A Phenomenological Study of the "Lived" Experience of Infertility as Perceived by Infertile Women

by

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READER'S APPROVAL

SALISBURY STATE UNIVERSITY SCHOOL OF NURSING

This is to verify that Tina Stone Collins successfully defended her Master's thesis entitled A Phenomenological Study of the "Lived" Experience of Infertility as Perceived by Infertile Women on May 2, 1991.

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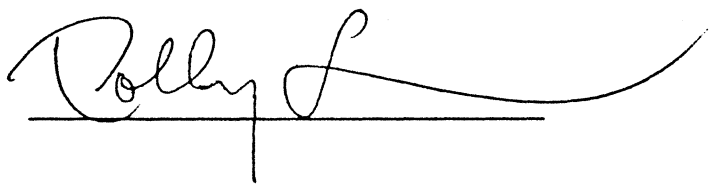

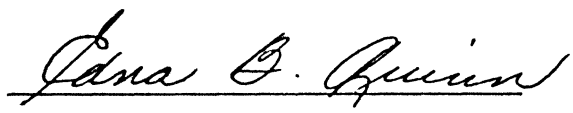

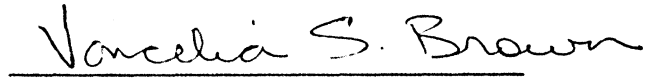

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ABSTRACT

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The purpose of this study was to explore the "lived" experience of infertility as perceived by infertile women. The objectives of the study were to describe accurately the "lived" experience of infertility as perceived by infertile women and to explore the meanings of the "lived" experience of infertility as it unfolded for them. A qualitative methodology that approached the experts on the phenomenon, the infertile women themselves, was used in achievement of these objectives.

Data were collected from eight infertile women who volunteered to participate in the study. The sample was obtained through the local RESOLVE infertility support group and personal and professional contacts. Unstructured tape recorded interviews were conducted with each participant with only the opening statement consistent across all interviews. Data analysis proceeded through transcription and coding of statements into groups of like content. Five categories of meaning evolved from fifty-five codes. Validation of the code and category development analysis was achieved through second confirming

interviews with four of the infertile women. A review of the literature also revealed support of the findings.

The five categories that arose from the analysis were as follows: emotional impact, relationships, physical impact, alternatives, and coping mechanisms. These five categories did not carry equal importance in the infertile women's experiences; the category of emotional impact was of utmost concern. The resultant description of the meaning of the "lived" experience of infertility as perceived by these infertile women illustrates how these women are reaching out for help, understanding, and support. It is important that nurses become aware of the special experiences faced by infertile women so that they may provide them holistic, informative, and supportive care. Further research that explores and expands upon the findings of this study is needed to increase nursing's knowledge base concerning the "lived" experience of infertility.

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CHAPTER I

THE RESEARCH PROBLEM

The discipline of nursing is holistic and humanistic in nature. Nursing's contribution to society is in its special involvement with individuals. "The nursing profession advocates the individual as author of his own world; definer of his own reality" (Oiler, 1982, p. 178). Nurses greatly respect and value individual experience and are especially concerned with such individual responses as hope, grief and uncertainty-- elusive concepts that can be clarified by attending to them as human experiences. Individuals' unique perceptions of reality are important in understanding their experiences. These perceptions of reality present themselves in the form of human responses, which collectively constitute the phenomenon of concern for the nursing profession.

The continuing development of nursing as a discipline requires a variety of ways of knowing (Munhall & Oiler, 1986). The process of nursing is an attempt to understand the world more adequately and to discover truths. In order to discover the truths about the experience of, for example, infertility as perceived by infertile women, nurses must investigate women's unique perception of reality related to their experience. Uncovering the phenomenon of concern to

infertile women may promote more holistic and human-centered nursing interventions. Discovery of this knowledge is accomplished through a qualitative investigation of the meaning of the infertility experience. Research is accomplished by going to the experts on this experience--the infertile women themselves.

Statement of the Problem

Infertility has been defined as "the inability to conceive a pregnancy after a year or more of regular sexual relations without contraception, or the inability to carry pregnancies to a live birth" (Menning, 1988, p. 40). One in every six couples of childbearing age in America is infertile--more than 10 million people in this country alone (Menning, 1988). The incidence of infertility in the United States was reported at approximately 10% of childbearing couples in 1976 (Link & Darling, 1986). More recently it has been reported that an estimated 15% of the population of childbearing age in America is infertile at any given time (Menning, 1988). Others have reported an incidence as high as 18% (Blank, 1985). The data concerning infertility have been subject to problems of collection and interpretation. The extent of infertility may have been underestimated in the past due to a reluctance of those affected to discuss

publicly what they believe to be both a private and a "shameful" matter. The very nature of infertility as an invisible handicap makes it easy for the public to overlook its existence. "The infertile population has been described as one of the most neglected and silent minority groups in our country" (Menning, 1980, p. 313).

Approximately 35% of infertility cases can be attributed to men, 35% to women, 20% to both members of the couple, and 10% to unexplained causes (Menning, 1988). The percentage of unexplained infertility is decreasing with advances in medical technology; it is estimated that 50-60% of all infertility can now be diagnosed, treated, and cured if the couple has access to expert medical care. These cures are achieved at tremendous physical, emotional, and financial cost--sometimes after years of effort.

Certain sociological, environmental, and medical factors are contributing to an increase in infertility. One factor associated with the rising incidence of infertility is that women are deliberately delaying childbearing, which is believed to increase age-related biological risk factors (Aral & Cates, 1983). A second factor is that women are entering the workplace in increasing numbers, which exposes them to occupational and environmental hazards believed to contribute to the

rise in age-specific infertility rates (Aral & Cates, 1983). A third factor associated with infertility is that women and men are having sexual relations earlier and with more partners, thus increasing their exposure to contraceptives and sexually transmitted disease, both of which are implicated causes of involuntary infertility (Aral & Cates, 1983). The change in public and medical thinking about the etiology of infertility has occurred due to advances in reproductive technologies. Infertility has become a more socially acceptable health problem (Anderson, 1989). These combined factors have led to the increased need and demand for health-care services related to infertility.

Having children is taken for granted by most people. The desire to have children, to be parents and raise a family, is something fundamentally human. Many couples invest a great deal of time, money, thought, and energy when they plan a family. If it becomes evident that the discontinuance of contraception combined with a regular pattern of sexual intercourse is not resulting in pregnancy or a viable pregnancy, the couple may find themselves on a strangely foreign and often stressful path. Instead of the private, sensitive, natural and joyful experience they hoped for, they are faced with medical intervention, high technology, and psychosocial distress, with no

guarantee of the desired pregnancy and healthy baby.

Infertile individuals and/or couples need help. The experience of infertility evokes many feelings in this population (Menning, 1988; Clapp, 1985; Mazor, 1980, Kraft, Palomba, Mitchell, Dean, Myers, & Schmidt, 1980). Some feelings, those based upon very real insults which society or the infertility investigation and treatment have caused, are rational. Other feelings, those based on false beliefs, or on childlike magical thinking, are irrational (Menning, 1988). Infertile persons can be helped in two distinct ways. They need information and they need understanding and support (Zion, 1988). They need to know what infertility is, what causes infertility, what treatments for infertility entail, how to locate medical care, what new technologies are available, and alternative solutions. Such information can impart an ability to cope with feelings of loss of control over their lives and destinies (McCormick, 1980).

Until more recently there has been a lack of understanding, and therefore support, for infertile persons. The psychosocial consequences of infertility - or to put it more simply, the feelings and their origins and impact - are a much less explored experience than the medical reasons for infertility. Infertile persons need to understand how to deal with

their feelings so that they can work towards a healthy resolution. Nurses who help the infertile population also need to understand the experience of infertility.

Purpose of the Study

The purpose of this study is to explore the phenomenon of the "lived" experience of infertility as perceived by infertile women. With a more comprehensive understanding of this phenomenon, nurses should be increasingly able to support infertile women as they strive to achieve a more balanced life. Nurses must take full advantage of the opportunity to witness the infertile woman's world through a full range of awareness. They must realize that opportunities to help her reside in using themselves as part of that world. To intervene effectively with infertile women, nurses must understand the meaning of the phenomenon, the "lived" experience of infertility. Ultimately this study should provide a data base to direct further research that may identify holistic, human-centered nursing interventions for the phenomenon.

Objectives of the Study

The objectives of the study are to describe accurately the "lived" experience of infertility as perceived and experienced by infertile women and to explore the meanings of the "lived" experience of

infertility as it unfolded for these infertile women. All preconceptions of what was known about the infertility experience were suspended and the phenomenon was explored with an open awareness of the perspective of these infertile women. In examining the phenomenon the "essence" of the experience was identified (Field & Morse, 1985). The substance and form of the results from the qualitative data emerged and were idiosyncratic to this study (Ammon-Gaberson & Piantanida, 1988). Theoretically conceptualized research questions illuminated individual perceptions and interpretations of the infertility experience. The research questions included, but were not limited to, the following:

- What are the feelings this experience evokes?
- What are the ways the individual deals with these feelings?
- What is the meaning of this experience for the individual?
- What are the explanations the individual gives for her infertility?
- How does the individual relate the experience to other aspects of her life?
- What changes does the individual perceive in her relationships with others?

- How is the individual reacting and adapting to these changes?

Theoretical Base for the Study

Phenomenology is the theoretical base underlying the selected methodology for this study. The phenomenological perspective was chosen since the purpose of the study was to understand the experience of infertility from the perspective of women who have "lived" it. After all, they are the experts on this experience.

Merleau-Ponty, an existentialist philosopher, refers to phenomenology as the "study of essences." In his view, phenomenology questions facts about our world in order to understand the world more adequately and to discover truths. It attempts to describe experience as it is "lived" without concern for how it came to be that way. Qualitative researchers utilize this philosophy as a basis for their studies because they believe that people and the world can be understood only through a description that discovers their contact with the world.

Merleau-Ponty (1962) has three key concepts in his view of phenomenology. They are consciousness, an understanding of human experience, and perception. Consciousness is one's existence in the world. It includes one's sensory awareness of and response to the

world. The world is always experienced through the subjectivity of being in the world. Consciousness is expressed in one's manner of approach to the world. A perspective on the world is formed. "It is not pure experience but an interpreted experience that constitutes reality" (Munhall & Oiler, 1986, p. 51).

The human experience is the next key concept described by Merleau-Ponty. "He explains that the existence of one's body in the world forms a system. Life experience is mediated through bodily existence of lived correspondence among objects" (Munhall & Oiler, 1986, p. 54). This lived experience is reality. In this reality there is a uniting of the perceiving subject and the objective world.

Discovery of the reality of the world is through perception, the last key concept of Merleau-Ponty's phenomenological view. He defines perception as "access to truth--the foundation of all knowledge" (1962, p. xvi). "Having established existence in the world as embodied consciousness constituting experience, perception is our access to experience" (Munhall & Oiler, 1986, p. 55). Therefore, in discovering truth, perception presents us with evidence of the world, not as it is thought, but as it is "lived." Truth, then, is a composite of realities, and

access to truth is a problem of access to human subjectivity.

Research Methodology

Phenomenological methodology is an inductive, descriptive approach to qualitative research (Omery, 1983). Subjects' realities are the subject matter of this type of inquiry and findings are expressed from this perspective. "All human behavior is understood in terms of subjects' orientations in the world, and as an expression of that perspective" (Oiler, 1982, p. 179). The goal of the method is to describe the experience and include the meaning within the experience. Descriptions of the phenomenon are compared and contrasted for recurring essences. This procedure allows for identification of the constituents of the phenomenon and their relationships. "Generalization is based on similar meanings rather than an exact duplication of essence" (Field & Morse, 1985, p. 28). The end product is a successful description of what has been seen. Studying the whole, the perceived and interpreted experience of these infertile women, makes it possible to reach an understanding of the parts. Discovery of meaningful knowledge about a woman's infertility experience can be derived only from an individual's inner world of experience. These truths

will add to existing knowledge concerning the "lived" experience of infertility.

CHAPTER II

REVIEW OF RELEVANT LITERATURE

The primary requisite of a phenomenological study is that no preconceived notions, expectations, or frameworks be present or guide the researcher as data is collected and analyzed. Preconceptions from the literature review and from this researcher's own biases were suspended during this research through a process called "bracketing" (Omery, 1983), which involves acknowledging what is known or thought about the phenomenon and placing it aside in one's mind as research proceeds. This study did not have validation as a primary goal; rather, it sought only to describe the "lived" experience of infertility as perceived by infertile women.

The literature concerning infertility has three basic focuses. The first, comprising studies largely conducted within the medical paradigm, takes precedence. A second area of concentration has emphasized the psychogenic causes of infertility. (This type of literature has declined.) The last area of research, which is becoming more widely explored, has focused on the consequences of infertility. The studies taking this focus include case histories, quantitative, combined quantitative/qualitative, and strictly qualitative approaches. Qualitative

researchers have employed descriptive, grounded-theory, and phenomenological methodology to explore the phenomenon of infertility.

