DOES INFERTILITY AFFECT MARITAL QUALITY? A QUALITATIVE STUDY

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DEDICATION

To Christopher and Miles,

You are my two favorite people in the world.

I love you.

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ABSTRACT

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DOES INFERTILITY AFFECT MARITAL QUALITY? A QUALITATIVE STUDY

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The purpose of this study was to examine the effects of infertility on marital quality. A phenomenological perspective guided this qualitative study in order to capture the individual meanings and lived experiences of the participants. A total of 13 women formed the sample for this study. The age of the participants ranged from 27 to 45, with a mean age of 34.6. All women who participated in this study were married, received an infertility diagnosis and received treatment for at least 12 months. The mean length of marriage was 7.9 years and the mean length of treatment was 2.6 years.

The semi-structured interviews were audiotaped and transcribed verbatim. The transcripts were read by the researcher and coded by emergent themes. Three themes and two subthemes emerged from the data. The themes include, And Baby Makes Glee, Adopting Marital Stress, and Clomid Made Me Crazy. The two subthemes that fall under the first theme, And Baby Makes Three, include Hopefulness and Supportive Spouse. Direct quotations from the participants give life to each theme. The results of this study were compared to current literature regarding marriage and infertility, and conclusions were drawn. Recommendations for family therapists and future research are presented.

The findings from this study suggest infertility treatment has a positive effect on marital quality and brings couples closer together. This study suggests the adoption process produces greater stress for couples and negatively effects marital quality. The infertility drug, Clomid, was also found to negatively affect marital quality when taken for treatment.

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CHAPTER I

INTRODUCTION

Infertility is defined as either the inability to conceive after one year (or six months if the woman is over the age of 35) of regular (three times a week) intercourse without contraception, or the inability to carry a pregnancy to live birth (Reed, 1987, 2001). According to the Department of Health and Human Services Centers for Disease Control and Prevention 2002 report, of the approximately 62 million women of reproductive age (18-44) in 2002, about 1.2 million, or 2%, had an infertility-related medical appointment within the previous year, and 8% had an infertility-related medical visit at some point in the past. Additionally, 7% of married couples in which the woman was of reproductive age (2.1 million couples) reported that they had not used contraception for 12 months and the woman had not become pregnant. Many authors suggest that 12% to 20% of couples will face infertility at some time during their child bearing years, which is the period in a woman's life between puberty and menopause (Abbey, Andrews, & Halman, 1991; Korpatnick, Daniluk, & Pattinson, 1993).

Recent improvements in fertility medication and treatment make pregnancy possible for more than half of the couples who choose to pursue treatment. The conception that infertility is usually a medical issue for women is not accurate. In fact, 25% of infertile couples have more than one factor that contributes to their infertility, including, but not limited to, abnormal ovulation, low sperm count, tubal blockage, or

endometriosis. In 49% of cases, it is reported that the male's reproductive issues are either the sole cause or a contributing cause of the infertility (Aronson, 2000). Contrary to popular belief, infertility rates have not increased since 1965, when the first national fertility survey occurred. Rates have remained consistent between 10-13% (American Society for Reproductive Medicine, 2001).

Infertility treatment (also known as ART, assisted reproductive technology) in the United States began in 1981 with in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). Congress mandates that ART Success Rates be published through the Centers for Disease Control and Prevention. In 2002, a new report was published regarding these success rates. The report says that the majority of ART procedures are IVF (71.8%), yet the number of successful pregnancies resulting from all ART procedures (approximately 71,000) was only 29%.

Infertility often comes as an unexpected shock to many couples. For many couples, having children is not a question of if, but when. The effects of infertility on a woman's emotional and psychological functions may be complex; depending on several variables including time elapsed since diagnosis, treatment undergone, cause of infertility, prognosis, emotional support available and her adaptive abilities (Edelman & Connolly, 1986). It is reported that a woman's response to an infertility diagnosis is similar to the models of bereavement (Seibel & Taymor, 1982), depression (Hunt & Monach, 1997; Syme, 1997), and anxiety or stress (Mori, 1997; Robinson et al., 1996; Salzer, 1991). Infertility represents a loss, but unlike bereavement, the losses from infertility are invisible. These losses may include self-esteem, security, control and faith

(Naish, 1994). The emotional experience of infertility has been related to a roller coaster ride, due to its ubiquitous uncertainty each month and because it is composed of a series of crises and never-ending stress (Salzer, 1991). Depression has also been linked to infertility in men and women (Domar, Broome, Zuttermeister, Seibel, & Freidman, 1992; Domar, Clapp, Slawsby, Kessel, & Orav, 2000).

Males' responses to infertility have been studied less than those of women. Daniluk (1997) reported that in the few studies that have been conducted, the man appears to be as emotionally distressed as the woman upon learning the diagnosis of infertility. While many women feel more able to express their feelings about their infertility, many men struggle with their own feelings and feel helpless in trying to comfort their spouse and to be frustrated at not being able to solve their own infertility (Greih, 1997). McDaniel (1994) studied the ways in which infertility affects men's self-esteem, and found that their sense of adequacy as a man was affected. When the infertility is rooted in the males' biology he often feels a higher level of shame, guilt, anger, isolation, and personal failure (Daniluk, 1997). Men's masculinity may be challenged and cause feelings of lost power and potency, which can cause possible impotence, or conversely, promiscuity (Syme, 1997).

Infertility can negatively affect marital quality in the couple dyad. Feelings of guilt and worthlessness are associated with couples facing infertility (Myers & Wark, 1996). Many couples turn to isolation as a coping mechanism (Salzer, 1991). Because the social stigma of childlessness can result in feelings of imperfection and a poor identity (Maill, 1986) many couples cut off social engagements with their family and

friends to avoid baby showers, family birthdays, or any engagements that includes signs of fertility, babies, or small children.

Making decisions about treatment can add more tension to an already stressful situation (Gibson & Myers, 2000; Hart, 2002). One partner may want to move forward with another round of treatment while the other partner may not. The inability to decide about treatment choices adds to the couples' frustration, as does the fact that there are so many choices in treatment (Sherrod, 2004). The expense of treatment is costly, and many treatments are not covered by insurance in most states (Gibson & Myers, 2000). The infertility industry reportedly generates approximately $2 billion per year (Braverman, 1997).

Statement of Problem

Because infertility treatment affects so many areas of the marital dyad (emotional, physical, financial) there has been growth in infertility research concerning not only the medical side of the issue, but the emotional side as well. Current interest has explored the emotional response differences between men and women to infertility treatment, therapeutic approaches to couples facing infertility, and the narratives of couples who have successfully or unsuccessfully emerged from infertility treatments. Although the majority of research has been done on the infertility treatment process, there is a lack of studies that have considered if marital quality is affected because of infertility treatments. The numbers of infertility medications have increased in the last ten years, many with intense side effects (Vargo & Regan, 2005). To date, there are no studies published that

look specifically at the side effects of infertility medications and their effect on marital quality.

Statement of Purpose

The purpose of this study was to explore whether or not infertility affects marital quality, and to explore whether or not prescribed infertility medication affects marital quality. This information is important for marriage therapists, medical doctors, nurses, religious counselors, and family members of the couple experiencing infertility. An exploratory study such as this helped identify the specific effects that infertility may have on marital quality. This information is helpful to any professional who works with couples who are facing infertility issues. One of the greatest frustrations for infertile couples is health care professionals' lack of knowledge and understanding regarding the significant emotional effects of the infertility experience (Sherrod, 2004).

Theoretical Framework

Phenomenology is a philosophical term that refers to a consideration of all perceived phenomena, both the objective and the subjective (Babbie, 1999; Miles & Huberman, 1994). Its roots come from the German mathematician Edmund Hussler (1859-1938), who emphasized very abstract ideas, commonly criticized by other philosophers such as Heidegger, Sarte, and Merleau-Ponty (Spiegelberg, 1982). His theory of phenomenology has been used in sociology, psychology, nursing, health sciences, and education (Tesch, 1988).

Phenomenology describes the meaning of the lived experiences for several individuals about a concept, or the phenomenon (Babbie, 1999). Phenomenologists work

closely with interview notes. The researcher assumes that through the continued readings of the notes and through vigilance over one's presuppositions, one can reach the essence of a phenomenon (Miles & Huberman, 1994). This leads to a practical understanding of meanings and actions and allows for each respondent to share the personal story of their lived experience (Moustakas, 1994). This process validates each respondent, and avoids the temptation to lump their experiences as a whole, but rather, give life to each story. This approach leads to the practical understanding of meanings and actions (Creswell, 1998). The set procedures for a phenomenological study are mapped out by Creswell (1998):

1. The researcher begins with a full description of his or her own experience of the phenomenon (infertility was the phenomenon for this study).
2. The researcher then finds statements (in the interviews) about how individuals are experiencing the topics, lifts out these significant statement and treats each statement as having equal worth, and works to develop a list of non-repetitive, non-overlapping statements.
3. These statements are then grouped into "meaning units" and the researcher writes a description of the experiences, including verbatim examples from the interviews.
4. The researcher next reflects on his or her own description and uses imaginative variation, seeking all possible meanings and divergent perspectives, varying frames of reference about the phenomenon, and constructing a description of how the phenomenon was experienced.

5. The researcher then constructs an overall description of the meaning and the essence of the experience. (p. 147)

Using these steps, a researcher can explore a phenomenon and re-visit the experiences of each respondent to feel the essence of their stories and how they may have different descriptions of the same phenomenon (Moustakas, 1994). Infertility is an experiential process; therefore, individuals who experience infertility will have different descriptions from one another yet be connected through the phenomenon of infertility.

