and Madam,

I am writing to inform you about a research project that is being conducted under the direction of the Clinical Psychology Department at the University of Hull and supported by the Hull IVF unit. The principal researcher is Ashleigh Kilbride, a Psychology Graduate in her final year of the Clinical Psychology Doctorate. The research is under the supervision of Dr Lesley Glover and Dr Sue Weaver from the University of Hull.

All couples who might be receiving treatment are invited to participate in the study which will explore couples' thoughts and feelings about their fertility problems and how they tackle their problem as a couple. The aim of the research is to gain a better understanding of how fertility problems may affect people's lives and relationships. Some couples find dealing with fertility problems difficult, whereas others less so. Psychologists are interested in this range of experience as gaining insight into the range can help shape the overall care for future couples by guiding the involved professionals. The more couples we hear from, the more accurate our understanding will be.

Your participation is voluntary. It is also independent and unrelated to the treatment you will be receiving from the IVF unit. The study involves the researcher, Ashleigh Kilbride, arranging a time to talk to both of you together as a couple about your thoughts, feelings and experiences related to having fertility problems. If you think you may wish to take part in the study, please fill in the permission form provided and return it in the FREEPOST envelope. You will then be contacted by telephone by Ashleigh Kilbride in order for her to give you more details about the study. If you still wish to participate, a mutually convenient time and place will be arranged to meet. As stated previously, you are under no obligation participate in this research, however, your contribution would be much appreciated.

Yours sincerely,

Dr John Robinson
Scientific Director
Hull IVF Unit

IVF Unit
Princess Royal Hospital
Salts House
Hull, HU8 9HE
PERMISSION FORMS

We, __________________________________________, have read the Research information letter. We understand that if we are contacted about the study we are under no obligation to participate.

We give permission to be contacted about the research study.

Woman’s signature: __________________________________________

Woman’s printed name: ________________________________________

Man’s signature: _____________________________________________

Man’s printed name: __________________________________________

Contact telephone numbers:


Appendix 6: Consent form

I understand that participating in this study involves completing questionnaires and being interviewed on one occasion with my partner. I understand the interviews will be audio taped.

All of my information will be kept confidential, in a secure place, without any identifying information.

I am entitled to withdraw from this study at any time should I so wish.

The study is independent from the IVF unit, and participation in or withdrawal from the study will have no impact on any current or future medical treatment I may receive.

Signed: ......................................................

Printed name: ..............................................