Researchers have made major strides in advancing scientific thought from viewing infertility as having a psychogenic etiology, to demonstrating that infertility precipitates numerous consequences. This change in focus was brought about by great advances in the medical field. In vitro fertilization, gamete intrafallopian transfer, embryo freezing and embryo transfer are examples of such advanced medical techniques to achieve conception. It behooves nursing professionals to advance at the same pace and to continue research that explores the consequences of the infertility experience. As medical options expand, the decisions faced by infertile couples will become more and more complex and stressful.

Case Histories

Menning (1977, 1980, 1988) has written extensively on the experience of infertility and was the initiator of a change in professional thinking to focus upon the consequences rather than the causes of infertility. She is the founder of RESOLVE, Inc., a national nonprofit organization which offers infertility counseling, referral and support groups. Experience as a counselor has exposed her to many case histories,

whose anecdotal material shows that infertility is a life crisis; affected couples experience feelings as a result of this crisis in a predictable order: surprise, denial, anger, isolation, guilt, depression, and grief. The desired goal is successful resolution of the crisis.

Quantitative Research Approaches

Quantitative research studies concerning the consequences of infertility have been mainly descriptive in nature and have had several limitations. First, a large majority of sample participants in these studies have been volunteers from infertility clinics. Secondly, a large number of the study participants appear to be mostly homogeneous with regard to race (white) and socioeconomic status (middle to upper income). Lastly, because researchers have utilized a variety of instruments in collecting data that describe the infertility experience, their findings are difficult to compare and synthesize.

Bernstein, Potts, and Mattox (1985) developed and tested an Infertility Questionnaire (IFQ) designed to measure the specific effects of infertility in three major areas: self-esteem, blame/guilt and sexuality. Seventy participants, 39 women and 31 men attending the reproductive endocrinology and infertility clinic at the University of New Mexico Hospital, completed the

questionnaire. In the study, women scored significantly higher for impairment of self-esteem than did men, though for blame/guilt and sexuality the gender difference was not statistically significant. It was determined that the IFQ in combination with a standard instrument to measure psychological stress might offer a better method to assess the emotional impairment that accompanies infertility.

The personal and marital adjustment of mothers and of voluntarily and involuntarily childless women was investigated by Callan (1987). In this study 60 mothers, 36 voluntarily childless women and 53 infertile women completed several measures of psychological well-being and marital adjustment. The three groups for the sample were located through a wide variety of strategies such as word-of-mouth referrals, university classes in psychology, newspaper articles, sterilization clinics, social networks, and an in vitro fertilization clinic. Levels of personal well-being for the three groups were very similar across indices. Infertile women, however, did report lower global levels of well-being and rated life as less interesting, emptier, and less rewarding. They were less satisfied than other women with the amount of success, interest, variety, and fulfillment in their daily lives. Infertile women, however, were more

positive about the amount of love in their lives and the level of support they received from family and friends, and were generally more satisfied with their marriage than were mothers and the voluntarily childless. The researcher thought this was either because of the benefits of childfree living or because of the sharing of their trials and frustrations in trying to have a child.

McEwan, Costello, and Taylor (1987) used a variety of instruments to investigate the psychological adjustment to infertility of 62 women and 45 men who visited the infertility clinic at the University of Calgary Health Sciences Centre in Alberta, Canada and who volunteered to participate in this study. "Approximately 37% of women and 1% of men of infertile marriages showed psychological disturbance" (p. 108). Because of the small number of men, only the predictors of adjustment for women were examined. Both medical and cognitive factors were found to contribute significantly to adjustment. Distress was greater among younger women and women who had not received a diagnosis than among women who had. Women who felt responsible for their infertility showed poorer adjustment, and this was most evident when infertility was not due to male factors. Also, women who believed their chances of conceiving to be lower than the actual

medical prognosis were more distressed. Finally, Protestant women showed better adjustment than women of other faiths. The researchers concluded that a larger sample and other assessment instruments were necessary to validate many of their findings.

In an effort to determine the long-term effects of psychological dysfunction associated with infertility, Bernstein, Mattox, and Kellner (1988) studied a group of 32 previously infertile couples followed at the University of New Mexico infertility clinic and a matched comparison of 20 never-infertile couples drawn from a private practice setting. The Hopkins Symptom Check List was utilized to collect data. It was found that during infertility the women had slightly elevated mean scores in three areas: depression, interpersonal sensitivity, and hostility. After resolution of infertility, these scores did not improve. When the previously infertile women were compared to the matched never-infertile group, results revealed a difference in the area of depression. Previously infertile women were significantly more depressed. Infertile men scored within the normal range for the same three areas. The researchers stated that a study design combining objective data from validated instruments and subjective data from interviews would reveal more information.

To assess the impact of infertility on marriage and self-concept, Hirsch and Hirsch (1989) studied two groups of subjects. One group consisted of volunteer couples who were seeking medical treatment for a perceived infertility problem at an infertility clinic; the other group, matched for age and socioeconomic background, was a volunteer control group of couples not yet attempting to conceive. The researchers utilized several instruments to obtain their data. Infertile couples perceived themselves as having more masculine personality traits than the control group. They also experienced significantly less sexual satisfaction than the control group. Infertile females exhibited a greater degree of discontent than the males. As investment (the amount of time and energy expended) in infertility increased, general discontent increased. Sexual satisfaction decreased with increased investment. As infertile women increased investment in their pursuit, their self-esteem decreased. Couples that were unable to share their feelings showed significantly higher levels of general discontent and of marital dissatisfaction. Since the sample consisted primarily of married, professional, upper-middle-class subjects, the results of this study cannot be generalized to the infertile population as a whole.

Draye, Woods, and Mitchell (1988) looked at gender differences in response to infertility. Thirty-nine females and 27 males attending an infertility clinic affiliated with a large teaching hospital in the northwestern United States voluntarily responded to a self-administered questionnaire. An Infertility Problem Inventory and six other questionnaires were combined in an attempt to explore the problem. There were no significant differences between the sexes for problems in the areas of marital relationship, relationship with family and friends or occupation. However, significantly more women than men experienced problems in their personal lives and in their relationships with the health care system. "Although occupational problem differences were not statistically significant, 48% of the women agreed that infertility had affected their long-range career plans" (p. 171). Women had significantly lower self-esteem scores than men. Neither women nor men exhibited difficulties in social support or in access to a confidant. While both women and men used a similar number of problem-oriented and social-support coping strategies, women employed more avoidance/withdrawal coping strategies, such as hoping for a miracle, than did men. The difference in depression scores between men and women was not significant. A limitation of this study is that data

was collected on the patient's initial visit to the infertility clinic and there was no method to measure change over time.

A psychosocial profile of infertile couples over a two-year period was presented in a study by Sahaj et al. (1988). Psychosocial data, including life change, social support, and personality traits were obtained prospectively from 134 individuals, 58 married couples and 18 women participating in an in vitro fertilization program at the Jones Institute of Reproductive Medicine at the Eastern Virginia Medical School. To capture the psychosocial description the researchers utilized five instruments. The first of these, the Life Experience Survey, assessed the positive and negative impact of major life events over the previous year. Despite the presumed adverse psychological influence of infertility, scores on this survey for both men and women did not differ significantly from normative data. Two other questionnaires, the Family Apgar and Friends Apgar, assessed the degree of satisfaction regarding interaction with family members and close friends. There was a high degree of satisfaction with family function, and scores were only slightly lower than normative data for friend interaction. Social support, therefore, was not significantly affected. The Multidimensional Locus-of-Control questionnaire which

measured perceptions regarding factors influencing health outcomes revealed unremarkable results. The last instrument, the Eyesneck Personality Inventory, looked at introversion-extraversion and neuroticism stability. The results again were insignificant with women being only slightly more neurotic. Overall, these psychosocial results were surprisingly normal. Generalization of findings from this study are limited since the sample included a select group of motivated couples participating in a very costly program.

A Quantitative/Qualitative Approach

Cooper (1979) utilized both quantitative and qualitative methodology to examine the effectiveness of RESOLVE in improving an infertile woman's sense of self-esteem and body image, and in changing locus of control to a more internal direction and in reducing self-defeating behaviors. Pre and post questionnaires were utilized with the control and experimental groups. The control group received no treatment intervention while the experimental group participated in a 15-week RESOLVE support group. Quantitative data, collected through the Tennessee Self Concept Scale, the Physical Self Subscale, and a Behavior Check List, did not confirm any significant changes in the experimental group that participated in RESOLVE. Personal interview analysis, however, indicated that infertile subjects

experienced many positive changes as a result of their participation. They felt they could express their feelings in the group and be understood; they received support from others; they gained information; they felt more relaxed, at ease, and less depressed; their communication improved with their spouses; they became more open about their infertility; they began to take better care of themselves; and they began to pursue alternatives to having a biological child. It was concluded that time is a necessary ingredient in working through the negative feelings related to infertility and that the 15-week interval was not long enough for any major internal changes to take place.

Qualitative Research Approaches

Descriptive Studies

Lalos, Lalos, Jacobsson, and Schoultz (1985) performed a descriptive study that investigated the psychological reactions to the medical investigation and surgical treatment of infertility. For two years 30 women with a diagnosis of tubal damage and 29 men were followed with repeated structured interviews. The women were all undergoing treatment at the Department of Obstetrics and Gynecology at the University Hospital in Umea, Sweden. Negative effects on sexual life were recorded in all individuals and were associated with

the planning of intercourse. Semen analysis was psychologically difficult for half of the men, and feelings of shame and degradation were common among them. Fear and anxiety among women increased before reconstructive tubal surgery, and postoperative depression was observed in 10 of them. Most couples overestimated their chances of having a child and half of them expected pregnancy to occur within a few months. After two years the couples voiced an increased need for professional support and counseling.

The expectations and coping of women undergoing in vitro fertilization were investigated in a descriptive study by Stewart and Glazer (1986). Data was gathered from structured interviews with three women who had completed an in vitro fertilization cycle at a large midwestern university hospital. Uncertainty of success of the in vitro fertilization cycle was difficult for the women to deal with; all three of them referred to its "up-and-down" nature. They all, however, maintained hope. Anxiety was present during the waiting time for two of the women. The one woman who did become pregnant had little recollection of anxiety during the wait but described more anxiety actually going through the physical discomforts of the medical procedures. All three women felt they had benefited from the consistency of care they received and the

orientation to reality that was enforced by the medical professionals. They liked being kept informed and knowing that someone was available to help. All three also described receiving great assistance, both emotional and physical, from their husbands in coping with the in vitro fertilization experience. Two of the women advocated informing family and friends of what they were undergoing as a method of coping. All three were satisfied with medical professionals' roles in educating, counseling and supporting them and their spouses.

Valentine's (1986) descriptive study of the psychological impact of infertility identified numerous issues and needs. Semi-structured interviews were carried out with 12 couples and two women experiencing infertility. The researcher solicited participants through media announcements, presentations, and a snowball sampling technique. Participants were asked to discuss their feelings, conflicts, sources of stress and methods of coping. All reported intense emotional reactions to their infertility and described years of emotional pain and suffering. Sadness, depression, anger, confusion, desperation, hurt, fear, embarrassment, humiliation, disappointment, unfairness and unfulfillment were described. Behavioral reactions such as disorganization, distractibility, exhaustion,

moodiness, unpredictability and obsessive behaviors were attributed to the psychological impact of the experience. The specific causes of these emotional and behavioral responses appeared to be related to experiences of crisis, loss and multiple stressors. Losses were multiple for the infertile couples: loss of potential children, loss of control, loss of self-worth, loss of life goals and loss of pregnancies. Stressors identified were medical procedures and personnel, comments from others, marital and sexual stress, and dealing with adoption workers. Coping mechanisms included supportive relationships with family, friends, and other infertile people, support groups for infertile people, infertility specialists who were competent and aware of the participant's emotional needs, obsession, and avoidance tactics. Decisions concerning alternatives were described as difficult and there was a sense of relief when decisions were made. Valentine's findings support the need for numerous intervention strategies for the infertile couple.

Grounded Theory Studies

"Grounded theory studies involve both an inductive and a deductive approach to theory construction in that constructs and concepts are grounded in the data and

hypotheses are tested as they arise from the research" (Field & Morse, 1985, p. 23).

Olshansky (1987a) used approaches suitable to grounded theory development interviewing 32 persons--15 married couples and two married women. Participants were recruited from a large university infertility clinic on the United States West Coast as well as from RESOLVE. Through the ongoing process of data collection and analysis, a grounded theory was generated whose core concept was that as persons experience unwanted infertility they take on and manage a central identity as infertile. They eventually attempt to rid themselves of this identity and get on with life. Prior to this, however, infertility becomes all-encompassing in their lives and everything else is pushed to the periphery. In order to rid themselves of this identity the infertile couples must take it on centrally. The work of taking on and managing an identity of self as infertile begins with symbolic rehearsals. This is a pre-identity stage where couples imagine what it would be like to be pregnant or a parent. The couples then informally identify with the identity as they begin to suspect a problem. They enter a more formal identity when they seek medical assistance. In order to manage this identity, infertile couples either overcome it by becoming

pregnant, circumvent it by achieving pregnancy through technological means, or reconcile it through adopting a child or remaining childless. One group of infertile couples unsuccessfully managed the identity by remaining "in limbo." Sample characteristics were a major limitation of this study; all participants were Caucasian and most were employed in professional occupations. Also, since infertility treatment is expensive, the study sample does not represent those who have no access to infertility treatment.