Research Questions

The following research questions guided this research project:

1. Does infertility affect marital quality?
2. Does prescribed infertility medication have side effects that affect marital quality?

Introduction

1. Please tell me a little bit about yourself.
2. Can you tell me about your hopes and dreams you had when you got married?
3. How did you imagine your future with your husband?

Interview Guide

1. What was your personal reaction to your infertility diagnosis?
2. Can you tell me about the quality of your marriage since your infertility diagnosis?
3. Has infertility affected the quality of your marriage? If so, how?
4. What have been your personal reactions to the changes in your marriage?

5. Has medication for infertility affected your marriage quality? If so, how?

Definition of Terms

Significant terms need further explanation to accurately understand important foundational constructs in this study. The following definitions provided clarity:

1. Antral follicle count refers to the number of resting follicles seen on an ultrasound early in a woman's cycle (Gordon & DiMattina, 2008).
2. Artificial Insemination (AI) is a term used to encompass a group of fertility procedures involving the introduction of sperm into the female reproductive tract without intercourse (Gordon & DiMattina, 2008).
3. Assisted Reproductive Technology (ART) is a term used to encompass a variety of fertility procedures that involve manipulating sperm and eggs to achieve pregnancy (Gordon & DiMattina, 2008).
4. Child bearing age is the period in a woman's life between puberty and menopause, which is broadly categorized between ages 18-44 (Centers for Disease Control and Prevention, 2004).
5. Coping mechanism refers to the way couples and individuals handle any stress.
6. Donor egg IVF is a type of in vitro fertilization procedure using the eggs from a young woman and with the resulting embryos transferred into the recipient (Gordon & DiMattina, 2008).

7. Endometriosis is the presence of tissue that is usually found within the endometrial cavity in another location (most frequently on the ovaries or along the uterosacral ligaments (Gordon & DiMattina, 2008).
8. Ectopic pregnancy is a pregnancy located outside of the uterine cavity, usually in the fallopian tube, though it can also occur in the ovary or abdomen (rarely) (Gordon & DiMattina, 2008).
9. Follicles are fluid-filled structures within the ovary that contain an egg (Gordon & DiMattina, 2008).
10. Folicle stimulating hormone (FSH) is a protein hormone produced within the pituitary gland at the base of the brain that promotes the growth and development of follicles, leading eventually to ovulation (Gordon & DiMattina, 2008).
11. Frozen embryo transfer (FET) is the placement of previously cryopreserved embryos into the uterus (Gordon & DiMattina, 2008).
12. Infertile is an adjective meaning not capable of initiating, sustaining, or supporting reproduction (Hart, 2002).
13. Infertility is the inability to achieve a pregnancy after one year of regular sexual intercourse without the use of contraception (Cook, 1987). If a woman is over the age of 35, infertility is defined as the inability to achieve pregnancy after 6 months of regular intercourse without the use of contraception (Hart, 2002).

14. Intrauterine insemination (IUI) is a treatment in which the sperm are washed and then placed within the uterine cavity (Gordon & DiMattina, 2008).
15. In vitro fertilization (IVF) is a treatment in which an egg is placed with a sperm cell in a laboratory culture dish for several days, and subsequently placed into the uterus (Gordon & DiMattina, 2008).
16. Laparoscopy is an outpatient surgical procedure that uses a telescope and video monitor to visualize the internal organs (usually to assess endometriosis) (Gordon & DiMattina, 2008).
17. Male infertility is defined as absent or diminished fertility caused by oligospermia (too few sperm), azoospermia (no sperm), or malformed sperm (sperm with two heads or two tails). It can also be caused by a hormonal imbalance, blocked sperm ducts, a large varicose vein in the testicle, retrograde ejaculation (semen slips back into the bladder during orgasm) (Vargo & Regan 2003).
18. Marital dyad refers to the husband and wife relationship.
19. Mycoplasma is a type of bacteria that may contribute to infertility (Gordon & DiMattina, 2008).
20. Oral contraceptive pills are daily medications, usually containing both synthetic estrogen and progesterone, that act as contraceptives by suppressing follicle growth and ovulation (Gordon & DiMattina, 2008).
21. Ovulation is the release of an egg from an ovarian follicle (Gordon & DiMattina, 2008).

22. Ovulation induction is the use of fertility medications to restore normal ovulation in a woman who does not have regular cycles (Gordon & DiMattina, 2008).
23. Progesterone is a steroid hormone produced by the ovary an then by the placenta during pregnancy. It is necessary for the successful implantation and development of an embryo (Gordon & DiMattina, 2008).
24. Reproductive endocrinologist is a physician who specializes in disorders of reproduction, including infertility (Gordon & DiMattina, 2008).
25. Secondary infertility is the inability to conceive after one live birth (Gibson & Myers, 2000).
26. Semen analysis is a laboratory test used to assess male fertility. It usually includes evaluation of the sperm volume, pH, concentration, motility and morphology in a sample (Gordon & DiMattina, 2008).
27. Treatment. For the purpose of this study, the term "treatment" will be defined as medical procedures or applications, including prescribed medication, intended to manage one's pursuit of biological conception.
28. Tubal ligation is the surgical sterilization of a woman, performed by cutting or occluding the fallopian tubes (Gordon & DiMattina, 2008).

Assumptions

Based on phenomenology, the assumptions in this study included the following:

1. The participants were open, forthcoming, and truthful with the researcher.
2. The participants were willing to share their insights.

3. Infertility is a difficult situation for married couples to experience.
4. Each couple's story was different.
5. Participants in this study represented a group normally distributed for infertility status, and that they gave accurate descriptions of their lived experiences.
6. The participants focused on specific contexts in which they live and work in order to understand their experience of infertility.
7. The researcher recognized that her own background shaped her interpretation and she positioned herself in the research to acknowledge how her interpretation flows from her own personal, cultural, and historical experiences (Creswell, 1998; Crotty, 1998).
8. Instead of starting with a theory, the researcher generated a pattern of meaning (Creswell, 1998).

Delimitations

1. Participants lived in the United States.
2. Participants were female.
3. Participants were legally married in the United States.
4. Participants were between the ages of 18-44 (on her last birthday).
5. Participants had a diagnosis of female infertility (type not specified).
6. Participants had not undergone treatment for a period longer than 12 months.
7. Participants were part of a childless couple during treatment.

The Researcher as Person

In qualitative studies, the researcher as a person is a part of the research process (Patton, 2002). The researcher was a graduate student at Texas Woman's University, in Denton, Texas and a fifth grade school teacher in Dallas, Texas. The researcher was 31 years old, married, and has one child, a son who is 18 months old. The researcher did not undergo any infertility treatment to have a biological child and did not have any family members who have struggled with infertility. There is no personal issue with infertility on the part of the researcher, simply an interest in the topic.

Summary

Infertility can have emotional, financial, and physical effects that may cause a couple to experience distress in their day-to-day lives. It is important that this topic be researched for professionals who work with these couples. The purpose of this study was to explore whether or not infertility has an effect on marital quality, and if prescribed infertility medication affects marital quality. Currently, there are a limited number of research studies on the effects of infertility on marriage quality and there are no studies on the relationship between infertility medication and marriage quality. This study shed light on the issue of whether infertility, and its medications, have an effect on marriage quality. The findings from this study provide useful information to family therapists who work with these couples, and any medical or mental health professionals who work with couples facing infertility. Research questions were examined using the phenomenological research method and snowball sampling was used to obtain an

adequate number of participants. Many assumptions were particular to this study, and some factors delimited this study.

CHAPTER II

LITERATURE REVIEW

Research containing the psychological effects of infertility has been slowly developing since the 1980s. Studies began in the 1950s with the studies of Labandiabar (1959) and Kostic (1960) (as cited in Seibel & Taymor, 1982) who reported that there may be a relationship between infertility and frigidity. In 1963, Eisner proctored Rorschach test to 20 women with an infertility diagnosis. Eisner reported that because all 20 women showed some sign of emotional disturbance, infertility must be caused by emotional factors. Before the 1980s, other researchers determined that men and women who were infertile displayed psychosexual maladjustments (Dawkins & Taylor, 1961; Sandler, 1959, as cited in Seibel & Taymor, 1982).

The 1970s brought new studies about infertility. In 1972, Mai and Rump examined the idea that infertile men and women were neurotic. Mozley (1976, as cited in Seibel and Taymor, 1982) offered the idea that infertility might be caused by unconscious motivations on the part of the infertile individual to protect their faulty reproductive functioning.

The 1950s, 1960s, and 1970s brought several research studies that linked infertility with personality or psychological attributes. It wasn't until the 1980s when researchers determined there was no difference between the personality or psychological

characteristics of infertile men and women versus non-infertile men and women (Greil, 1997).

Between 1980 and 1997, there have been over 94 quantitative articles and over 26 qualitative articles published examining psychological distress and infertility (Greil, 1997). Personality characteristics, distress levels, and gender differences have been the focus of studies since the 1980s. These articles have provided the infertility research field with a solid starting point. The following literature review will uncover the key research studies conducted in the field of infertility since the 1980s.

Emotional Factors

Infertility is a stressor that affects both husbands and wives. The literature suggests that infertility is more stressful for women, although most studies have not included men/husbands. If the experience of infertility is different for women and men, the next question is whether women and men cope differently. While most research done on infertility has been written through the perspectives of women, Elliot (1998) employed bio-physiological and psychosocial perspectives to explore the complex relationship between male sexuality and male factor infertility. It was concluded that sexual dysfunction can be both a contributing factor to fertility problems and a by-product of the diagnosis of male infertility itself. It is suggested that health care providers can more effectively address the needs of couples with male factor infertility by taking a sexual history as part of an initial infertility assessment, and by encouraging couples to temporarily view sexual functioning and the quest for pregnancy as separate issues (Antonia, Andrews, & Halman, 1991). One study done by Jordan & Revenson (1999)

concluded that gender be taken into account when creating treatment plans for clients in therapy who are dealing with infertility.

Valentine (1986) studied the psychological impact of infertility and found that married couples experiencing infertility reported emotional reactions such as sadness, depression, anger, confusion, desperation, hurt, embarrassment, and humiliation. Behavioral reactions to infertility included disorganization, distractibility, exhaustion, moodiness and obsessive thoughts and behaviors. Factors of self-blame and avoidance coping were the best predictors of psychological distress in individuals who experience infertility in a 1995 study done by Morrow, Thoreson, and Penney.

Strauss, Hepp, and Staeding (1998) studied the psychological characteristics of infertile couples and found that the psychological variables explain a relatively small amount of variance of the pregnancy criterion and also, couples who terminated treatment after one year reported higher levels of marital discord and interpersonal complaints than couples who did not terminate treatment after one year. Berghuis & Stanton (2002) conducted a longitudinal study to examine depressive symptoms in infertile couples over several insemination attempts. Results indicated that couples who had several failed attempts over the course of two years reported higher levels of depressive symptoms. The longer the failed attempts, the higher rate of depressive symptoms existed. According to Olshanky (2003) previously infertile new mothers experienced repeated and sustained interferences with significant relationships over the course of their infertility, which lead to depression for some of the women in the study.

Kirkman (2003) studied the ways in which women work through the emotions of infertility. She described how a woman may have an entire life sketched in her mind about the way she wants her future family to play out. Infertility causes this dream to remain just that, a dream. Infertility has been found to challenge one's sense of self (Becker, 2000; Downey & McKinney, 1992, Korpatnik, Daniluk, & Pattinson, 1993; Moller & Follstrom, 1991; Monach, 1993; Olshanky, 1987; Gibson & Myers, 2004). This sense of self that was planted by one's family of origin can be disrupted by not being able to naturally conceive a biological child. When infertility is experienced by a woman or a couple, he or she must not only deal with the personal loss, but also the expectation from their family of origin that will not be attained. Kirkman (2003) explains:

> The loss of identity as a mother, of children who exist only in the autobiographical narrative, of relationships with those children and grandchildren, of hopes and dreams of the future, of participation in the world of mothers, acknowledgement by society as fully developed women, of a genetic future: all these loses confuse even the woman herself, because she cannot point to something tangible that has gone. (p. 244)

Infertility Perceptions

Kopper and Smith (2001) studied the perceptions of childless couples on a college campus in northern Iowa. A total of 661 undergraduate college students (456 females and 205 males) were studied. The most negative view of childless couples was those couples that were childless by choice. In that case, the male was rated more negatively

than that of the female target character. Couples who were childless due to infertility were rated with most positive affect, including sympathy.

LaMastro (2001) conducted a similar study but found different results. This study found that college students view childless couples (both voluntary and involuntary) as "possessing less interpersonal warmth" and believe that childlessness is a discrediting attribute. LaMastro (2001) concluded that this type of belief system regarding infertility might be a contributing factor to feelings of isolation among infertile individuals. Isolation is another aspect of coping with infertility (Salzer, 1991). Couples often do not share the diagnosis with friends or family, but attempt to conceal their situation by denying the want of children or avoiding social situations all together (Hart, 2002).

Hare-Mustin (1988) argues that perceptions, therapeutic interventions and gender theories have not kept up with the changes since the preindustrial times. She argues that infertility should not be seen as a life course disaster, but a hurdle along the way, similar to race issues or gender issues that continue to be a struggle for women. When couples conceal their infertility, it only makes the stigmatization worse over time for that individual couple and the infertility community as a whole (Hare-Mustin, 1988). Often times, the only groups of people to discuss infertility are young women who are trying to conceive. Therefore, young girls are still receiving the message that conception is possible for everyone, just as jaded as the notion that "Mr. Right" will come along for every young girl as well (Letherby, 2002). This is simply not true. Infertility must be discussed by society at large to change the societal perception (Letherby, 2002).

In 1987, the first IVF baby was born in England (Su & Chen, 2006). Since then, women all over the world have the attempted this form of treatment. Su & Chen (2006) studied how women become resilient following unsuccessful fertility treatment. This study examined 24 women who decided to terminate further infertility treatments after multiple failed attempts at in vitro fertilization (IVF). The overarching theme for the study became "transforming hope." Three categories were determined to best characterize what the women reported, including: accepting the reality of infertility, acknowledging the limitations of treatment involving high technology, and re-identifying one's future. The women reported feeling a sense of power once they reached the final decision to end treatment. Some reported that adoption would be the next route, while others decided to live a life child-free. Both groups reported a sense of resiliency, not from simply living the treatment experience, but in making the decision to terminate any further treatment.

Daniluk (1997) conducted a similar study. This study examined 37 women who reportedly abandoned treatment after several years of unsuccessful attempts. The results indicated that each of the 37 women reached a discrete point in which they knew to "let it go." Most reached this point once they realized they had "left no stone unturned" or thoroughly pursued every treatment option available. Many reached the point when the cost of treatment began to interfere with their quality of life or when the emotional toll was simply too costly for themselves or their marital dyad. The decision to terminate

treatments gave the women felt a sense of personal control over a situation where they otherwise felt powerless.

A woman's response to that of an infertility diagnosis is similar to the models of bereavement (Seibel & Taymor, 1982), depression (Syme, 1997), and anxiety or stress (Salzer, 1991). Because childbearing is a major, normative transition for both men and women, the experience of infertility has been conceptualized as a crisis (Atwood & Dobkin, 1992). In the case of infertility, couples usually require two years of healing before they report feelings of normalcy in their marriage and thorough emotional resiliency (Pepe & Byrne, 1991). It is this two year period that following the termination of treatment that appear to be the most difficult (Pepe & Byrne, 1991).

Cognitive Behavioral Therapy

In terms of infertility, the cognitive behavioral approach has received much study, and has been linked to great success with couples and individuals who are experiencing infertility (Myers & Wark, 1996; Newton, 1999; Smith & Smith, 2004; Tuschen-Caffier, 1999). The cognitive behavioral approach refers to the approaches inspired by Albert Ellis (1962) and Aaron Beck (1976) that emphasize the need for attitudinal change to promote and maintain behavioral modification (Nichols, 2006).

Newton (1999) studied how a social learning-cognitive behavioral perspective in therapy can help infertile couples. Newton reported that couples need to learn a new set of skills in order to cope with the unique demands that infertility and treatment places on the couple relationship, and a cognitive behavioral approach can teach couples those new skills. Newton (1999) reported that infertility is like no other problem a couple will face,

due to its unexpectedness and shock to the future the couple may have designed in their mind.

A more specific study was completed in 1999 by Tuschen-Caffier. The purpose of this study was to evaluate the impact of a six month cognitive behavioral therapy for infertile couples. The changes in the 17 infertile couples were compared to two control groups. Following the six month therapy program, results indicated that the cognitive behavioral therapy group showed an increase in sperm concentration, a reduction in thoughts of helplessness, and a decrease in overall marital distress. The therapy participants also reported higher levels of sexual pleasure during the nonfertile period of the menstrual cycle. The problem-focused thoughts had decreased and a live birth rate was higher in the therapy group than the control groups. From this study, it appears a cognitive behavior approach may be an effective approach for the therapeutic treatment of infertile couples (Tuschen-Caffier, 1999).

The cognitive behavioral approach has been proved to adequately address the needs of a couple experiencing infertility. According to Myers and Wark (1996), this approach has several strengths when applied to infertile couples, including a comprehensive approach that has proven effectiveness for a vast array of issues and has techniques for identifying and countering automatic thoughts. Cognitive behavioral therapy can address a couples' decision making process since it focuses on communication skills, and cognitive behavioral therapy has a long history of treating sexual dysfunction, which is a common occurrence in couples experiencing infertility

(Myers & Wark, 1996). Cognitive behavior therapy deals with distorted beliefs, which in many cases may be the key in changing couple dynamics (Watts, 2001).

Smith & Smith (2004) believe that cognitive behavioral therapy is the most broadly and widely used form of counseling interventions, and believe that this is the most effective form of counseling with infertile couples that can result in changing their world view. This change is needed because infertility, for many couples, is one of the most serious medical and psychological crises they will encounter in life (Smith & Smith, 2004). In a study done on the infertility population, 50% of the women indicated that their infertility was the most upsetting experience of their lives (Stewart & Robinson, 1989). Others studies have pointed out that respondents rate infertility as stressful as death of a spouse or child (Kedem, Mikulincer, Nathanson, & Bartov, 1990).

A combination of cognitive behavioral techniques can help a couple during the roller coaster ride of infertility treatments. According to Smith and Smith (2004), the most common strategies used in cognitive behavioral therapy include relaxation techniques, cognitive distortions and cognitive restructuring, scheduling activities, recognizing cognitive errors, ignoring myths about infertility, and sensate focus exposure. This therapy can also address how a couple should interact with immediate family members who aren't sure how to act or what to say around the infertile couple.

Smith and Smith (2004) conducted a unique study in which they examined how well cognitive behavioral therapy works with couples who actively practice a religion or faith. They found that cognitive behavioral counseling can be especially helpful if the infertile couple is part of a religious or church community. Religion brings on a whole

new set of issues for the infertile couple. Many religious couples feel the Bible places a negative light on childless couples, including the stories of Sarah, Hannah, Abraham, and Isaac. Also, another popular passage in the Bible refers to a curse for male infidelity. The curse resulted in the words, "he shall be childless" (Leviticus 20:21-22). Other Biblical references can make childless couples feel "cursed." As noted in Psalm 127:3-5:

> Lo, children too are a gift from the Lord; the fruit of the womb, a reward.
> Like arrows are in the hand of a warrior, so are children born in one's youth.
> Happy, blessed and fortunate is the man whose quiver is filled with them!
> They will never be shamed contending with foes at the gate.