In the previous study Olshansky (1987b) discovered that careers were often influenced by infertility. Olshansky interviewed 17 married infertile women, recruited from an infertility clinic and RESOLVE, and discovered three patterns by which women manage their careers in light of infertility. The first and most prevalent pattern was that career identities often became peripheral; many women spoke about how they focused less on their careers, put less effort into them, and did not progress professionally as much as they would have liked. The second pattern was that some women became more involved in their careers as a strategy for coping with their feelings surrounding infertility. In the third pattern, applicable to only a few, women integrated infertility into their careers by becoming professionally involved in work related to

infertility. Again, a major limitation of this study was the large number of professional women in the sample; issues relevant to women in lower socioeconomic classes were not addressed.

In analyzing data from interviews with seven couples who had chosen high-technology options in their pursuit of infertility, Olshansky (1988) identified six themes: "driveness," difficulty getting on with life, marital and sexual disruptions, uniqueness of responses related to personal meaning, financial stresses, and exacerbated cyclical pattern of hope and despair. The availability of high-technology options often increases the drive to become pregnant: couples feel obliged to try everything, and as newer technologies become available they often have difficulty stopping infertility treatments and getting on with life. Health care professionals contribute to the problem by urging couples to try everything to succeed. Yet many high-technology treatments constitute a direct insult to the sexual and marital relationship. Stress is often created in decision-making about treatment. Each spouse at times responds individually, rather than as a couple, to the infertility experience. This response is based on each spouse's personal meaning of infertility and its subsequent treatment. The financial stress imposed by high-technology options is

overwhelming. The work of infertility often leads to an up-and-down cycle of hope and despair. Olshansky's research is again limited since the sample contained only middle and upper income professional couples.

Grounded theory methodology was used by Sandelowski, Harris, and Holditch-Davis (1989) to explore the transition to parenthood of infertile couples who achieve parenthood through adoption or biotechnical means. "Mazing, the process of negotiating the paths to parenthood, was found to be a key component of that transition and the core variable that integrates the experiences of infertile couples after a period of trying but failing to have a child of their own on their own" (p. 220). Forty infertile couples were interviewed. Because the process of mazing demands vast expenditures of time, physical and psychic energy, and money, the infertile couples documented fatigue in trying to have a child. Once in the maze, couples engaged in an accounting process: they weighed their options, calculated resource availability and need, and determined what they were willing to invest. They exhibited six patterns of pursuit. Sequential tracking was exhibited by couples who tried one option at a time. Backtracking involved restarting medical regimens or adoption options. Getting stuck in a treatment groove was a third

pattern. A fourth pattern, paralleling, was the pursuing of multiple options simultaneously. Taking a break, withdrawing from the pursuit of fertility or parenthood for several months to years, was the fifth pattern. (Breaks necessitated by moves to new locations, financial and insurance constraints, and the need to recover from failures and losses, however, had positive consequences. They allowed couples to recapitalize their waning financial, physical, and psychic reserves.) Drawing the line was the sixth and final pattern, seen in couples no longer willing to invest in medical solutions. At some point in the failed quest for a child, infertile couples finally reframed their true desires--a pregnancy or a child. This is the final task in coming through and out of the maze. As with other studies, a major limitation of this one is in it's homogeneous sample--all white and all with sufficient income to seek costly infertility services and formal adoption procedures--though the authors themselves are cognizant of the limitation: "This study excludes many individuals and couples unable but wanting to become parents who choose to do nothing but wait for God to grant them a child, who cannot afford infertility and adoption services, who are reluctant to suffer the scrutiny of medical personnel and caseworkers, who attempt folk or other

extra medical remedies for infertility or who arrange intrafamily or other kinds of private adoptions without engaging medical or legal systems" (p. 226).

Blenner's (1990) grounded theory research studied 25 couples as they underwent infertility assessment during the several phases of their treatment. The sample was solicited from a local nonprofessional infertility conference, two local infertility support groups, an article placed in a community lay infertility newsletter, and brochures placed in offices of infertility specialists. Blenner's sample included a wide variety of blue collar workers and professionals at various stages in the treatment process. However, with the exception of one biracial couple, the sample was all white. Blenner's findings yielded a stage theory of passage through infertility treatment explaining the psychosocial responses of couples to their infertility from prediagnosis to posttreatment. The theory comprises three concepts--engagement, immersion, and disengagement--and eight stages through which infertile couples seem to go. In stage one, a dawning of awareness of possible infertility; couples become puzzled and use a buffering strategy (delaying assessment). Stage two evolves when an infertility workup is done and a diagnosis is made. Now the couples search for causes and experience guilt, along

with feelings of loss and differentiation from the fertile world. They feel a need to pursue treatment in order to avoid regrets later. To gain understanding and support, they read literature on infertility, seek out other infertile couples, or just generally share with others. Throughout stage two, however, they experience some "insensitive" remarks and "nonsense" advice. Stage three begins when couples enter treatment and their energy and optimism are strong.

In stage four, couples are intensely involved in treatment and focus their lives on infertility. They exhibit feelings of loss of control over their lives. Careers and life events are affected by infertility. The couples begin to label themselves as infertile. They channel frustration and anger at others, such as health professionals, and express feelings of anger about injustice. They begin to isolate themselves from social activities, such as baby showers, that might increase their pain. Couples in stage four seek out support groups. Stage five involves a spiraling down as time passes and treatment options decrease. Couples use avoidance strategies and feel a loss of control over their emotions. (Four women reported feeling suicidal during this phase.) Stage six involves letting go and experiencing a gradual acceptance. Treatment begins to be questioned and normalizing of

life begins. Revitalization is a coping strategy used by couples to give themselves a "mental vacation." Termination is difficult. Couples became involved in examining options of childlessness and adoption. Stage seven evokes feelings of relief and expectations of getting on with life. Some experience grief reactions after they decide to remain childless. Those who adopt become frustrated in this process. In the final stage the childless couples experience an inner peace and begin a new focus. Adoptive parents reengage with fertile people, but still feel pangs of grief over pregnancies, holidays and family-related experiences, but they are able to move on. The actual steps in the process depend on each subject's gender and perceived meaning of the infertility experience. The length of time spent in passage is variable.

A Phenomenological Study

Sandelowski and Pollock (1986) explored the experience of infertility using a phenomenological perspective. They interviewed 48 infertile women (26 private practice patients and 22 infertility clinic patients) with diverse backgrounds and conditions of infertility in an attempt to overcome sampling limitations of other researchers. Nothing about the initial interviews was planned besides an opening question that asked the participants to tell the

researcher what it was like not being able to have a baby when she wanted to. The qualitative data revealed three major elements found in the women's descriptions. These included varying expressions of ambiguity, temporality, and otherness. Findings of the study are compared and contrasted between the private practice and the infertility clinic subjects. Ambiguity was the first and most prevalent element expressed. These expressions included uncertainty about the reason for infertility, ambivalence toward physicians, floundering in the pursuit of life goals, doubtfulness about whether or not pregnancy was achieved and whether or not it would be carried successfully, uncertainty about the efficacy and safety of diagnostic and treatment regimens, disbelief about past fertility and uncertainty about future fertility, and uncertainty about what in life is within human control. A larger number of clinic patients had been given no definitive diagnosis. Also, in contrast to the private practice patients, they complained very little about their physicians. The clinic group of women were not as persistent in their pursuit of medical care as the private practice patients. Intertwined with expressions of ambiguity were expressions of a heightened consciousness of chronological and biological time. The second element, temporality, was

expressed in terms of setting and extending time limits, time wasted or running out, time and time-consuming rituals, body or menstrual time, planning and waiting and reviewing, delayed childbearing and the slowing of time. The women in the private practice group had planned life trajectories whereas the clinic group waited longer to seek medical care to determine why they were unable to have children. Temporality was related to the ambiguity of not knowing how much time it would take to achieve success or when the "end" would arrive. The third element, otherness, the feeling of separation and deviance, was manifested in the making of social comparisons, the sense of being unfairly singled out, the feeling of not fitting in and being left out, the perception that no one understands and the feeling of defectiveness. The clinic group of women appeared less angry and more accepting, believing they would have children when it was "meant to be" and when "God was ready." The clinic group less frequently expressed the three elements. The researchers questioned whether the differences in the infertility experiences of women of divergent socioeconomic backgrounds, in particular race and class, are real or spurious. Differing findings for the two groups may in part have been attributed to the shorter interview periods of the clinic group and the fact that these

women were less verbal. Distance from the researcher created by class, race, and setting could also have affected the findings.

Conclusion

The review of literature reveals the limitations of various approaches to exploring the phenomenon of infertility. Case histories offer interesting accounts and knowledge of the infertility experience but fail to present validated research. Quantitative studies have been reductionistic and context-stripping, failing to capture the entire phenomenon under study. The quantitative studies have, moreover, been deductive in nature, whereas infertility is an experience that demands a holistic approach; no one element can be viewed by itself. On the other hand qualitative approaches, inductive in nature, seek to explore the whole experience, not just its parts. Many qualitative studies, however, have sample characteristic limitations, as shown above. The existence of only one phenomenological study (Sandelowski & Pollock, 1986) enforces the need to explore the "lived" experience of infertility.

CHAPTER III

METHODOLOGY

The primary instruments of a phenomenological study are the researcher/interviewer and the study participants. In striving to discover the perspectives of humans who live the experience, the researcher/interviewer must recognize that he or she herself is also involved in a world (Oiler, 1982). Phenomenological research proceeds as the direction of the experience indicates. Omery (1983) describes the phenomenological method as a method that is not based on a preconceived framework. Data are organized and described as they are found and then reported in the natural language of the event. Accordingly, in-depth, unstructured interviews with the experts on the phenomenon, the infertile women, were completed. Research questions, as described in the objectives of the study section, were kept in mind but a minimum of structure was imposed on the interviews. The following opening statement was utilized for all interviews: "Tell me about your experience of infertility, what it means to you, what feelings and ideas you have about it. Basically, just describe your experience. Start with when you first thought you were infertile if that is easiest." Further researcher/interviewer statements or questions were dependent on the participant's

responses. This approach allowed the researcher/interviewer to obtain the most meaningful and rich description of each participant's experience.

The phenomenological methodology of Giorgi (cited in Omery, 1983) was utilized. This methodology involves six steps:

Step 1. Naive description of the phenomenon accomplished via an interview with the subject.

Step 2. The researcher reads the entire description to get a sense of the whole.

Step 3. The researcher reads the description more slowly and identifies individual units.

Step 4. The researcher eliminates redundancies in the units, clarifying or elaborating the meaning of the remaining units by relating them to each other and to the whole.

Step 5. The researcher reflects on the given units, and transforms the meaning from concrete language into the language or concepts of the science.

Step 6. The researcher then integrates and synthesizes the insights into a descriptive structure which is communicated to other researchers for confirmation and/or critique.

Identifying the Phenomenon

Inasmuch as the phenomenon for this research method is any experience that affects human response,

the "lived" experience of infertility as it is perceived by infertile women is the phenomenon of concern in the present study.

Universe of Content

The phenomenon was explored using participants who have "lived" the experience of infertility. Initial selection of participants was accomplished via contact with the president of the local RESOLVE chapter; continued selection was based on the findings that emerged during the course of the study. The researcher surmised after four interviews that there was a need to obtain participants who were not intimately involved with RESOLVE in that the special nature of the support group might be affecting the experience. This shift in sampling allowed further exploration of the scope and range of the experience from different perspectives. Participants who the researcher thought might have a different perspective were then interviewed. A more complete picture of the phenomenon of the "lived" experience of infertility was obtained.

Sampling

Initially a pilot interview was conducted to determine the effectiveness of the opening statement in eliciting a response. The statement was so effective in obtaining a wealth of rich and meaningful data that

the pilot interview was included in the data analysis. The president of the local RESOLVE chapter acted as the "gatekeeper" for beginning the purposeful sampling process (Lincoln & Guba, 1985). Three participants were nominated and contacted by the "gatekeeper." All were known to be eager to verbalize about their experience and gave permission to the "gatekeeper" for the researcher to contact them. An additional subject was interviewed after she contacted the researcher upon hearing about the study in the community. The last three participants were obtained through personal and professional contacts who thought of infertile women they knew and described the study to them. The infertile women were then given a card on which they placed their name and phone number or address and a stamped envelope to return to the researcher if they desired to participate in the study. Initially they had been given the researcher's phone number to call but this approach proved unsuccessful.

Written informed consent (see Appendix A) was obtained from each participant after the consent was read to each. A brief, self-administered demographic questionnaire (see Appendix B) was then completed by each participant. This questionnaire was number coded to eliminate the use of names and to protect the participants' confidentiality.

Because in qualitative methodology the sample size is small due to the length of the data-gathering interviews and the detail of the completed description (Sandelowski, 1986), a total of eight infertile women were interviewed. Sampling ceased when no new information was forthcoming and redundancy was deemed achieved (Lincoln & Guba, 1985).