This may seem as nothing more than an old scripture, but problems arise when these readings are woven into homilies and sermons on Mother's Day, Father's Day, or other holidays in church settings across the country. Couples can be reminded of their infertility even sitting in church, a usually safe place where couples can go to find spiritual healing and emotional strength (Smith & Smith, 2004). This is an example of the difficulties faced by infertile couples. Society can gently remind couples of their infertility daily. The infertile couple thinks nothing of these messages, but to the infertile couple, they are like daggers (Smith & Smith, 2004)

Summary

Although the infertility research has increased since the 1980s, more research needs to occur. Past research efforts related to infertility have been limited by the following flaws: overemphasis on women, small sample sizes, primitive statistical techniques, and non representative samples (Griel, 1997). With new issues arising within

the infertility field, such as embryo adoption and embryo testing, much more research needs to be done to thoroughly examine this important topic. Studies are being conducted all over the world, as infertility seems to raise emotions, ethical dilemmas and interest in dialogue. With one in six couple affected by infertility, this is not an issue that will likely go away or fade out. This topic is important to couples all over the world, and the above research is just a small sample of the work that has been conducted, but much more remains.

CHAPTER III

METHODOLOGY

The purpose of this study was to explore whether or not infertility affects marrital quality. The results from this study aid any mental health professionals who work with couples or individuals who are experiencing infertility. A qualitative research approach was used due to the hefty emphasis on lived experience and personal insight (Patton, 2002). Data were collected through in-person interviews with women who struggled with infertility. The interviews were audio recorded for transcription. Chapter III presents the methodology of the study. The population and sample are identified, and the procedures used to protect the participants are outlined. Instrumentation is described, and the methods of collection and treatment of data are also explained.

Research Design

Phenomenological research highlights the lived experience of individuals and gives voice to their experience of a specific phenomenon (Moustakas, 1994; Patton, 2002). This type of research also focuses on the way individuals describe and make sense of their experiences and provides a rich description of these stories (Crewsell, 1998). The assumption for this particular study was that married women who have experienced infertility have a shared experience, and this shared experience has given them meanings specific to them based on their experience. Although the theme of infertility was similar within the stories of the women, the meanings were much different.

Data Collection

Data collection was done through face-to-face interviews. Through this avenue, a personal and collaborative process evolved where the participants felt comfortable telling their stories of infertility and marriage. The researcher used a semi-structured interview guide (Appendix E) and interviews were recorded for accuracy, and later transcribed. Semi-structured is defined as a type of interview that, while having specific objectives, permits the interviewer some freedom in meeting them (Tesch, 1990). The participants decided on the location for the interviews.

Instrumentation

In this study, the researcher was the instrument, as the interviewing process was the main element to gather data in this type of research. The following research questions guided the research:

1. Does infertility affect marital quality during infertility treatments?
2. Does prescribed medication for infertility have side effects that affect marriage quality?

To begin the interviews, three warm-up questions were asked:

1. Please tell me a little bit about yourself.
2. Can you tell me about your hopes and dreams you had when you got married?
3. How did you imagine your future with your husband?

Following the three warm-up questions, five questions were the focus of the interviews:

1. What was your personal reaction to the infertility diagnosis?

2. Please tell me about your marriage since your infertility diagnosis.
3. Has infertility changed your marriage, if so, how?
4. What have been your personal reactions to the changes in your marriage?
5. Do you think infertility medication had side effects that affected your marriage quality?

In the event of reluctance to respond or a lack of information provided, the researcher utilized prompts, clarifying questions, and active listening to elicit further responses. Appropriate prompts included

1. Tell me more.
2. Please give me some examples.
3. What else can you tell me?
4. Would you like to add anything else?

Protection of Human Subjects

Information required by the Institutional Review Board (IRB) of Texas Woman's University concerning the study was submitted and approved prior to initiation of the data collection process. Professional research ethics were adhered to by the researcher through the provision of informed consent, assuring the women's right to voluntary participation and withdrawal at any time. Participants had the opportunity to ask questions during the recruitment process as well as during the interviews. At the completion of each interview, participants were given a referral list of professional therapists and other resources for information pertaining to counseling and infertility issues. Participants were told they could contact the researcher directly at any point

during or after the research process. The researchers' email and telephone numbers were given to each participant.

Participants and Sampling Procedures

The target population consisted of adult participants who identified themselves as legally married women who had been diagnosed infertile and who sought infertility treatment. A complete list of criteria for this study included:

1. Participants must live in the United States.
2. Participants must be female.
3. Participants must be legally married in the United States.
4. Participants must be between the ages of 28-45 (on her last birthday).
5. Participants must have a diagnosis of female infertility (type not specified).
6. Participants must have been undergoing treatment for a period longer than 12 months.
7. Participants must be part of a childless couple during treatment.

Participants for this study were recruited on a local level. Due to time and financial restraints, participants were chosen based on snowball and convenience sampling. According to Babbie, (1998) snowball sampling is implemented by "collecting data on the members of the population you can locate, and then asking those individuals to provide the information needed to locate other members of that population whom they happen to know" (p. 174). This method is a chain referral, and the word "snowball" refers to the accumulation of other subjects. Convenience sampling was used due to its low

cost and ease of access. This pool of women was gathered through personal and professional contacts of the researcher.

Pilot Study

A pilot survey was tested with the first three women of the interviews. Following the interview, the three women made recommendations regarding the face-to-face interviews. The purpose of the pilot study was to assess any changes needed in the interview questions and to standardize the interview procedures. This process allowed the participants to make comments about the design, comfort level of the questions and general thoughts about the experience. No changes were suggested or made in the remaining interviews.

Interview Procedures

The interview was the central focus of this study. The purpose of this research was to explore the question, "Does infertility affect marital quality?" Due to the emphasis on lived experience and personal insight, qualitative methodology offered a holistic environment where the unique stories of the participants bloomed. Qualitative methodology is defined as the nonnumerical examination and interpretation of observations, for the purpose of discovering underlying meaning and patterns of relationships (Babbie, 1998). Creswell (1998) likens qualitative research to an intricate fabric, full of different colors, textures, minute threads and various blends of material. The fabric is not simple in its design or in its explanation, but its outcome is rich and valuable.

Quantitative methods alone would not reveal the unique, individual process by which women experience infertility. Jayarante (1991) hold that qualitative methods may be appropriate "if the research goal is descriptive of individual's lives and designated to promote understanding of a particular viewpoint of the subject" (p. 102). Ragin (1987) highlights the dichotomy between qualitative and quantitative research when he states that quantitative researchers work with few variables and many cases, while qualitative researchers work with few cases and many variables. The basis of qualitative methodology was compatible under these personal interview circumstances.

The researcher conveyed an attitude of respect while also maintaining a neutral stance so that participants were able to speak freely (Patton, 2002). The researcher made every effort to suspend her biases when interviewing the women. The researcher presented herself in a professional, yet caring manner.

The researcher met with each participant at an agreed location. After greeting the participant and thanking them for their participation, the researcher gave the participant the consent form to fill out. At this time, the researcher went over the consent form (Appendix B) with the participant, and the participant signed the consent forms. One copy of the consent form was given to the participant and the researcher kept the second copy for her records.

Next, she gave the participant the demographic sheet to fill out (Appendix D). While the participant filled out the demographic sheet the researcher set up the audio recorder. The researcher brought extra batteries and tapes in case any of the recording material should default. Paper and pens were also included so the researcher could take

notes during each interview. A short test was taken to insure the recorder was working properly for each interview.

After the equipment was set up and the demographic sheet was filled out and collected, the researcher began the interview protocol. The interview protocol established a rapport between the researcher and the participant. This gave the participant a chance to get to know the researcher before the proceeding with the formal interview. The proposed time for the interviews was 30–45 minutes. During this time, a semi-structured interview guide was used (Appendix E). At the conclusion of each interview, the researcher thanked the participant for sharing her story and asked if there was anything else she would like to add to her responses. The researcher gave the participant the referral list and her contact information. Participants were again reminded to contact the researcher if they had any questions or concerns regarding the study.

Treatment of Data

After each interview, the researcher listened to the audio recording of the interviews once before transcribing them. The researcher listened to the tapes so that she could confirm the tapes were recorded clearly, and she made more notes as she listened to the tapes. Each tape was transcribed by the researcher. Three hard copies of the transcriptions were made: one for notations and color-coding, another for cutting the papers to organize the categories/themes. The third copy was locked in a cabinet in case the researcher needed an extra copy during the coding process. The master list with the personal names and codes of each participant was also stored in a locked cabinet.

Data Analysis and Procedures

Following the interviews, the tapes were transcribed by the researcher. The researcher read the transcripts several times in order to organize and sort the data. The answers from the open-ended questions were re-read by the researcher until themes began to emerge.

Creswell (1998) suggests several steps that must be achieved for data analysis regarding phenomenological research. The steps include developing a list of meaning statements from participants, grouping the meaning units, textural descriptions of each story, and a description of how the phenomenon was experienced by each participant. Once these steps are complete, the researcher will begin to see themes emerge.

The researcher followed these steps. The researcher cut and coded individual responses by color so that groupings and categories were easily recognizable during the data analysis process. Once the researcher re-read through the transcripts several times, the themes were established and then contemplated for meaning by the researcher. Two triangulators were used for the credibility of this study.