Recording

Times and settings for the interviews were chosen by the participants. The natural setting of the participant's home was chosen by all. The interviews were conducted in an area of the participant's home where it was suggested that she would feel most comfortable in talking. Interviews were conducted with only the researcher/interviewer and the participant present. All the participants agreed to have their interviews tape recorded. They were told that if they did not desire to be taped the interviews could proceed without the recording, and that they could terminate the interview at any point and the researcher would erase the tape recording in the participant's presence. Each tape recording was number coded with the participant's corresponding number-coded demographic questionnaire. The participant's responses controlled the length of the interviews. Interviews lasted one to two hours. Only one initial interview was needed to

develop a relationship and elicit a description of the experience. The interviews were very intense and the majority of the participants cried at some point during the interview. However, no serious emotional distress occurred and the researcher assessed each participant's status prior to leaving the participant's home.

Codes and Categories

After data were collected from each interview and transcribed, like units of information were coded on index cards into groups of similar content. Quotes from interviews were listed together for each interview according to topic and codes were assigned to closely reflect the original data. Interpretation of meaning was avoided as much as possible. A number of codes of similar meaning arose from this perusal. Frequency of occurrence for each code will be reported in the following chapter.

Coding was completed and category development began after some time and reflection. The codes were compared and contrasted with all other codes for any inherent relationships or similarities. The codes were then grouped into categories. Each category contains a number of codes.

Confirmation

In order to validate the code and category development analysis, four of the eight participants were visited again by the researcher. The intent of this interview was for member-checking purposes to establish validity of the study (Lincoln & Guba, 1985). After all, the infertile women are the experts on the "lived" experience of infertility.

All participants except two were amenable to a second confirming interview. The researcher chose a total of four participants. Two of the participants chosen were actively involved in the RESOLVE support group and the other two were not. One of the latter two participants was of a different race, socioeconomic status, and stage of treatment pursuit. The researcher attempted to choose participants so that a total picture of the experience could be confirmed.

Each of the four participants was issued each category with inclusive codes. Statements representing each code were presented to each participant for verification that they supported the code. Each participant was then asked to verify if the codes within the categories were inclusive. Then each participant was asked to validate the entire code and category analysis as a total description of the "lived"

experience of infertility as perceived by infertile women.

CHAPTER IV

DATA ANALYSIS

This chapter presents a final synthesis of the qualitative data obtained from the eight participants' interviews. The analysis is inductive in nature--that is, the general is inferred from the specific. The resulting description of the lived experience of infertility as perceived by infertile women is an analysis reflected in codes and category development. The codes reflect the way in which the phenomenon is constituted in consciousness and provide access to truth about the experience. Categories arise after the phenomenon is probed for the essence of the experience. Each category contains codes that are illuminated by a representative statement or statements from the data.

Demographics of the Participants

Demographic information on the eight participants is presented in Table 1. It should be noted that five of the eight participants have achieved one or several pregnancies that have proven unsuccessful. Since the initial interview two participants achieved a pregnancy through an in vitro fertilization attempt, but subsequently miscarried. The participants were at various stages of treatment, ranging from beginning the medical pursuit to being resolved to being childless. The length of time the participants have been pursuing

Table 1

Demographic Information

	Age	Race	Marital Status	Level of Education	Total Household Income	Religious Preference	Etiology of Infertility
Interview 1	37	White	Married	1-2 years post high school	>$50,000/yr -	*	septum in uterus; endometriosis; tubal adhesions
Interview 2	34	White	Married	Master's Degree	>$50,000/yr	Protestant	anovulation; sperm antibodies
Interview 3	31	White	Married	Master's Degree	>$50,000/yr	Protestant	partial tube; scar tissue; endometriosis
Interview 4	24	White	Married	Bacca-laureate Degree	$30,000 - 39,999/yr	Protestant	polycystic ovarian disease; low semen
Interview 5	37	White	Married	Master's Degree	$30,000 - 39,999/yr	Protestant	unknown
Interview 6	26	White	Married	1-2 years post high school	$20,000 - 29,999/yr	*	absence of fallopian tubes; one ovary
Interview 7	25	Black	Married	12 years	$10,000 - 19,999/yr	Protestant	unknown
Interview 8	36	Black	Married	1-2 years post high school	<$10,000/yr	Protestant	endometriosis

(* - No Response)

infertility treatment ranges from four to ten years. All participants were married at the time of the interview. Five of the participants hold professional occupations, two are students, and one participant was unemployed at the time of the interview.

Codes

Coding names were assigned to reflect the primary topic of the participants' statements. A code designates units of data with similar meaning. The codes are presented in Table 2 with the number of participants who made statements concerning that topic. Three of the codes included statements from only one participant. Thirteen of the codes were topics addressed by all eight participants. In all, fifty-five codes were identified.

Categories

Relationships among the codes revealed five categories of the lived experience of infertility. The categories were developed after codes containing common elements were grouped together. Category names reflect the principal element described by the code statements. Table 2 gives the names of the categories with a listing of the codes included in each of them. The five categories will be discussed in detail and will

Table 2

Categories with codes and number of participants mentioning them

	Number of participants
I. Emotional Impact	
Anger	8
Anxiety	7
Decreased self-esteem	4
Desperation	1
Devastation	4
Emotional pain/Hurt	7
Exhaustion/Tired	3
Fear	5
Frustration	5
Grief/Loss	6
Guilt	2
Isolation	4
Jealousy	2
Obsession	7
Out of Control	6
Relief	1
Roller coaster effect/Up-and-down	2
Sadness/Depression	8
Suicidal Thoughts	1
Tearfulness	8
Trauma	3
Unfairness	8

Table 2 (continued)

Categories with codes and number of participants mentioning them	Number of participants
II. Relationships	
Advice	4
Children	8
Comments	7
Family	8
Friends	8
God	8
Husband/Partner	8
Medical professionals	7
Sex	4
III. Physical Impact	
Expense	7
Holidays/Special occasions	4
Medical procedures	8
Menses	6
Miscarriage/Ectopic pregnancy	5
Physical abnormalities	7
Physical pain	4
Time	7
Travel	5
Work	5
IV. Alternatives	
Adoption	7

Table 2 (continued)

Categories with codes and number of participants mentioning them	Number of participants
Childlessness	5
Decisions	5
In vitro fertilization	5
Lack of information	5
Uncertainty	5
V. Coping Mechanisms	
Avoidance	8
Breaks	2
Hope	8
Pets	3
Personal coping mechanisms	8
Projection	4
Rationalization	5
RESOLVE support group	5

include the code statements to illuminate the meaningful description of the lived experience of infertility as perceived by infertile women.

Category I. Emotional Impact

The codes within this category illuminate the numerous emotions expressed by the infertile women. Each participant's interview was replete with a variety of emotions. Statements reflecting this category consumed the majority of each interview's time. Of the 55 total codes, the greatest number (22) fell within this category. Three of the codes within this category were stated by only one participant, enforcing the idiosyncratic nature of the emotional impact of the experience. The code statements within this category indicate the very emotional nature of the experience of infertility.

Anger

Anger is an emotion that was expressed by all eight participants. This anger was directed at the participant's situation and at others. Several statements that represent this code include:

- "I am in the anger stage now and I know I will move out of it at some point--but that is where I am right now."

- "I really felt angry because everything had

seemed to go so well."

- "I had a rage inside of me! I was angry! With who I don't know!"

- "It started making me mad because it was like they were thinking I was not having kids because I don't want to."

- "Oh! I have really been angry a lot!"

- "I am pretty angry at the medical profession."

- "It makes me angry at times that my husband can't tell me things that maybe I would like to hear."

Anxiety

Many of the participants expressed feelings of anxiety:

- "We did our first in vitro fertilization attempt and I was anxious. It's emotionally stressful at times."

- "I am getting more anxious now because I would like to meet with them and kind of resolve in my mind."

- "Trying to do it all--trying to go to school, get pregnant, at the same time raise children."

- "I am beginning to get my anxiety under a level that I can handle."

- "I tend to worry about it. There is always something upsetting things."

Decreased self-esteem

Four of the participants spoke about their feelings of decreased self-esteem:

- "I feel like I am failing, I'm trying to get pregnant and it's not working."

- "There are a lot of feelings of failure. That you are just not complete. You don't feel like you are succeeding at something that could be important for your family life and future."

- "It does something to your self-esteem as a woman. You are just not measuring up."

- "My self-esteem was low."

Desperation

Only one participant voiced a statement that suggested how desperate she felt in the experience:

- "I was just so desperate to have a baby. A year ago I would have said 'I have to do anything that I need to do to have a baby!'."

Devastation

Two participants expressed feeling devastated over their situation:

- "I was so devastated it took me a couple weeks to get my wits back together on thinking about it." (after an announcement of a family member's pregnancy)

- "Husbands don't really understand how

devastating it can be."

Two other participants expressed feeling devastated after the loss of a pregnancy.

- "Just the thought of that being taken away from me was devastating."

- "I went home and cried after the ultrasound. I was just devastated."

Emotional Pain/Hurt

The emotional pain perceived during the experience was expressed by a majority of the participants. Several statements that illustrate this emotion were:

- "I think in some ways I had to have been hurt first--that is just pain!"

- "Now that I cannot have children and have started to accept the fact, rather than ignore it I am actually feeling the hurt."

- "I enjoy seeing their kids and being a part of their lives but it hurts to be around them when you know you don't have them in your life."

- "I mean it was just a constant pain that I felt."

Exhaustion/Tired

Three participants voiced feelings of exhaustion due to the situation:

- "I guess because there are so many tears you

just get so exhausted that you feel sick."

- "I am tired of it! My emotions are constantly churned up. I never have a placid moment anymore. It just seems like it wears me out for awhile."

One of these participants and another participant discussed being tired of medical procedures.

- "I am tired of it! I don't want anymore."

- "The day before I am all worried about it and the day after I am exhausted."

Fear

Differing reasons for fear were mentioned by five of the participants:

- "I am afraid of what the doctor is going to find and that there is nothing he can do."

- "I guess I got scared wondering what the doctor was going to do to me."

- "I guess it was a real fear of knowing one way or the other."

- "I am afraid to get pregnant. I'm afraid to chance losing the other tube. I'm afraid of the whole sequence of it."

- "Just a whole lot of fear that I would have a miscarriage."

Frustration

The feelings of frustration associated with the

experience were related by five of the participants:

- "I guess one of the first feelings was frustration. What can I do about this? I'm just frustrated! Give me an answer! I want this fixed!"

- "This last cycle was so frustrating. We had done all the right things and it was worse than ever."

- "It's frustrating because after going through all of that and the financial strain, they couldn't do anything for me."

- "Now that I have started to accept the fact I feel the frustration."

- "Just thinking there is nothing I can do. It is very frustrating."

Grief/Loss

Feelings of grief or loss were expressed by five of the eight participants who had experienced the loss of pregnancies. The following statement specifically illuminates this feeling:

- "Of course there was terrible grief. When you first find out you are pregnant it is the happiest thing that you can imagine. Then to have it all and to lose it."

Other expressions of grief or loss were identified:

- "You go through stages. I have heard it compared to death. I think it's true. I think there

are times when you grieve a lot."

- "I mean it was just a constant loss that I felt. I knew that I was going to have to really grieve not having a biological child because I wanted to be pregnant, to go through delivery, and to breastfeed."

- "I have already lost a tube."

Guilt

Guilt was expressed by two participants. One stated this feeling concerning her ability to have a child:

- "I try to give my husband everything he wants. But I just haven't been able to give him a child yet."

The second participant who voiced this feeling was questioning continued pursuit of her reason for infertility.

- "I feel guilty and I say 'Why am I doing this? I should be home having babies and taking care of my marriage'."

Isolation

Four participants described feelings of isolation. These statements encompassed aspects of being left out and alone in the experience:

- "I do sometimes feel kind of isolated."

- "I shy out of conversations when children come up. I feel a little left out but understandably."

- "It's hard seeing everybody walking around with kids and I'm like everybody is pregnant but me."

- "It's my problem because I am the one that can't get pregnant. I have to deal with it on my own."

Jealousy

Only two participants spoke of any feelings of jealousy. These feelings were directed at others who were able to have children:

- "I had real mixed feelings when the baby was born. I mean there was a part of me that was kind of excited and a part of me that was very jealous."

- "Now I don't have any pangs of jealousy."

Obsession

All but one of the participants voiced the obsessive feelings that they have experienced. Their infertility appeared to be a constant thought:

- "It really does affect your whole life. I mean it affects your entire life! The hard part is you can't turn it off. You live with the thought from the morning till the time you go to bed."

- "I get reminded of it everyday. You really get obsessed during cycles. I might not know what day of the month it is, but I know what cycle day it is."

- "The other thing is just never getting rid of the thought. Never having a break of thinking about

being pregnant or having a baby. It's always there. That's all you think about. You can just never get away from it. Going to sleep you think about it, the first thing you wake up, you dream about it, you wake up in the middle of the night and think about it."

- "It's hard not to think about it all the time."

Out of Control

Several of the participants related feelings of being out of control of their emotions:

- "I went from there to being--I guess maybe a feeling of being out of control."

- "There are days when I feel like I am going berserk--it upsets me to a point where I am irrational!"