Credibility

Triangulation is one technique used in qualitative studies to improve credibility (Creswell, 2002). There are several forms of triangulation. For the purpose of this study, the researcher chose triangulating analysts. This process included two individuals who read through the data independently. Both triangulators were past graduate students who completed coursework in advanced research methodology at the doctoral level. These triangulators were given hard copies of the 13 transcripts to read. No identifying

information was included in the transcripts and they did not see any demographic information. Each transcript was coded with the participant's number only. The triangulators were asked to read through the transcripts and identify patterns or themes they noticed within the transcripts. The researcher then met with each triangulator independently and discussed the data. The researcher compared her emergent themes with that of each triangulator. Emergent themes were discussed, chosen, and confirmed by the researcher and the triangulators.

Ethical Considerations

Because the topic of this project can be difficult to discuss, the researcher took precautions during the interviews to safeguard the emotional well-being of each participant. Patton (2002) suggests the interviewer attempt to balance empathy and neutrality during the interviews. As a student of therapy, it seemed possible to the researcher that the interviews might turn into therapy sessions. The researcher used self-talk to remind herself that research was taking place, not therapy. The referral list that was given to participants served as therapeutic resources following the interviews. However, if during the interview, the participant or the interviewer wanted to take a break, one would have been taken. No breaks were requested during the interviews.

Another ethical consideration was loss of confidentiality. Confidentiality was protected to the extent that is allowed by law. Code numbers were used in place of participant's real names. The master list of code numbers and names, audio tapes of the interviews, field notes, and hard copies of the transcripts were placed in a locked cabinet,

accessible only to the researcher. The transcripts read by the triangulators did not contain any real names, only participant's code numbers.

The researcher wished to not only highlight general themes of this research, but to validate and celebrate the lived experience of the participants who experienced infertility and to explore if it affected their marital quality. Statements made within this project were not intended to generalize all women who have experienced this phenomenon, so the researcher conveyed emotional tones carefully. The researcher attempted to present the data in a scholarly narrative yet preserve the unique voices of the participants. This was done using direct quotes from the interviews to give the themes a richer depth, and bring to life each story within the context of the research.

Limitations

Although this study gathered important information about infertility and its effect on marital quality, there were limitations to the study. Snowball and convenience sampling limited the number of participants available. The sample consisted of 13 Caucasian women who are located in Texas. High annual household incomes and education levels were also limitations. Another limitation was the researcher was the only data collector which limited the diversity of perspective.

Summary

The purpose of this study was to explore if there are effects on marital quality during medical treatment for infertility. Participants were recruited through personal and professional contacts of the researcher. The researcher gathered 13 women for this study. Participants were recruited on a local level.

Data were gathered using a semi-structured interview. Interviews were audio recorded and transcribed into hard copies. The first three participants served as the pilot study. No changes were made to the interview guide. Professional ethics were discussed concerning provisions of informed consent and confidentiality. Approval from the TWU Institution review Board was assured prior to institution of the survey.

CHAPTER IV

RESULTS

The purpose of this qualitative study was to explore the question, "Does infertility affect marital quality?" This chapter reports the findings from the analysis of data that were collected from the interviews. The researcher conducted a pilot study of the first three interviews to determine if the questions and style of questioning was adequate and appropriate for this study. No changes were made to the interview process following the first three interviews. The researcher interviewed 13 women who volunteered and were eligible for the study. The interviews were audiotaped and transcribed verbatim and the data were analyzed for themes. In this chapter, the researcher presents the descriptions of the sample and a description of the three emergent themes.

Sample Description

The sample size consisted of 13 women who ranged in age from 27–45 with a mean age of 34.6. The researcher conducted 13 individual interviews with women from the Dallas/Ft. Worth area. Each of the married women had a diagnosis of infertility, type unspecified, and sought treatment for a period of 12 months or longer. The women ranged in number of years of marriage from 3 to 21 years. The mean years married was 7.9 years. Ten of the 13 women had children at the time of the interview and two were pregnant at the time of the interview. One woman was child-free.

The degrees earned by the women included seven bachelor's degrees and six master's degrees. All participants self-reported as Caucasian. The women varied in religious affiliations, including four Catholic, two Methodist, one Lutheran, one Presbyterian, one Episcopalian, one Non-Denominational, and three reported having no religious affiliations. The socio-economic status included six women who reported annual household incomes ranging from $150,000 and above and seven reported annual household incomes of $110,000-$149,000. Seven women reported working full-time, one reported working part-time, four reported working as a full-time parent, and one reported unemployment. None of the women attended counseling during the time frame of their infertility treatment.

The avenues in which the women gained children include: three became pregnant naturally (without treatment), two adopted children, three women became pregnant through in vitro fertilization, two became pregnant through inner uterine inseminations (IUI), and five became pregnant through Clomid. One woman is child-free. The length of years of treatment ranged from 12 months to 5 years, with a mean of 2.6 years of treatment.

Participant 1

Participant 1 is 38 years old, married, and has two daughters. Participant 1 has been married for 9 years and received treatment for infertility for 5 years. Her treatments included Clomid, Premarin, five rounds of IUI, and two rounds of IVF. She became pregnant both times with successful rounds of IVF.

Participant 2

Participant 2 is 31 years old, married, and has one daughter, age 5 months. Participant 2 has been married for 5 years and received treatment for infertility for two years. Her treatment included Clomid, acupuncture, herbal teas, and five rounds of IUI's. She became pregnant through a successful combination of Clomid, acupuncture, and an IUI.

Participant 3

Participant 3 is 36 years old, married, and has two sons. She has been married to her husband for 10 years and received treatment for infertility for 3 years. Her treatments included Clomid, progesterone injections, two rounds of IUI's, and two rounds of IVF. After an eptopic pregnancy and a miscarriage, Participant 3 became pregnant twice through successful IVF treatments.

Participant 4

Participant 4 is 29 years old, married, and is currently pregnant with her first child. She has been married for 5 years and received treatment for 12 months. Her

treatment included Clomid and acupuncture. Participant 4 became pregnant through a successful round of Clomid.

Participant 5

Participant 5 is 34 years old, married and has two sons. She has been married to her husband for 6 years and her treatment of 13 months included Clomid. Participant 5 became pregnant through a successful round of Clomid.

Participant 6

Participant 6 is 40 years old, married, and has one son. She has been married for 16 years and received treatment for infertility for 5 years. Participant 6 underwent two unsuccessful rounds of IVF and an IUI with a sperm donor. Participant 6 and her husband later adopted a baby boy.

Participant 7

Participant 7 is 27 years old, married, and has one son and one daughter. She has been married for 3 years and received treatment for infertility for 15 months. Her treatments included Clomid and progesterone injections. Participant 7 and her husband adopted their daughter. The day after the adoption was finalized, Participant 7 found out that she was pregnant through a successful round of Clomid. Participant 7 and her husband now have a daughter (through adoption) and a son (through Clomid treatment).

Participant 8

Participant 8 is 38 years old, married, and has two sons. She has been married for 9 years and received treatment for infertility for 5 years. Her treatments included

Clomid, five rounds of IUI's, and two rounds of IVF. She became pregnant twice through successful IVF treatments.

Participant 9

Participant 9 is 31 years old, married, and is currently pregnant with triplets. She has been married for 5 years and received treatment for infertility for 18 months. Her treatments included Clomid, progesterone injections, and three rounds of IUI's. She became pregnant with triplets after an IUI coupled with progesterone injections. Her triplets are due in July 2009.

Participant 10

Participant 10 is 32 years old, married, and has one son. She has been married to her husband for 5 years, and her treatments of 15 months include Clomid. Participant 10 became pregnant through a successful round of Clomid.

Participant 11

Participant 11 is 29 years old, married, and has one daughter. She has been married to her husband for 4 years and her treatments of 12 months included Clomid and progesterone shots. She also experienced one miscarriage. Participant 11 became pregnant through a successful round of Clomid.

Participant 12

Participant 12 is 45 years old, married, and is child-free. Participant 12 has been married for 21 years and received treatment for infertility for 14 months. Her treatments included Clomid and a tubal flush. After two failed attempts at adoption, Participant 12 and her husband made the decision to live child-free.

Participant 13

Participant 13 is 40 years old, married and has one son. She has been married to her husband for 10 years and her treatment of 3 years included Clomid, progesterone injections, IUI, and IVF. Participant 13 became pregnant through a successful IVF.

Table 1

Participant's Study Number, Age, Race, Religion, and Annual Household Income

Participant	Age	Race	Religion	Annual Household Income
1	38	Caucasian	Catholic	$150,000+
2	31	Caucasian	Episcopalian	$150,000+
3	36	Caucasian	Lutheran	$150,000+
4	29	Caucasian	Methodist	$150,000+
5	34	Caucasian	Presbyterian	$110,000-$150,000
6	40	Caucasian	No affiliation	$150,000+
7	27	Caucasian	Non-Demon.	$150,000+
8	38	Caucasian	Methodist	$110,000-$150,000
9	31	Caucasian	Catholic	$110,000-$150,000
10	32	Caucasian	Catholic	$110,000-$150,000
11	29	Caucasian	Catholic	$110,000-$150,000
12	45	Caucasian	No affiliation	$110,000-$150,000
13	40	Caucasian	No affiliation	$110,000-$150,000

Table 2

Education Level, Employment Status, Counseling History During Treatment

Participant	Education Level	Employment	Counseling History
1	Master's Degree	Full-Time	None
2	Master's Degree	Full-Time	None
3	Master's Degree	Full-Time	None
4	Bachelor's Degree	Full-Time Parent	None
5	Bachelor's Degree	Part-Time	None
6	Master's Degree	Full-Time Parent	None
7	Bachelor's Degree	Unemployed	None
8	Master's Degree	Full-Time	None
9	Bachelor's Degree	Full-Time	None
10	Bachelor's Degree	Full-Time	None
11	Bachelor's Degree	Full-Time Parent	None
12	Bachelor's Degree	Full-Time Parent	None
13	Master's Degree	Full-Time	None

Table 3

Participant's Years of Marriage, Treatments Received, and Length of Treatment

Participant	Years of Marriage	Length of Treatment	Treatments Received
1	9	5 Years	Clomid, IUI, IVF
2	5	2 Years	Clomid, Premarin, IUI, Progesterone
3	10	3 Years	Clomid, Progesterone, IUI, IVF
4	5	12 Months	Clomid, Acupuncture
5	6	13 Months	Clomid
6	16	5 Years	IVF, IUI
7	3	15 Months	Clomid, Progesterone
8	9	5 Years	Clomid, IUI, IVF
9	5	18 Months	Clomid, Progesterone, IUI
10	5	15 Months	Clomid
11	4	12 Months	Clomid, Progesterone
12	21	14 Months	Clomid, Tubal Flush
13	10	3 Years	Clomid, Progesterone, IUI, IVF

Findings

The purpose of this study was to explore the effects of infertility on marriage quality. The focus was to explore the lived experience of women who underwent treatment for infertility and its effect on their marriage. To guide this study, the researcher focused on the following two research questions:

Research Question 1. Does infertility affect marital quality?

Research Questions 2. Did prescribed medication have side effects that affected your marriage?

In qualitative studies, the study is directed by the interview questions. The following questions were included:

1. What was your personal reaction to your infertility diagnosis?
2. Can you tell me about the quality of your marriage since your infertility diagnosis?
3. Has infertility affected the quality of your marriage? If so, how?
4. What have been your personal reactions to the changes in your marriage quality?
5. Did infertility medication have side effects that affected your marriage quality?

The researcher analyzed the participants' narratives by listening to the audiotapes and re-reading transcripts from each interview. As themes began to emerge she grouped verbatim quotes that would support each of the three themes: And Baby Makes Glee,

Adopting Marital Stress, and Clomid Made Me Crazy. This effort highlights the lived experience of infertility and its effect on marital quality.

Theme One: And Baby Makes Glee

Each woman had a different story to tell, but the women that fall under this category had one unifying thread: glee. Each of these women became pregnant through some form of treatment, had at least one successful pregnancy, and produced a healthy biological baby. Their stories of infertility were told in retrospect, and were peppered with quotes such as, "Yes, treatment was tough, but we got through it together" (Participant 10). The women had an "it-wasn't-so-bad-after-all" attitude about the infertility process and its effect on their marriage. Two sub themes emerged under the theme And Baby Makes Glee. They include Hopefulness and Supportive Spouse.

Hopefulness

The majority of the women felt "hopeful" due to the amount of emotional support received from their spouse, friends, and medical team. "We always felt hopeful each month. It was like we got a fresh start each month or each cycle. So it didn't work out last month, we'll try again." (Participant 2)

Many women also referred to the doctor's appointments as a time of great hope. Participant 11 reported that the nurse she worked with was special. "She was like a mother to me. She never made me feel rushed along. 'Here's your pills. Good Luck.' Nothing like that. She was great and so full of hope every time I was there, over and over."

Participant 13 used the term "hope" to describe her own feelings throughout treatment. "It was hard to stay optimistic month after month, we would take breaks and then get back into it. It was hard, but each time we decided to try again or try something new it was with new hope every time."

Supportive Husband

The women in this group responded with positive coping styles as a couple. They felt infertility brought them closer together and strengthened their marriage. Participant 9, who is currently pregnant with triplets, was the participant who reported the most positive comments about her marriage during infertility treatment. Participant 9 is Catholic and reported that she and her husband were "full of faith" throughout the process. Her husband, like many other of the husbands in this study, administered the daily shots of progesterone but didn't mind.

> I have the most supportive husband ever and we have a wonderful, open, and close marriage. Infertility was emotional, but with our faith in God and each other we got through it together. It was frustrating at times. The infertility was frustrating, but never our marriage. That was always the good part. (Participant 9)

Six of the women reported feeling "supported" by their husbands, doctors and nurses. "My husband was my rock. He let me cry or vent whenever I needed to. Each month I had a breakdown and he never made me feel like I should just get over it. He was awesome" (Participant 11). Although some mentioned feelings of "stress" during treatment due to the financial burden of treatment, none of the ten women from this theme mentioned feelings similar to bereavement, depression or anxiety.

Participant 2, who said she went to the doctor's office weekly, was always accompanied by her husband who took great care in learning about infertility.

> He never missed an appointment. In fact, if you ask him today about all this infertility stuff he could tell you better than me about the treatments. He would always ask a million questions and he got to know the staff so well. It became like his little research project. He was really into it. I couldn't tell you half the stuff he could about IUI's and all that stuff. (Participant 2)

Participant 3, who experienced the widest variety of complications and treatments out of all 13 women in the sample, said she is married to a "sensitive guy" which helped in the process.

> We grieved together during the miscarriage, the eptopic pregnancy, and the unsuccessful attempts at IUI's. My husband would always tell me, "Whatever it takes, we'll do it." It definitely had a positive effect on our marriage. At times he wished he could do more for me because he knew I was bearing the brunt of the treatment. (Participant 3)

Participant 6 used the words "passively supportive" to describe her husband's reaction to the infertility treatments. She said he was "cautiously optimistic" due to the unknown results of the treatment and because he didn't want to upset her if the round of treatment was unsuccessful. Participant 5 has similar responses when talking about her husband.

> He was probably more stressed than me because he never knew what mood I was going to be in when he got home every night. He was probably like, "Who's it

gonna be tonight?" No, but he was great, really great. I could not have done it without him. (Participant 5)

Of the 13 women interviewed, 10 of them stated positive feelings toward their marriage and reported very positive comments about the strength and supportiveness of their husbands during this time. Many of the participants mentioned "tough times" in the marriage during treatment, but when asked overall if infertility affected marital quality, the 10 women in this category answered in this regard, as Participant 3 summed up,

> Yes, infertility affected my marital quality, but in a good way. It's tough. I think infertility can make or break a marriage. You really have to rely on each other and be on the same page and be committed. It's a lot to ask. (Participant 3)

Theme Two: Adopting Marital Stress

While most of the women reported positive marital quality during treatment for infertility, three of the 13 women reported that their marriage "hit the lowest point" during this time. Participant 12, Participant 7, and Participant 6 are included in this section. Their stories combine infertility treatment with the adoption process. This combination compounded the stress in their marriage.

Participant 12

Participant 12 is 45 years old and has been married to her husband for 21 years. She was 25 when she married her husband who was 24 at the time. They dated for three years before marriage but never discussed future family plans. Three years into the marriage Participant 12 brought up the idea of having a baby and her husband said, "Oh, I

don't want children...ever." This was quite surprising to Participant 12. She said he later gave in to the idea of trying.

> I think it was more of an acquiescence on his part. He probably thought, I'll just give in and it won't' be so bad. I don't want her to leave me. But it was bad. The doctor's appointments stressed him out. He had to give sperm, we had to have sex at scheduled times, there were too many doctors appointments. It was bad. I had a tubal flush that was very painful and he didn't like seeing me go through that pain. The whole thing stressed him out. He started to withdrawal and put distance between us. That was how he coped. (Participant 12)

Infertility runs in the family for Participant 12. Her mother and her identical twin sister both had problems with infertility. After three rounds of unsuccessful Clomid treatments she found out that she had severe endometriosis, which she had surgically removed. "The doctor said it was one of the worst cases of endometriosis she had seen." Even with a variety of treatment, Participant 12 could never have become pregnant. She found this out after 18 months of treatment and much distress to her marital quality.

> I knew my husband didn't want children to begin with, now we were dealing with all of the infertility stuff. Also, at the time I was doing social work, so I was seeing the effects of children whose parents didn't want them. I would never intentionally put a child into a situation where the parents didn't want them. I said we're not going to do it. He was very happy with that. I called the whole thing off. He was OK with that, very OK. (Participant 12)

Participant 12 stopped considering all forms of treatment, even in vitro fertilization because the emotional stress would have been too difficult to handle.

> I was never willing to do the in vitro. I had seen too many people do it and fail. I knew I didn't want to set myself up for failure. I knew what the odds were and I knew if it didn't work, I would be devastated. I wasn't willing to go there emotionally. (Participant 12)

Several years later, Participant 12 and her husband had the opportunity to adopt. Participant 12 said her husband acquiesced once again. This time it was to the idea of adoption. They had the nursery set up and had mentally prepared themselves for parenthood. A week before the baby was born, the biological mother changed her mind. "It was very hard. Very hard. After that, my husband said no, we're done with that. And I was OK with that, because it was so hard. I didn't want to go through that again." Yet, years later, Participant 12 and her husband had another opportunity to adopt a different baby and again, the biological mother changed her mind.

> Yes, infertility has been the top stressor in our marriage. It was horrible, horrible. It was very stressful because it was walking on pins and needles...not wanting to upset the egg cart. I knew he didn't really want it so I was trying to keep him appeased and not push him too much. I internalized a lot. My friends were supportive, probably overly supportive. They encouraged me to not tell him about treatment, but I knew I couldn't do that to my marriage. Looking back, I probably would have taken a more active lead in the decision making about all of it. Although I would have still stopped at some point because I knew the stress

was so much that if we continued on we probably wouldn't be married at this point. (Participant 12)

Today, Participant 12 is happy with her child-free marriage of 21 years. She reports that she and her husband now have friends and siblings who are raising teenagers. Watching them deal with adolescent issues makes them very pleased that they do not have children at this point. Participant 12 said her new attitude about being child-free has only occurred within the last few years.