- "Before I was not in control."

- "You feel like you are coming apart inside. You just fluctuate from one emotion to another and it's a very irrational time."

Relief

Only one participant spoke of a feeling of relief. This feeling was expressed by a participant who had resolved to end her pursuit of having a child:

- "I remember the day that I started my period after the last cycle. It was like instant relief and okay it is finally over! Let's get on with our life!"

Roller Coaster Effect/Up-and-Down

Two of the participants explicitly expressed the up-and-down or roller coaster effect of the emotional experience:

- "I was starting to get on what everybody refers to as that emotional roller coaster ride where you waited each month to find out if you were pregnant."

- "Instead of being on a roller coaster up-and-down, everything has become more steady."

Sadness/Depression

The feelings of sadness and depression were expressed in a similar context by all participants. One of the participants exhibited an increased degree of depression:

- "I guess it could be getting to there were periods of a sort of depression. I never went into a horrible depression but right around the time you get your period you were just low, and it was really hard to pull yourself up."

- "I go through different stages. Sometimes I am really sad and depressed over it."

- "I think I get a little depressed."

- "It makes me sad sometimes."

- "I just remember feeling so sad."

- "I have been dealing with depression for six years."

Suicidal Thoughts

Only one participant voiced thoughts about taking her life due to her experience. The following statement by this participant shows the intensity of her feeling:

- "Before I honestly can say that if I can't have kids I don't want to live. That was my attitude for a long time. Don't tell me this is all there is to life. Cause if I can't have kids there isn't anything! I never tried, but I thought about it lots and lots of times. Like this is it!"

Tearfulness

During the majority of the interviews tears were shed. Crying was reported by all eight participants:

- "I remember crying when I hung up the phone, although I sort of knew. I'd started spotting before they called me and my gut feeling told me it hadn't worked."

- "I cried for like an hour in the office."

- "I remember just a lot of tears. Just crying a lot! There has to be a child in my life!"

- "Well there was a lot of emotion. There was a lot of crying and soul searching."

- "I remember crying a lot."

- "I would just cry to myself. I used to just sit up and cry."

Trauma

This emotion was expressed by those participants who had reported a loss of a pregnancy. The following statements illustrate this emotional impact:

- "The emotion of it all is pretty traumatic. All the hormones get way up there and coming down from a pregnancy."

- "The first miscarriage wasn't as traumatic as the second one."

- "I was finally pregnant and it was normal and then you are shot back down again--it's too much emotional trauma!"

Unfairness

All eight participants expressed concern over the unfairness of their situation and had difficulty understanding why they were chosen for this experience:

- "Why me? This is really unfair!"

- "It's not fair! It's not fair! This is my big thing!"

- "It just didn't seem fair."

- "I guess maybe I felt a little injustice. She was having a baby that should be mine. I wished it was me. This should be me too!"

- "I was just thinking this should be me too!"

- "For a moment I felt she got them and I didn't."

- "It seemed so unfair that it could happen to them so easily."

Category II. Relationships

This category illustrates how the infertility experience has affected the infertile women's relationships with others, both positively and negatively. Some of the relationships could be described as supportive, while others appeared to be unsupportive. A large number of the codes in this category were mentioned by all of the participants. The impact of the infertility experience on these women's social world was apparent.

Advice

Four of the participants mentioned advice they had received from others concerning their experience:

- "Of course everybody in life tells you that if you are infertile to relax!"

- "They would say 'You are trying too hard!'."

- "Why don't you adopt!"

- "She kind of said to me 'Why don't you, you know you have been through so much, why don't you just try to deal with it, maybe make a decision in your own mind that maybe this isn't going to happen and just get that resolved in your own mind.'."

Children

All eight participants expressed statements concerning their relationships with children:

- "When I would find out that I wasn't pregnant I really found a need to be close to my kids at work."

- "I mean this little baby is the most special thing in my life."

- "I enjoy seeing the kids and being a part of their lives but it hurts."

- "I can handle kids who are seven, eight, nine, or ten years old. That doesn't affect me. It's those little ones that really get to me."

- "I don't have much patience with my husband's daughter anymore."

- "The birth of my sister's child brought a lot of joy. So it's made it easier to accept since I have him."

- "I go to my friend's house a lot and play with her baby."

- "I feel that I have a lot of maternal instinct and when I am around children I have a good rapport with them and it's just natural."

Comments

Seven of the participants mentioned comments received from others that differed from advice, as the following statements illustrate:

- "'So when are you going to get this family going, you guys, are you just going to be selfish and just have your own little twosome?' That was like somebody stabbing me in the back."

- "They are constantly asking 'Why don't you have kids?'"

- "I had one person tell me she thought it was God's plan for me not to have a child since I did such important work and that it would take me away from my work."

- "'Are you pregnant yet?'"

- "There are times when someone unknowingly will say 'Well, do you have children?' and that is sometimes hard to answer."

- "Everybody keeps asking why I don't have a baby."

- "'When are you going to have kids?'"

Family

Relationships with various family members of the infertile women were described within the context of their effects on the experience. It could be seen that both positive and negative relationships existed:

- "My family, it's kind of funny, I've never had a close relationship with my father and he is very uncomfortable about the whole thing and really doesn't know what to say."

- "My mother really tries to understand, but she is so excited about this grandchild." (family is expecting birth of first grandchild)

- "My family accepted whatever I needed to do. They all understood and gave me time."

- "My mother is very good. She has been through a lot with me. She has helped me. She has dealt with it emotionally with me."

- "My family was not very supportive of me."

- "My sister and I have gotten closer than we have ever been in our lives since she started having kids--where I couldn't and she kind of shares her kids with me."

- "My family really hasn't said anything about it. I guess I know they are wondering why I haven't had a child yet."

- "My family just more or less didn't realize what I was going through."

Friends

Relationships with friends were significantly affected by these infertile women's experience. Again, both positive and negative results appeared:

- "We have stayed friends with friends who have gone on and had family although, in some ways it always does change your relationship when you don't have children and they do."

- "Most of my friends do not have children and I have noticed that we do sort of become more acquaintances than friends with the ones that do."

- "We had a close relationship and we had to work hard to maintain it because we didn't want to lose a friendship because she got pregnant."

- "I am starting to have more friends that don't have children and am finding that even though I enjoy my other friends that have children it's just not quite the same."

- "I had a real close friend who didn't seem to know what to say."

- "I had a friend who got pregnant and I just couldn't bear to be around her."

- "I guess it has made our relationship stronger. We go places together and take her baby."

- "My friends all have children. I shy out of conversations with them when children come up."

God

All eight participants mentioned God and God's relationship to their experience. The most poignant account of this follows:

- "I remember having a real problem with my faith and religion. How could this be God's plan? Church is the hardest time for me. For some reason church is where I feel most exposed. I guess maybe because in

church it's a conversation with God. I felt God had abandoned me. That just made no sense to me at all. Then by losing your faith you don't have that to get you through the tragedy you are going through."

Several others offered descriptive statements concerning this relationship:

- "I have found that my faith has helped me anyway even when I am angry. I'm not the first person that has been angry at God but I know he can handle it. I can take my anger to him and he can deal with it."

- "I guess the first question was 'Why?' and blaming it on God. I figured that God was playing a trick on me. I don't really think God does it to anybody. I think God helps you through it."

- "But see, through God all things are possible. See that is where he comes in. Because he has done things like that for me before. I would talk to God about it."

Husband/Partner

The effect of the infertility experience upon the marital relationship was mentioned by all participants. Several statements describing the support as well as the tension that developed in this relationship are as follows:

- "With my husband I think it has actually improved our relationship. I think we have actually

grown stronger going through all of this and have become close because nobody can understand it like people going through it. And you really are going through it together. I mean it is definitely the two of you."

- "I think our marriage is stronger for this experience. But there is a lot more tension."

- "I never thought it caused a great deal of stress to my marriage at the time but I think right now it is."

- "In lots of ways it has brought us closer because we have had to deal with this together. Sometimes I feel we don't talk about it enough."

- "I can't talk to my husband that much even though he is emotionally supportive."

- "It probably should have brought us closer. We probably have had more struggles because of it. I guess there is a wedge--not being able to have our own kids."

- "Maybe just stress level--making it harder for us to deal with things."

Medical Professionals

The participants voiced much discontent about medical professionals:

- "I asked questions and the nurse said--well first I asked to set up an appointment to discuss it

with the doctor and they wouldn't do it."

- "They were cold. There wasn't sharing of information. The way they handled your treatment was unorganized."

- "I think having a doctor I really didn't trust didn't help. I have been to three different doctors for infertility."

- "I lost all faith in the medical profession. I figure they really don't know too much and really can't do much to help. It's a sad thing if you feel you can't trust the doctors."

- "The nurse didn't say anything to me about what the doctor would say or do."

- "The doctor never called me."

Several participants found contentment after seeking out infertility specialists.

- "I am really happy with my specialist because he knows how to deal with women that are in the situation emotionally. He knows to call you back as soon as possible with test results. He knows to explain fully what everything means and what your options are."

- "I went to specialists and finally ended up with one that I was very confident in and comfortable with."

- "My specialist, his mannerism, the way he dealt with it, helped me deal with it."

Sex

The sexual relationship was mentioned by four participants. It appeared that this relationship was negatively affected as described in the following statements:

- "It has a tremendous effect on your sexual relationship. It becomes so mechanized. You take sex out of the enjoyment realm and put it in the job realm. I really felt I had to work on having sex just for sex and not for trying to produce offspring."

- "It was terrible on our sex life. I mean it just ruined it. You couldn't be spontaneous."

- "We were just having more of a normal marriage which is probably good. Except in my case I may not get pregnant unless I really do it at the right times."

- "That took some getting used to. She asked me how often we had sex and I said 'Everyday' and she started laughing. I said 'Well, we have been trying!'"

Category III. Physical Impact

The experience of infertility affected the day-to-day life of the infertile women. The element of time involved in this experience was evident. The infertile women's lives were filled with concerns: physical abnormalities contributing to their infertility, a variety of medical procedures undertaken to diagnose and treat their infertility, long-distance

travel for such procedures, financial concerns over the cost of such procedures, the effect of the infertility medical regime on their work and careers, and the now different response to holidays and special occasions. The physical impact and emotional loss of a pregnancy were definitely evident in the women's lives. With each passing month the physical sign of menses continued to represent the infertile women's loss.

Expense

The expense of infertility studies presented valid concerns for a large majority of the participants. Pursuit of help often was curtailed for lack of money:

- "I mean there is just no such things as savings after a while, after you keep pursuing this."

- "Financially it causes a lot of tension. My husband kind of resents the debt that it has put us in."

- "Pergonal is so expensive. The whole procedure is very difficult and expensive."

- "They want to make sure you are a good candidate and that it is just not an alternative and a very expensive one."

- "Oh it is just an extreme expense and we didn't have the money. My husband and I have had a lot of arguments over finances."

- "It all comes down to whether you want to put

that amount of money into something that is not guaranteed. You can spend thousands and thousands of dollars and still not have a child. I can honestly say that if I did win the lottery in vitro fertilization would probably be the first thing that I did with the first fifty thousand dollars."

- "I can't afford it now. I'm not pursuing any of that due to finances."

Holidays/Special Occasions

Holidays appeared to be very difficult times for four of the participants:

- "I guess in some ways the time it really does come up is holidays. Holidays are real, real tough!"

- "I feel like I can't carry on Christmas traditions. It seems like there is not any point if you don't have kids aside from the religious significance."

- "There are always family holiday dinners and to think I won't have any children at those family gatherings..."

- "I think it hits home. There are the seasons. Certainly Christmas and Easter and all the holidays you want family. Just wanting to share some of that."

One of the above participants also mentioned a special occasion that sometimes bothered her:

- "Baby showers are another thing and I never know

from one to the next whether it is going to bother me."

Medical Procedures

The variety and number of medical procedures endured by a majority of the participants had a physical impact on them. One very humorous statement describes the very serious physical insult to one of the infertile women:

- "My belly button looks like it has been through a war from all of the laparoscopies."

Several of the participants spoke of the use of basal body temperature charts to determine their time of ovulation:

- "It almost becomes this habit. Even if you don't need to do it, it is almost tough to put the thermometer away. It becomes so routine."

- "First things were basal body temperature charts."

- "The temperature taking wasn't hard--it just took some getting used to cause you couldn't move in the morning."

Menses

The physical occurrence of the infertile women's menses was seen as a symbol of their infertility. They longed for their menses not to occur. It was mentioned by six of the participants:

- "When you are in the middle of your period your body is telling you 'You are not pregnant!'."

- "Oh God! My period started again!"

- "Those days of just waiting for your period to start and going to the bathroom five times as much as you usually do so you can check to see whether your period has started or not."

- "Everytime I would get my period I would go into a depression."

- "As soon as my period is a day late I am thinking this could be it!"

- "I am three days late now."

Miscarriage/Ectopic Pregnancy

The physical impact of a miscarriage and/or an ectopic pregnancy was mentioned by five of the eight participants. This code represented a significant loss and physical insult. Several statements describe this:

- "When I was nineteen I had a pregnancy that went six months and it ended in a miscarriage."

- "The first miscarriage I carried to four months and then one day I started hemorrhaging."

- "I didn't know I was pregnant. I just ended up at the hospital in pain and I had an ectopic pregnancy and the one tube I had left ruptured."

- "I guess it was eight weeks later it turned out to be an ectopic pregnancy and they didn't get it in

time."

- "I have already lost a tube and the second ectopic was in the other tube."

Physical Abnormalities

An interesting array of physical reasons for the women's infertility evolved in the data. These physical abnormalities were of a great concern to the women. The effect was most poignantly expressed by the following statement of one of the participants:

- "I have no tubes, one ovary, and a uterus! That's it!"

Physical Pain

The pain associated with medical procedures was mentioned by two participants:

- "I mean you are shot and poked and prodded until you want to just scream and shout."

- "He put me through all of these tests and they were extremely painful."

Two participants discussed pain from a physical abnormality:

- "I probably concentrate on the backaches and sideaches a little more than I would like due to my endometriosis."

- I have endometriosis and I have extreme pain from this."

Three participants discussed the pain associated with a miscarriage and ectopic pregnancies:

- "I went through three months with an ectopic pregnancy and had a lot of pain."

- "I started having pain in my right side. Another ectopic!"

- "A week after that I had the miscarriage. It was very painful. It was like going through labor pains I thought maybe."

Time

Seven participants mentioned the physical aspect of the passage of time. This involved waiting for a pregnancy, waiting and timing of medical procedures, the healing effects of time, and the problem of running out of time. Numerous statements illustrate this code:

- "The doctors said in a couple months to try again and we tried for two years."

- "We sat down and made a two-year plan of action of what we were going to do medically."

- "It's amazing how time has healed."

- "It's a timetable."

- "I have given up five years of my life to this and truly monopolized five years of my life."

- "When you get my age you really don't have time to wait around."

- "I am waiting for a new procedure."

- "I guess you have to wait. But I don't want to wait fifteen years."

- "The doctor is never going to tell you to stop. So it can go on for years and years."

- "It's the wait from the time the treatment ends until the time you start your period."

Travel

The impact of travel for medical procedures concerning infertility was mentioned by five of the participants. Several statements describe this:

- "For people who live near their doctor it's not a big deal. But when you have to take off and go to Baltimore every time it is really different. Every time I ovulated I had to take a road trip."

- "I don't understand why they don't have the medical services on the Eastern Shore that people need. My doctor recommended for some things that I go to Baltimore."

- "The first part of the procedure I would be driving back and forth and stretching my life between two locations."

Work

The effect of infertility upon the infertile women's work world was voiced by several participants. Some spoke of positive experiences, others negative:

- "I work hard at my work because of the fact that I don't have a family. In some ways I get a lot out of my work. What I am doing in some ways is healing."

- "I don't think it affected my work ability except for the fact that I had to miss so much work because of treatments. There was a time when I thought I would have to change my line of work since I work with children. But now I feel like it is a substitute for me."

- "I ended up leaving my job because I never knew when I was going to ovulate. I couldn't hold my job because of failing at getting pregnant."

- "The store closed where I worked. I just decided to sit home for awhile and try to relax. I was under a lot of stress at work."

- "Professionally I have always been able to do reasonably well. And here I am going off on that track again. I guess I just needed to refocus on something else."

Category IV. Alternatives

The infertile women described alternatives or options they faced in their pursuit of a child. These options included continued pursuit for a biological child through very advanced medical procedures or resolving to accept adoption of a child. Still others considered the possibility of a life without children.

The decisions within the experience were numerous and weighted with strife and uncertainty. A lack of information only complicated this aspect of their experience.

Adoption

Seven of the participants have pondered adopting a child to resolve their desire for a child. The difficulties discussed concerning this alternative were as follows:

- "I used to think of course I would adopt and right now in my life I don't necessarily feel as staunch about that as I did."

- "If it were me with a younger man who didn't have his own children I think the natural course of action would have been to adopt."

- "I still toy with the idea of adoption. It's hard to take that step right now."

- "Of course we could always adopt. But it's not the same. I guess you really want children bad if you adopt."

- "I've always expected a little more out of my husband than what he was willing to give as far as adoption goes."

- "Some of these adoptions people rush into. I have to resolve the infertility before I think about that."

- "I haven't come to grips with that totally. I haven't ruled out children. I haven't ruled out adoption."

Childlessness

The prospect of a life without children was considered by several of the participants:

- "We have always loved doing things together and if we didn't have children I could really see us continuing to enjoy that."

- "All of a sudden I realize that maybe choosing a childfree alternative wouldn't be so bad."

- "And I think a lot of it is just realizing what we have together and is it something we absolutely need in life. I wonder if I would want my life without children."

- "I guess it's done something to me emotionally because now I feel like I don't want children."

Decisions

Five of the participants described the difficulties they encountered in making decisions about alternatives. Several statements illustrate this:

- "You think about it every day. But every day my decision might be different. How many times am I going to do in vitro fertilization? Would I adopt? Would I be childfree?"

- "I think we'll make some real hard decisions after the laparoscopy."

- "In today's age there is so much to do. That even makes the decision to stop harder in terms of medically. There is always something you can do. So in your heart of hearts I think you are approaching the time to stop, but actually making the decision is so tough."

- "Those seem to be my only alternatives right now [in vitro fertilization and adoption]. My husband wants me to make my own decision. I almost wish he could make it for me."

- "It was my and my husband's decision for them to remove my last tube."

In Vitro Fertilization

In vitro fertilization was being undertaken by one participant at the time of her interview. She still, however, had a question concerning this alternative:

- "How many times will I do in vitro fertilization?"

Three other participants have considered this alternative.

- "I could never do in vitro. But I'm not there yet. I could end up doing it."

- "My husband was very uncomfortable with in vitro to the point that that was where we knew we were going

to stop. So that ruled out in vitro."

- "I would like to meet with the in vitro specialists to see if this is something I want to do."

One participant would like to consider this as an alternative but finds the expense of the technology overwhelming.

- "If I won the lottery I would go for in vitro!"

Lack of Information

A lack of information concerning alternatives within the experience was voiced by several participants:

- "I don't know enough about in vitro fertilization to make a judgment and to say."

- "I didn't know whether I should be quitting and the doctors would say leave that up to them. And I didn't know if that's what I should be doing or not."

- "It seemed like I had to be in charge of my own treatments and I knew nothing about it."

- "I wasn't smart on those medical kinds of things. I didn't know."

- "I didn't know what the doctor was going to do to me."

Uncertainty

Being uncertain about what they should do or will do concerning their experience was frequently addressed

by five of the participants:

- "I couldn't tell you at this point what I am doing after this if this doesn't work. I mean deep down inside I want to have our own, but if that's not to be I don't know which way I am going to go."

- "I guess I am still trying to figure out what I should be doing next. I am in limbo."

- "My attitude is negative. I don't know if I will go through any more. So I guess I am still going to try."

- "Sometimes we want to do in vitro and sometimes we don't want to."

- "Well really I am just not sure."

Category V. Coping Mechanisms

This category contains eight codes. The personal coping mechanism code was included due to the very individualistic nature of coping presented by all eight of the infertile women. The majority of the coping mechanisms were positive, but a few appeared almost pathologically extreme.

Avoidance

Freeing themselves from thoughts or involvement in situations was a strategy utilized by all eight participants:

- "The baby was born and I was okay but I really

didn't get involved right away."

- "I chose not to go home this summer. I was protecting myself from seeing those family gatherings. Not just knowing it, but being home and seeing it."

- "I have a good friend with three children. I know she would like me to share a lot but I choose not to."

- "I guess I have not thought about it enough. I haven't had much chance to set down and talk to anybody about it like I am with you right now. Just not thinking about it is the way I am coping."

- "I made sure that I went to the sunrise service. There were not as many kids at six o'clock in the morning."

- "I had a doctor's appointment but I didn't keep it."

Two participants described more extreme avoidance tactics.

- "I was drinking. I tried to block it out. I stayed in my room for about six months."

- "I have been housebound where I would not leave the house. I shut myself off. Tried to run away from it. Trying to forget about it."

Breaks

Two of the participants spoke of taking a break from their pursuit as a method of coping:

- "I gave it a break for awhile. I didn't go back that fall. It really felt good to take a break."

- "I couldn't have kept taking it at that point. I needed a break."

Hope

For all eight participants, hope was an important and frequently utilized method of coping. Optimism sustained their pursuit. The following statements very vividly portray this:

- "You start feeling optimistic again. You think this is going to do it! I came home just knowing I was going to be pregnant this time."

- "I am hoping the doctor will say your chances are great and we'll keep trying."

- "I would have such irregular periods I might have thirty days of hoping this was the time I was pregnant."

- "There was always a hope that I would still get pregnant. That I could still do it."

- "After the first miscarriage I had some hope that it would be okay the next time."

- "My doctor has said that there is a very slight chance that I could become pregnant and it would be normal and they would not know how it happened. That it could happen! It has happened before! It is less than a one per cent chance but it could happen!"

- "I have a little chest filled with baby clothes that I have bought. I have got all kind of stuff in this hope chest. That is what I call it."

- "My religion has helped me the most. Cause there is hope. There definitely is hope."

Personal Coping Mechanisms

Each individual participant voiced some idiosyncratic coping mechanisms to deal with their experience. Some of these are as follows:

- "It helps to put the word out that you are having problems."

- "Talking with someone who has been through it has helped."

- "Being around children is helping me cope."

- "Seeing friends that don't have children and that they don't need this has helped a lot."

- "Exercise is a good outlet."

- "The spiritual counseling was real helpful."

- "Praying has helped the most."

- "Reading information is helpful."

Pets

Three of the participants spoke about how their pets assisted in coping with the infertility experience. One statement expressed this code well:

- "I have pets because I have a nurturing need.

And they are helpful. And when you need a hug or when you sit up because you can't sleep cause you are upset they are always there. They are like surrogate children. I think it helps. They'll never take the place but they do okay."

Projection

Four of the participants utilized the coping mechanism of projection. It appeared that projection of anger at husbands and medical professionals was most evident:

- "I'll do it and grit my teeth and push it down and then it comes out in another way. Usually with my husband. We'll have an argument. I'll come home and yell at him for no good reason and then I'll think back 'What is bothering me?'. Most of the time it's somebody's kid or kids somewhere. I don't wish this on anybody!"

- "I guess I am pretty angry at the medical profession at what has happened. That anger may be improperly directed but part of it is valid."

- "I just had a rage in me and I had to put it somewhere. So since he was the other party to it I just kind of blamed him."

- "There are times when I was very angry and I probably took it out on my husband where I shouldn't have. I was so unhappy with myself that I thought I

was unhappy with him."

Rationalization

Other reasons, besides physical abnormalities, were voiced by participants to possibly explain their infertility. This code demonstrates the imagination of the infertile women. Several of their imaginative statements follow:

- "I've been lucky. I wonder if this is my suffering. If this is my cross to bear."

- "I guess maybe I could think there was a reason for it. It was supposed to be a learning experience for me. Maybe there are some negative influences on me that caused that and if I could become more healthy and more spiritually positive myself that would help."

- "Maybe it's just not my time to have a baby."

- "I felt it just wasn't for me at that time."

- "I have become more accepting of the fact. It wasn't meant to be. It just wasn't meant to be."

RESOLVE Support Group

The RESOLVE support group was mentioned by five participants who related the positive influence this group has had on their experience and ability to cope:

- "Talking with the people in RESOLVE has helped a lot."

- "During all of this RESOLVE is emerging and I'm

not saying that had totally something to do with my emotional state. Although I can contribute some of it to it. In some respects I have healed."

- "RESOLVE has so much information and all of a sudden you are getting your hands on the most recent information and all of a sudden it changed my feelings. I felt like I was in control."

- "I started going to RESOLVE meetings. They were extremely helpful because they gave you information and emotional support."

- "I keep in contact with the people from RESOLVE."

Confirmation

The four second confirming interviews resulted in validation of the code and category analysis. Two of the four participants again shed tears when some of the statements were read. The emotional impact category elicited the most emotional response. The following statements by the four participants illustrate the participants' validation of the data analysis:

- "The emotional impact category just pulled at my heartstrings."

- "I just can't believe this. I have been sitting here listening to you and saying to myself 'This is what I have been through!'."

- "I don't think you have missed anything."

- "The quotes back up the codes validly."

- "It's good to hear the others' comments. It helps to know others feel and go through the same things."

- "Everything looks good to me. It describes it fully."

- "Obsession! Oh my God! How true!"

- "They all fit. This is excellent."

- "The emotional impact category really hits home."

- "Look at all the feelings! Wow!"

Conclusion

The eight interviews yielded fifty-five codes consolidated under five categories of descriptive topics of the lived experience of infertility as perceived by infertile women. Findings, conclusions, nursing implications, and recommendations will be discussed in the final chapter.