Participant 7

Participant 7 was married at age 24 after dating her husband for less than a year. Eight months into the marriage the couple began caring for a little girl whose mother had given her up to Child Protective Services. Also during this year Participant 7 was taking Clomid (8 cycles) and injectable shots of progesterone. She experienced two miscarriages and was on the highest dosage of Clomid possible. Nine months later, Participant 7 and her husband legally adopted the little girl they were caring for daily. The day after the adoption was finalized, Participant 7 wasn't feeling well. Out of habit, she took a pregnancy test and it was positive. Within two days, the couple adopted a 15 month old baby girl and found out they were pregnant with their own biological child. The adoption process and her treatment for infertility spanned a time frame of 15 months. Participant 7 summed it up, "It was a very active year."

Participant 7 reported having an "ok" marriage before having children although she admits her marriage was somewhat "superficial" because they didn't really know

each other when they got married. They only dated for a year and most of that year the couple was busy planning a large Texas wedding.

> I don't think we were connected at the very beginning. Plus, we had different ideas about family. I was raised in a tight family with three other siblings. My husband comes from a very broken home. His mom left them when he was three years old, doesn't really know his dad. So for him, family wasn't too big on his plan. Out of the kindness of his heart he knew that I wanted a family. In the beginning I loved him but I wouldn't say I was in love with him. Everything was so fast that first year. (Participant 7)

The most stressful weekend for Participant 7 and her husband came in May 2007. The birth mother of the little girl formally asked the couple to adopt her child. That same day, Participant 7's endocrinologist told her that she had a good amount of follicles that were healthy and strong and if they had sexual intercourse that weekend they would surely get pregnant. These two big decisions fell in the same weekend for Participant 7 and her husband.

> That weekend began the rockiness of it all for my husband and me. Our finances were out of order. We were so confused. That weekend was the hardest on our marriage. I wanted to keep trying with our own pregnancy and my husband thought we should slow down. It was a battle. It really was. (Participant 7)

Participant 7 and her husband fought often over the issues with infertility and adoption. Participant 7 considered leaving her husband and even divorce. She admits that

when things got tough during arguments, she usually was the first to leave the house angry.

> There was a time when I was sitting in my living room thinking I want to leave him and go back to my Mom in Temple because I couldn't believe he didn't want to have a baby with me. It was a battle with my husband. It was my body. Who was he to tell me when I could have a baby or not? We were not intimate at all during that time. It was hard that year because we were trying to learn each other, have a baby and go through an adoption process. There was times where I thought I just would tell him I had taken a round of Clomid and we'll just get pregnant and he'll never know. Then, of course, there were time when I thought I wanted a divorce too. It was awful. Our marriage was a struggle. Some days were tough and some days we were on a natural high. We were up and down. Sometimes I felt real alone. I would go to my mother's house. We fought a lot, a lot. It was really rough. We were dealing with stuff at our age that people don't usually deal with. We went though the lowest of lows that anybody could possibly go through in a relationship with infertility. (Participant 7)

Participant 7 did not cut off social engagements with friends but she did keep her infertility a secret. "We kept our fertility issues very private because I thought people would think I was nuts for trying to adopt and going through infertility treatment at the same time."

Although Participant 7 and her husband are still married today with two children, the 15 months of treatment have taught them much about their marriage. "You learn so

much about someone through infertility. It is such a growing experience. It's tough." Participant 7 and her husband plan to have two more children in the future.

Participant 6

Participant 6 was married for four years when she and her husband realized there was a problem with infertility. Through five years of treatment, Participant 6 and her husband spent $80,000 on medical testing, two in vitro fertilizations, several IUI's (some with a sperm donor), and an adoption. She reported that finances were the most stressful part of the experience. "By the end I was emotionally spent. I felt like fertility doctors were sales guys. I could not go through another process or listen to any more doctors talk about options. I was done with all that."

Participant 6 said that she and her husband had "a pretty good savings" before they started treatment.

> I remember the first year we did treatment – when we were doing our taxes – we realized we had spent $22,000. And that was just the beginning. The money aspect definitely caused us the most stress. There were a lot of heated discussions during that time. And that's putting it nicely. (Participant 6)

Once it became clear that Participant 6 could not have a child on her own, she began exploring the idea of adoption. After one tour of an adoption agency she quickly told her husband, "I'm not doing that." A few months later, a doctor called Participant 6 and said,

> One of your girlfriends told me about your infertility and I hear you might be interested in adoption? I have a mother who just delivered last night and wants to give up the baby. Have your attorney call me today if you are interested.
>
> Two days later, Participant 6 brought home her adopted son. (Participant 6)

In sum, Participant 6 and her husband battled infertility for five years, spent $80,000 on treatment and the adoption process, but ended up with a perfectly healthy baby boy.

> There were a lot of dynamics that play into this fertility story. It was a complete roller coaster and was emotionally draining. But, as usual, the finances were the hardest part for us. Money tends to wedge us apart, but at that time we were in good financial shape. We had the money to spend but it was still very stressful. I can't imagine what it would have been like if we didn't have the money to spend because I would have done it all anyway. I was on a mission. We were going to have a baby. He was great, he never tried to discourage me but the money part was difficult. (Participant 6)

A positive aspect of Participant 6's story is how she and her husband externalized their infertility problems. "It was us fighting the fertility problem. That is usually how we handle problems and this one was no different, just more costly."

Theme Three: Clomid Made Me Crazy

Clomid is a synthetic drug that forces a woman's body to ovulate. It is taken for 4 days each menstrual cycle. Presently, there are no studies that address Clomid in conjunction with marital quality. Of the 13 participants, six mentioned Clomid as a

prescribed medication that had adverse side effects that affected their marital quality in a negative manner. While all of the six women reported hot flashes and emotional dips, the following three women had the most severe reactions to Clomid.

Participant 7

Participant 7 took eight cycles of Clomid. She started with the lowest dosage (50 mg) and worked her way up to the highest (200 mg) over the course of 15 months. While on Clomid, Participant 7 gained ten pounds, experienced bloating, hot flashes, irritability, and anxiety.

> It was miserable. Clomid was worse than pregnancy. I was really mean on it. Every time they would up my dose I would cry because I didn't want to go through it. My husband didn't want to go through it. I was also trying to take care of this little girl and then trying to be sociable. My husband is in a business where we have to do a lot of dinners with doctors and I never wanted to go. I was miserable. I was really sad and mean. It was awful. The medication made me mad. (Participant 7)

For Participant 7, being on Clomid was more stressful on her marriage than the actual infertility.

> It's this little pill you take and it becomes your entire world. There is so much hope in those 5 little pills. And it makes you completely obsessed with the calendar. My husband would probably pay anything for me NOT to be on that stuff again. He hates Clomid. I hate Clomid. Here's the deal with Clomid, the highs and lows comes with each doctor's appointment. You go in there with your

husband and the doctors and nurses are all so excited and hopeful for you. They put an image of your body up on the screen and say, "Look, you have 7 great follicles this time. If you get pregnant this cycle you'll have a January baby! Then you get all excited and leave the office. You go to lunch with your husband and talk about all the details of the office visit and a January baby. Then you do everything you're supposed to and it all fails again anyway. It's a total roller coaster ride. Clomid tricks you into thinking everything will be great, just as planned! (Participant 7)

Participant 7 found solace through talking to her mom, who took Clomid as a young woman as well. Participant 7 thought it was quite humorous that her mom took Clomid with all four children, but never discussed it with her husband, who was an orthopedic surgeon.

My Dad never even knew my Mom was on Clomid. He thought I was too hard on my husband when I was on Clomid. I guess that's why... he didn't even know his own wife took Clomid with all four of their kids! Crazy! My mom said the doctor just gave her the pills but never explained anything about them. My, how times have changed! (Participant 7)

Participant 7 said she and her husband were finally able to realize her emotional dips were caused by the medication. "We laugh now because we realized that little medication was taking over. It made me completely nuts."

Participant 1

Participant 1 went through treatment including, Clomid, progesterone injections, IUI's, and IVF's, yet she reported that Clomid, by far, had the worst side effects on her and the marriage.

> Clomid makes me insane, like crazy insane. Like really really depressed. You know how sometimes you wake up and you say 'I feel pretty today' and then the next day you wake up with your period and feel totally disgusting? Clomid was like that to the 100th degree. It's a synthetic drug; it's not a natural drug. It made me crazy. I could tell myself rationally-there's no reason for me to feel this sad. I knew it was the medication. I could feel it my veins. I could like feel it in my face. I took 6 cycles but I had to take breaks in between cycles because it made me feel so bad. (Participant 1)

When asked what was worse: being on Clomid or being infertile, Participant 1 chose being infertile.

> The medication is self-induced craziness and depression. I was not the same person emotionally. I had a stir of synthetic hormones surging in my body. So that was a temporary thing. When the medication leaves your body, the sadness about not being pregnant is something continual and a little bit at a time. It's more harmful. The medication part is right in front of you for a short amount of time. (Participant 1)

In terms of marital quality, Participant 1 said her husband knew it was the medication that made her so emotional yet they still found themselves at odds over minor

things around the house. They both knew the minute she took the pill, she was going to transform into someone else. "He hated it. I hated it. I would not go through it again. If I wanted another baby I would go straight to IVF. I would not do Clomid again. It literally made me insane."

Participant 12

Participant 12 knew her husband really did not want to have a baby in the first place. Adding a synthetic drug to the situation was not going to make things any easier at home so she only took Clomid for three cycles before ending the medication.