CHAPTER V

SUMMARY

Discussion of Findings

Phenomenological research focuses on understanding empirical matters from the perspective of those who are being studied, and stresses the primacy of consciousness and subjective meaning in the context of the situation (Omery, 1983). The purpose of this study was to explore the "lived" experience of infertility as perceived by infertile women. Through this exploration a description of the experience evolved and the meaning of the experience of infertility emerged. Significant features of the experience, selected through an inductive process, add to existing knowledge concerning the meaning of a woman's infertility experience. No absolute conclusions were drawn. The description that arose is not necessarily the only possible one. However, the knowledge that emerged is expected to be useful in guiding nursing practice that deals with women's experiences of infertility.

The data in this study was categorized into the following five aspects of a woman's infertility experience: the emotional impact, relationships, the physical impact, alternatives, and coping mechanisms. The emotional impact of the experience was the most prominent finding. These five categories do not

represent a linear model of the infertility experience. Instead, there are interactions among the categories that impact upon the total experience.

The findings of the fifty-five codes and the five categories of the infertility experience did not differ substantially from what is found in the literature concerning the experience of infertility. The uniqueness of this study is the organization of the codes and the resulting identification of the categories of the infertility experience. The five categories are conceptually distinct from one another, yet describe interrelated aspects of an experience.

Emotional Impact

The emotional impact category clearly displayed the large variety of emotions that the infertility experience evoked. This category included twenty-two of the total fifty-five codes. With such a large number of codes arising within one category, it was evident that the emotional impact of the experience was very complex. Numerous researchers have documented the emotional impact of this experience.

Anger was mentioned by all of the infertile women. The large number of studies that supported this code suggests the frequency of occurrence of this emotion (Menning, 1977. 1980, 1988; Valentine, 1986; Sandelowski & Pollock, 1986). However, Sandelowski and

Pollock (1986) did describe that their Black low-income participants less frequently expressed **anger.** These findings were not supported by the Black low-income participants in the present study.

Sadness/depression was a second emotion mentioned by all of the women. This combined code represented a continuum with **sadness** being the more healthy reaction and **depression** representing the more unhealthy reaction. Henning (1977, 1980, 1988), Bernstein et al. (1988) and Valentine (1986) supported this finding. For one participant in the present study, the emotion of **depression** degenerated into **suicidal thoughts.** Blenner (1990) was the only researcher that reported such an occurrence.

A frequent manifestation of **sadness** and **depression** was the emotional response of **tearfulness.** This code was elicited through both verbal and non-verbal communication. No other researcher specifically described **tearfulness.**

Depression is an emotion that was frequently preceded by feelings of **decreased self-esteem.** The infertile women voiced expressions of "failure" and ideals of "just not measuring up." Hirsch and Hirsch (1989), Bernstein et al. (1985), and Draye et al. (1988) supported the code of **decreased self-esteem.**

Grief or loss reactions often followed periods of depression. The infertile women expressed such reactions in response to pregnancy loss and to the loss of the prospect of children in their lives. This code was well documented in the literature concerning the consequences of infertility (Menning, 1977, 1980, 1988; Valentine, 1986; Blenner, 1990). **Devastation** and **trauma** were responses to such **losses**. Neither of these codes has been described by previous researchers.

Such losses in the infertile women's lives corresponded with the additional feelings of **loss of emotional control**. Sandelowski and Pollock (1986) described feelings of loss of life control. Blenner (1990) discussed infertile couples' attempts to gain control by focusing their lives on the infertility experience.

This total focus was best explained by the feelings of **obsession**. All of the infertile women expressed statements supporting this code except one woman who reported her negative feelings toward such an emotion. Valentine (1986), Olshansky (1987a) and Olshansky (1988) supported the code of **obsession**.

The result of **obsessive** behaviors was **exhaustion**. Sandelowski et al. (1989) and Valentine (1986) have documented infertile couple's fatigue due to the pursuit of fertility. One of the infertile women who

described her **obsession** also became **desperate** in her pursuit. Valentine (1986) confirmed the code of **desperation.**

Frustration was a likely result of failure to have a child after participating in such **obsessive** behaviors. Blenner (1990) also described **frustration** and its subsequent **projection** onto others.

The code of **unfairness** was the last code within this category that was reported by all of the infertile women. A significant question posed by the participants was "Why me?" Extreme responses of **unfairness** were mentioned by two participants in the code of **jealousy.** Sandelowski and Pollock (1986) and Blenner (1990) reported similar expressions of **unfairness** and feelings of being left out due to the infertility experience. **Isolation** described by the infertile women corresponded to such feelings. Being alone in the experience was difficult. Menning (1977, 1980, 1988) and Valentine (1986) also described emotional reactions of **isolation.**

An unexpected code within the emotional impact category was **relief.** The one infertile woman who voiced this response had made the decision to remain childless prior to the time of her interview. She expressed a desire to get on with life. Only one researcher identified this response (Blenner, 1990).

Contrary to expectations, guilt was mentioned by only two participants in the present study. Two other researchers described more frequent expressions of guilt (Menning, 1977, 1980, 1988; Bernstein et al., 1985).

Anxiety was a code that recurred throughout the entire physical, emotional, social, and alternative decision-making experience. Literature supported anxiety related to waiting for a diagnosis (McEwan et al., 1987), waiting for infertility surgery (Lalos et al., 1988), decision-making (Olshansky, 1988), and waiting for in vitro fertilization results (Stewart & Glazer, 1986). Anxiety appeared to be intensified due to feelings of fear. Valentine (1986) and Lalos et al. (1985) also addressed fear.

The aforementioned wide array of emotions supports the code of roller coaster/up-and-down effect. The infertile women vacillated between emotions. Stewart and Glazer (1986), Olshansky (1988), and Blenner (1990) referred to such an emotional pattern portrayed by infertile women.

Relationships

The category of relationships consumed the second largest amount of interview time. The infertile women's social world was both positively and negatively

affected by the experience. Positive effects were seen in supportive relationships.

An underlying strand of tension evolved as the study participants described the effects of the experience upon their relationship with their husband/partner. Several of the infertile women felt this relationship had been strengthened, despite the tension. Others viewed this relationship in an unsupportive and stressful context. Callan (1987) and Stewart and Glazer (1986) reported improved marital satisfaction in coping with the experience. In contrast, Valentine (1986), Olshansky (1988), and Hirsch and Hirsch (1989) found increased marital dissatisfaction and described marital problems as additional stressors. Because all of the participants in this study were married, no outcomes concerning single infertile women can be described.

The sexual relationship with the husband/partner was adversely affected by the infertile woman's attempts to conceive. Sex was viewed as a mechanism, rather than an act of enjoyment. Hirsch and Hirsch (1989), Lalos et al. (1985), and Valentine (1986) also supported such sexual disruption in the lives of infertile individuals.

One of the most interesting codes that evolved concerning relationships was the infertile women's

discussion of their interaction with God. Some were very angry at God, but then found solace with God's assistance. Sandelowski and Pollock (1986) found that infertile women's antagonism often spread to their relationship with God. The two Black participants in the present study emphasized the importance of this relationship. All of the infertile women in the present study were Protestant. (Two did not respond to the question of religious preference on the demographic questionnaire.) McEwan et al. (1987) documented that Protestant women, compared to infertile women of other faiths, showed better adjustment to the infertility experience. No comparisons or contrasts can be shown in the present study due to this limitation.

Family relationships were affected both positively and negatively. Some family members had difficulty understanding the experience and didn't know what to say; others were very supportive and shared in the infertility experience. Still others totally ignored the situation. Valentine (1986) and Sahaj et al. (1988) reported high degrees of satisfaction regarding interaction with family members. No researchers addressed family member's lack of understanding concerning the experience.

The relationship with friends paralleled the interaction with family members. Friends had difficulty

knowing what to say; relationships with friends who had children changed; several of the infertile women described increasing interaction with friends who did not have children or who were infertile. Callan (1987), Valentine (1986), and Blenner (1990) reported positive support from friends.

Negative aspects of the family and friend relationships were discussed under the codes of comments and advice. Both codes presented distress for the infertile women. Valentine (1986) and Blenner's (1990) infertile couples also described "insensitive" remarks and "nonsense" advice.

The relationships with medical professionals was an informative code as it related to nursing practice. Study participants' anger was a frequent emotion directed at nurses and physicians. Comfort was attained by several infertile women after they located infertility specialists. Nurses were mentioned by two participants in this study. One needed more information from the nurse, while the other felt her access to the physician was blocked by the nurse. Draye et al. (1988), Valentine (1986), and Blenner (1990) described infertile couples' problems with the health care system. Valentine (1986) supported the positive effects of infertility specialists.

The last code to be discussed within this category

was relationships with children. Here again, both positive and negative effects were expressed. Some of the infertile women viewed the relationship in a supportive context; others reported distress when interacting with very young children. An exact description of this code was not identified by any previous researcher.

Physical Impact

Physical impact is the third category that arose in the description of the "lived" experience of infertility. This category affected the infertile women's being as well as their physical environment and lifestyle.

The most significant intertwining thread of this category was time. All of the study participants were acutely aware of the passage of time. The older infertile women reported a sense of pressure involved in their pursuit of fertility. Numerous researchers support this finding (Cooper, 1979; Stewart & Glazer, 1986; Sandelowski & Pollock, 1986; Olshansky, 1987a; Sandelowski et al., 1989; Blenner, 1990).

The time involved with medical procedures was mentioned by all of the participants. The insult of a variety of medical procedures was described. Valentine (1986), Olshansky (1988), and Sandelowski et al. (1990) identified medical procedures as stressors.

Medical procedures were undertaken by the infertile women in an effort to identify physical causes for infertility and to treat physical abnormalities. Two participants had unknown diagnoses and verbalized increased distress. McEwan et al. (1987) also found that infertile women who had no diagnosis suffered additional concerns.

Pain associated with medical procedures, physical abnormalities, and occurrences of miscarriage and/or ectopic pregnancies were mentioned by the infertile women. Stewart and Glazer (1986) discussed physical pain associated with in vitro fertilization. However, no researcher investigating the experience of infertility has addressed the other types of physical pain identified by the present study.

The expense of medical procedures was an additional problem voiced by all eight participants in this study, except one who had just begun her medical treatment pursuit. Due to cost, two of the infertile women were no longer pursuing treatment. Olshansky (1988) and Sandelowski et al. (1989) described such financial barriers.

Travel for medical procedures was a code that was not identified in a review of the literature. Perhaps this is due to the rural setting of this study. Other infertility studies have been done in urban areas where

infertility services are accessible.

Medical procedures also adversely affected some of the infertile women's work. The travel, time, and expense interfered with work responsibilities. Some of the infertile women, however, viewed their work in a positive context. Draye et al. (1988) and Blenner (1990) described adverse effects on careers. Olshansky (1987b), in contrast, reported both positive and negative effects.

The failure of medical procedures and the pursuit of fertility was represented by the appearance of the infertile woman's menses that recurred with each passing month. Sandelowski and Pollock (1986) are the only researchers that addressed the impact of menses.

The last code discussed within this category is the impact of infertility on lifestyle changes concerning holidays and special occasions. Life without children during these times with family, friends, and children was described as difficult. Avoidance of such situations was frequently mentioned. Blenner (1990) reported infertile couple's isolation from special occasions and pangs of grief over holidays and family-related experiences.

Alternatives

Alternatives were an additional insult to the lives of the infertile women. They represented

decisions concerning pathways in life. The process of decision-making was intensified due to the emotional, physical, and social impact of the experience. Uncertainty pervaded this process and a lack of information concerning alternatives served to complicate the experience. The majority of participants who expressed concern about alternatives were in the latter stages of the fertility pursuit.

Valentine (1986), Sandelowski et al. (1989), and Blenner (1990) described their study participant's examination of options and difficulties with decisions. The code of uncertainty corresponded to Olshansky's (1987a) state of "being in limbo" and Sandelowski and Pollock's (1986) element of ambiguity. These researchers described how uncertainty served to complicate the experience of infertility.

The infertile women in this study, regardless of educational level, lacked information, thereby increasing uncertainty concerning alternatives. Information gained from participation in RESOLVE assisted with this dilemma. Cooper (1979) supported that infertile women who participate in RESOLVE gain information, thereby decreasing uncertainty, and improve decision-making concerning pursuit of alternatives. The infertile women also expected information from medical professionals. Stewart and

Glazer (1986) emphasize the importance of medical professionals' roles in education. Additionally, the infertile women sought information as a method of coping. Blenner's (1990) infertile couples read literature about infertility in an effort to gain support and understanding.

Coping Mechanisms

The final category of coping mechanisms illustrates how the eight infertile women dealt with their physical, emotional, social, and alternative decision-making experiences. A variety of numerous personal coping mechanisms evolved due to the unique nature of each participant's experience. However, many of the infertile women did share the same strategies.

Hope was the predominant coping mechanism identified in the data. It was viewed as a positive survival strategy. Stewart and Glazer (1986) and Lalos et al. (1985) also reported positive aspects of their participant's maintenance of hope. In contrast, Draye et al. (1988) described hoping for a miracle as an avoidance/withdrawal mechanism.

An additional positive coping mechanism was the act of taking a break, or a rest, from the pursuit of fertility. The tremendous emotional, physical, and social impact, as well as the multiple decisions concerning alternatives, mandated occasional periods of

relief from the experience. Sandelowski et al. (1989) and Blenner (1990) described breaks in the mazing process, "revitalization," or "mental vacations" as methods of coping with the infertility experience.

The positive effect of **RESOLVE** was an expected coping mechanism. Participants intimately involved with the local **RESOLVE** chapter had no difficulty describing the advantages of **RESOLVE**. Communication with and support from other infertile individuals, as well as information-sharing, were two of the qualities of this support group. Blenner (1990) and Valentine (1986) described utilization of infertility support groups as a coping mechanism for their infertile participants. In contrast, Cooper's (1979) quantitative data did not reveal positive effects. However, Cooper's (1979) qualitative data supported advantageous results of participation in support groups.

A totally unexpected coping mechanism that evolved in this category was **pets**. Menning (1988) was the only researcher to describe **pets**. Her anecdotal data portrayed pets as a universal outlet for the longing to nurture that is felt by infertile couples. This study's findings support such anecdotal data.

The second most frequently mentioned coping mechanism was **avoidance**. This coping mechanism was

viewed positively unless it progressed to extremes of substance abuse or social and physical withdrawal. Draye et al. (1988), Blenner (1990), and Valentine (1986) also described this code.

Projection was a coping mechanism utilized by the infertile women to deal with emotions and relationships. The participants in this study were aware of their use of this coping mechanism and its negative effects upon their relationships. Anger was the most frequently projected emotion. Recipients of this projection were husbands/partners, God, medical professionals, and children. Blenner (1990) reported that infertile couples channel anger at others.

The last coping mechanism identified was rationalization. This mechanism was utilized by the infertile women to explain non-physical reasons for their infertility. Participants of low-income status were more accepting of their situation, believing it was "not my time" or that it "wasn't meant to be." Sandelowski and Pollock (1986) also described their predominantly Black low-income sample as more accepting of their fate.

The research findings indicate that the experience of infertility is a total human experience. Infertile women are unique, physical, emotional, social, and spiritual beings. Categories I, II, and III--emotional

impact, relationships, physical impact--address these concepts. Constant interaction between these categories required infertile women to develop coping strategies in order to adapt to the changing experience. This concept is addressed by Category V--coping mechanisms. The additional insult of alternatives intensified the infertile women's strife in determining an acceptable path in life. This last concept is represented by Category IV--alternatives. The constant interaction among all five categories provided a description and meaning of the "lived" experience of infertility as perceived by infertile women.

Conclusion

The significance of this study is the examination of women's infertility experiences and the resulting delineation of the five categories of the experience--the emotional impact, relationships, the physical impact, alternatives, and coping mechanisms. Although descriptions of experiences similar to many of the codes have been proposed in previous research, this study validates the occurrence of the code experiences as part of the infertility experience. The most important benefit of this study is the evolution of the codes into distinct categories that present a holistic portrait. This depiction illustrates the meaning of a

woman's infertility experience. With an awareness and understanding of the meaning of this experience, nurses can address infertile women's multitudinous needs. Further exploration of the experience will add to nursing's present knowledge base concerning the "lived" experience of infertility.

Nursing Implications and Recommendations

Phenomenological methodology is a valuable research technique for examining the human context of an experience. It allows inclusion of an individual's psychological and sociological responses to an experience in addition to the physiological responses. This technique is consonant with nursing's emphasis on holistic individualized assessment and treatment. Infertile women have a right to such a holistic approach from the nursing profession. The ultimate purpose of this study was to provide a data base for further research to identify nursing interventions for the phenomenon--the "lived" experience of infertility.

Nursing professionals, especially those interested in women's health, need to increase their awareness of women's infertility experiences. More understanding of this experience enables nurses to improve assessment skills. Nurses are likely to encounter these clients during some of their most vulnerable moments. This study's findings have implications for nursing practice

in a variety of settings--fertility clinics, genetic counseling centers, family planning centers, private physician's offices, and other health and mental health facilities serving infertile women. Regardless of setting, nurses have an important role in the infertile women's experience. The roles of the nurse in this experience are numerous--educator, clinician, patient advocate, lobbyist, counselor, resource person, and researcher. As infertility increases, the need for infertility clinical nurse specialists will increase.

This study identified five descriptive categories that encompass the "lived" experience of infertile women. All of these categories can be addressed by nursing practice in order to improve the quality of life for infertile women. Each category will be discussed within the context of nursing implications.

The emotional impact category elicits numerous nursing implications. Nursing professionals working with infertile women must have an empathetic attitude and recognize the numerous emotional responses to the infertility experience. Through anticipatory guidance the nurse can prepare the client for feelings that may emerge. The infertile woman should be made to feel that her reactions are not only acceptable and tolerated, but also common to and shared by many others undergoing the same experience. Through the

development of a close therapeutic relationship, the nurse can encourage the infertile woman to express her feelings and concerns about the experience. The infertile client can be encouraged to develop a diary of her feelings, responses, and experience. Such documentation can promote exploration and ventilation of feelings. This approach may prevent emotional disturbances that lead to disruption in functioning and poor mental health. Extremes of emotional reactions must be recognized by the nurse and appropriate referrals implemented.

The relationships category provides the professional nurse with a variety of challenges in dealing with the infertile woman and her social world. Assisting the client in acknowledging and respecting the positive and negative aspects of her relationships is essential. Nurses must encourage discussion about relationships with family, friends, children, God, husband/partner, and medical professionals. The husband/partner relationship must address the sexual relationship as well. Open communication between the infertile couple must be encouraged. Involvement of the husband/partner in the experience is essential. To assist friends, family, and the general community in dealing with this experience, the nurse must increase public awareness. This can be accomplished by

community presentations of issues faced by infertile individuals and couples. Nurses can have on-going input through association and involvement with local infertility support groups such as RESOLVE. If there are no local RESOLVE chapters available, nurses can coordinate the development of such a group. Education concerning the emotional, physical, social, and alternative decision-making experience, as well as infertile women's methods of coping, will contribute to the overall mental health of the family and community. In addition, nurses must acknowledge the spiritual implications of the experience and encourage assistance of religious caregivers if the client so desires. As an expert clinician, the nurse is a very important adjunct to the physician. By being accessible for information and support and by allowing access to the physician, the nurse can greatly assist the infertile woman. Educating and involving the infertile woman's interpersonal contacts will alleviate a great deal of anxiety for the client.

The physical impact category allows the nurse to utilize her educational abilities. Nurses can begin with basic education concerning the reproductive system, how it works and possible problems that interfere with fertility. An understanding of the medical procedures utilized to obtain a diagnosis or

treat infertility is essential. The time involved in the infertility work-up should be thoroughly explained and shortened if at all possible. Most importantly the expense of the medical regime should be addressed. An assessment of each client's financial resources, including insurance coverage, is essential. Nurses can become politically involved in present and future lobbying efforts to mandate insurance coverage for infertility treatments. By educating the community, nurses can make employers aware of the physical work involved in the experience and thus obviate many career difficulties. Travel for medical procedures should be considered when scheduling appointments and alternate plans developed if at all possible. The emotionally charged experiences of miscarriage and ectopic pregnancy require nursing care that provides extra support and sensitivity for the infertile woman during this time of physical and emotional loss.

The category of alternatives allows the nurse to be an expert resource person. Identification of resource agencies, referrals, and provision of educational literature are additional tasks. The infertile woman needs encouragement to discuss her uncertainty and difficulties in decision-making. Provision of information allows the nurse to become a patient advocate in supporting the infertile woman's

decisions. Whatever the client decides, whether it be adoption, childfree living, or pursuit of high technology options, the nurse must assume a non-judgmental attitude.

The last category of coping mechanisms encompasses the role of the nurse as an expert counselor. Nurses must be aware of the large variety of coping mechanisms utilized by infertile women in various situations. All of the coping mechanisms identified in this study are, at least at the onset, positive and should be supported unless they become pathological. Suggestion and support of breaks from the medical regime should be encouraged. The infertile woman should also be encouraged to realize that this is acceptable behavior. Myths concerning reasons for infertility should be dispelled. Projection as a coping mechanism should be acknowledged by the infertile woman. Discussion concerning its effects on relationships is essential. Nurses must not discourage hope, since it provides the infertile woman with strength. Lastly, nurses should actively refer the infertile woman and her husband/partner to RESOLVE so that communication with other infertile women and couples can be fostered and a wealth of information can be obtained.

The five descriptive categories present numerous nursing implications concerning the phenomenon of the

"lived" experience of infertile women. In order to identify further implications, nurses must address their role as expert researchers and continue to uncover knowledge concerning this phenomenon.

Recommendations for Future Research

Qualitative research studies have an important quality--they stimulate further questions concerning present knowledge. Such stimulation serves to encourage nurse researchers to continue to explore a phenomenon. This qualitative research study has raised numerous questions concerning the experience of infertility: "What is the perception of extended family members concerning the infertile woman or couple?"; "What role does religion play in the infertility experience?"; "What are the long-term effects of sexual disruption in the lives of infertile couples?"; "How do women who adopt and women who remain childless adjust psychologically?"; "What is the "lived" experience of infertility as perceived by infertile men?"; and "Is treatment accessible to infertile women of lower socioeconomic status?" Further nursing research concerning these questions will add to nursing knowledge and improve the life experiences of infertile individuals.

Summary

Nursing has a professional obligation to address the needs of infertile women. Each individual's experience of infertility is unique. Infertility is not a discrete entity, but is an ongoing "lived" experience as the infertile woman responds to the cause of her infertility and begins to adapt to the change in life circumstances and find meaning in the experience. The total life experience of infertile women encompasses the emotional impact, relationships, the physical impact, alternatives, and coping mechanisms.

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APPENDIX A

CONSENT FORM

I agree to talk to Tina Collins, a student at Salisbury State University, about my feelings concerning my infertility. I understand that I will be a part of a study that will increase understanding of what it means to be infertile.

I agree that our talk will be taped, unless I do not want this. The talk will last one to two hours. I am willing to talk to Tina a second time to hear what she has found in the study. I am also willing to fill out a question sheet that Tina has just shown me. I understand that this question sheet, my tape, and what is typed from my tape will not have names on them, but will be numbered. Only Tina will hear what I talk about and only she and her teachers will read what Tina types from our talk. I understand that what I say will be kept strictly confidential and my name will not be used in any way.

I understand that if I am asked a question that I do not want to answer I may choose not to answer it. Also, I understand that I may stop our talk or drop out of the study at any time. If I decide this, Tina will erase my tape in front of me.

If I have any questions about the study I know I can call Tina at (301)749-4996 or write to her at 2000 West Clearlake Drive, Salisbury, Maryland 21801.

DATE: _____

_____
RESPONDENT'S SIGNATURE

_____
RESPONDENT'S PHONE NUMBER

_____
INTERVIEWER/RESEARCHER

APPENDIX B

NUMBER CODE _____

DEMOGRAPHIC QUESTIONNAIRE

1. AGE _____YRS.

2. RACE _____WHITE _____BLACK_____OTHER
   (PLEASE CHECK) _____HISPANIC _____ASIAN

3. MARITAL STATUS _____SINGLE_____DIVORCED_____OTHER
   (PLEASE CHECK) _____MARRIED_____SEPARATED

4. HIGHEST LEVEL OF EDUCATION
   (PLEASE CHECK)
   _____LESS THAN 12 YEARS
   _____12 YEARS
   _____1 - 2 YEARS POST HIGH SCHOOL
   _____BACCALAUREATE DEGREE
   _____MASTER'S DEGREE
   _____GREATER THAN MASTER'S DEGREE

5. TOTAL HOUSEHOLD INCOME
   (PLEASE CHECK)
   _____LESS THAN $10,000/yr.
   _____$10,000 - $19,999/yr.
   _____$20,000 - $29.999/yr.
   _____$30,000 - $39,999/yr.
   _____$40,000 - $49,999/yr.
   _____GREATER THAN $50,000/yr.

6. RELIGIOUS PREFERENCE _____

7. PHYSICAL CAUSE FOR INFERTILITY

   _____
   _____
   _____
   _____
   _____

8. INFERTILITY TREATMENTS EXPERIENCED

   _____
   _____
   _____
   _____
   _____

   (i.e. drugs taken, surgeries,
   procedures, etc.)

CURRICULUM VITAE

TINA S. COLLINS

PERSONAL

Address: 2000 West Clearlake Drive
Salisbury, Maryland 21801

Telephone: (301) 749-4996 Home

EDUCATION

Salisbury State University Nursing	M.S.	1991
Salisbury State College Nursing	B.S.N.	1981

Other coursework: Applied Epidemiology Course, Atlanta Center for Disease Control, 1985

LICENSE

Registered Nurse — Maryland

PROFESSIONAL EXPERIENCE

1988 - Present	Pediatric Office Nurse Agarwal, Clendenen, and Associates Salisbury, Maryland
1985 - 1988	Community Health Nurse Wicomico County Health Department Salisbury, Maryland
1983 - 1985	Community Health Nurse Worcester County Health Department Snow Hill, Maryland
1981 - 1982	Coronary Care Nurse Peninsula General Hospital Medical Center Salisbury, Maryland

HONORS

Sigma Theta Tau Nursing Honor Society, 1990
Salisbury State College Nursing Honor Society, 1981
Phi Kappa Phi National Honor Society, 1980