> Clomid was awful. It just was something I never felt before. I had hot flashes all the time. My shins and the top of my feet would sweat all the time. I was mean to my co-workers, my husband, my Mom, everyone. It was like Dr. Jekyll and Mr. Hyde with me. Crazy. I took three cycles of it and I stopped. That was enough for me. (Participant 12)

The women who took injectable shots of progesterone did not report any adverse side effects that affected their emotional health. One woman (Participant 1) did report that the shots left large knots under her skin at the injection site but no emotional changes resulted from the progesterone. Participant 2 reported hot flashes from taking the medication Premarin, which is also designed to force a woman's body to ovulate, but no adverse emotional reactions from this medication.

Summary

The results this qualitative study were presented in this chapter. No changes were made to the interview process after a pilot study of the first three interviews was

conducted. Thirteen women were represented in this study. The confidentiality of each participant was protected by using a numerical coding system. The demographics of the sample, the emergent themes, and verbatim quotes were presented in this chapter. Three themes emerged from the interviews: And Baby Makes Glee, Adopting Marital Stress, and Clomid Made Me Crazy. Two sub themes were also included: Hopefulness and Supportive Husband. The women shared their stories about infertility and their marriages. The quotes chosen for this dissertation best illustrate the lived experience of infertility and its effect on marriage. The women shared their stories of becoming mothers or making the decision to live child-free. Their stories are included in this chapter.

CHAPTER V

CONCLUSIONS, DISCUSSION, LIMITATIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this qualitative study was to explore the question, "Does infertility affect marital quality?" Thirteen women were interviewed and shared their stories about infertility and how it affected their marital quality. Each participant was asked a total of 8 questions with follow-up and clarification questions dispersed throughout the interview. All 13 interviews were audiotaped and transcribed verbatim by the researcher. The transcripts were re-read several time and analyzed for themes. This chapter includes the conclusion, a discussion of the findings and implications of the study. Limitations of the study are presented, and recommendations for family therapists and future research are also included.

Conclusion

A phenomenological research method was utilized in order to capture the lived experiences of each of these women. Infertility is an experiential process; therefore individuals who experience infertility have different descriptions from one another. The idea of phenomenology is to re-visit the lived experience of each of the participants to feel the essence of the individual stories and experiences (Hixson, 2003). This process validates each respondent, and avoids the temptation to "lump" their experiences together as a whole, but rather, give life to each story.

Phenomenology encourages the researcher to pull out significant statements, find themes and exhaust the description of each experience and illuminate the essence of the phenomenon of infertility (Hixson, 2003). Each of the 13 women included in this study had a slightly different experience with infertility, yet three distinct themes emerged that unite their stories. The women from this study shared their experiences of infertility and its effect on their marriage quality. They also discussed how prescribed medication affected their marital quality as well.

Conclusions reached from the research are as follows:

1. Infertility may bring some couples closer together.
2. The adoption process negatively affects marital quality more so than infertility.
3. Clomid negatively affects marital quality and the emotional health of women who take this prescribed medication.
4. Husbands often feel helpless during treatment because the woman is enduring the physical, and sometimes painful, aspect of treatment.
5. There is great disappointment when a birthmother changes her mind during the adoption process.
6. Medication for the treatment of infertility may cause women to feel depressed, sad, mean, or down.
7. Infertility is a costly enterprise that may cause stress to couples.
8. Some women feel infertility doctors and their staff are unrealistic about possible outcomes during treatment.

9. Some women consider not telling their husbands about certain treatment options they are considering due to financial or emotional concerns.
10. The process of infertility is regularly compared to a roller coaster ride.

Discussion

Infertility had an impact on the marital quality of all 13 participants. For ten of the women, it was a positive impact, and for three participants it was a negative impact. Although all 13 participants are past the infertility stage, their lived experience has become part of their identity as married adults and parents. The following is a discussion of how this particular study's results support or contrast with current literature regarding infertility and marriage quality.

That Wasn't So Bad

Several researchers in the past have found that a woman's response to an infertility diagnosis is similar to the models of bereavement (Seibel & Taymor, 1982), depression (Hunt & Monach, 1997; Syme, 1997), and anxiety or stress (Mori, 1997; Robinson et al., 1996; Salzer, 1991). The results of this study stand in contrast to the studies listed above. Of the thirteen women in this study, ten of them reported feeling "hopeful" during treatment, and they reported feeling "supported" by their husbands, doctors and nurses. Although some mentioned feelings of "stress" during treatment due to the financial burden, none of the ten women from this theme mentioned feelings similar to bereavement, depression, or anxiety. Eleven of the thirteen women described their marriage as successful and supportive before they became involved with infertility treatments. Two women (Participant 7 and Participant 12) described their marriages as

"selfish" (Participant 7) and "rough" (Participant 12). Both of these women attributed their low marital quality to their youth. Participant 7 and Participant 12 were both married in their early 20's after a short courtship with their spouse. Both commented that age was a significant factor in their marital stress before the infertility treatments.

The current literature reports that women who experience infertility also report low marital satisfaction and feelings of isolation, loneliness, and sadness, (Myers & Wark, 1996). Feelings of guilt and worthlessness are also commonly associated with couples facing infertility (Myers & Wark, 1996). The reports from this study appear to explain the experience of infertility and its effect of marriage differently.

Of the 13 women interviewed, 10 of them stated positive feelings toward their marriage and reported very positive comments about the strength and supportiveness of their husbands during this time. In fact, many of the women gave all the credit to their husbands for being so supportive, and none of them gave themselves the credit for enduring treatment, including synthetic drugs or invasive surgeries.

Many of the participants mentioned "tough times" in the marriage during treatment, but when asked overall if infertility affected marital quality, the ten women in this category answered in this regard, as Participant 3 summed up, "Yes, infertility affected my marital quality, but in a good way."

According to Olshanky (2003) previously infertile new mothers have experienced repeated and sustained interferences with significant relationships over the course of their infertility, which could lead to depression. None of the women in this study reported long-term interference with their spouses or any other significant relationship; however,

all participants remained married to the spouse with which they shared infertility and twelve of the thirteen women now have children with that spouse. In retrospect, they thought infertility brought them closer together as a couple.

One reason for the differences listed above could be the fact that the ten women who fall under the category And Baby Makes Glee all had a positive outcome following treatment. They all ended up with a baby by a variety of means. The previous studies that report themes of sadness, depression, and grief may have had a different methodology than this study. They may have interviewed women who never achieved a healthy pregnancy, delivery or adoption. The outcome of this study may be contingent on that fact that the majority of the women ended up with a baby. Also, this study interviewed women retrospectively, as the researcher could not find a woman who was currently undergoing treatment who wanted to share her story. The 13 women included in this study volunteered to tell their stories after they had either conceived a child, successfully adopted or chose to live child-free. Prior studies may have interviewed women while they were receiving treatment. The timing of the information gathering may have been the catalyst for the difference in participant responses between this study and previous studies.

Husband's Helplessness

Daniluk (1997) reported that in the few studies that have been conducted, the husband in the relationship appears to be as emotionally distressed as the wife upon learning the diagnosis of infertility. While many women feel more able to express their feelings about their infertility, many men struggle with their own feelings and feel

helpless in trying to comfort their spouse (Greih, 1997). The reported response of Participant 12's husband is consistent with the findings of these two studies in that he also became emotionally distressed and struggled with his feelings of helplessness while his wife was experiencing painful treatment procedures. She reported that he began to withdrawal and become distant. This is also consistent with the research on men's responses to infertility (Daniluk, 1997; Syme, 1997). Participant 8's husband reportedly "escaped because he didn't know how to comfort me or maybe it was just he didn't want to make me cry." Participant 3 also reported that her husband wished he could do more for her because he knew she was bearing the brunt of the treatment procedures and their painful side effects.

The report about participant 12's husband also confirms the study done by Morrow, Thoreson, and Penney (1995) that posits self-blame and avoidance coping are the best predictors of psychological distress in couples who experience infertility. Her husband withdrew emotionally and did not know how to handle the problems that infertility presented to their new marriage.

Strauss, Hepp, and Staeding (1998) studied the psychological characteristics of infertile couples and found that couples who terminated treatment after one year reported higher levels of marital discord and interpersonal complaints than couples who did not terminate treatment after one year. Berghuis and Stanton (2002) conducted a longitudinal study to examine depressive symptoms in infertile couples over several insemination attempts. Results indicated that couples who had several failed attempts over the course of two years reported higher levels of depressive symptoms. The longer the failed

attempts, the higher rate of depressive symptoms existed. The women in this study who received IUI's did not report higher levels of marital discord or even depression, but women who were going through the adoption process did report negative marital quality during that time.

Time Heals All Wounds?

Research shows that couples usually require two years of healing before they report feelings of normalcy in their marriage and thorough emotional resiliency (Pepe & Byrne, 1991). It is this two year period following the termination of treatment that appears to be the most difficult (Pepe & Byrne, 1991). Participant 12 reported that her ability to "joke around" about not having children has only occurred in the last few years, which indicates that it took her marriage far more than two years for emotional healing. Participant 12 was the only participant who chose to terminate treatment and to live child-free.

Decisions, Decisions

Participant 7 and her husband had trouble agreeing on further treatment once the adoption looked as if it might become a reality. The weekend they spent deciding what to do was agonizing for them. This line of thinking is consistent with current literature that highlights the struggles couples go through when trying to decide on treatment options. Making decisions about treatment can add more tension to an already stressful situation (Gibson & Myers, 2000; Hart, 2002). One partner may want to move forward with another round of treatment while the other partner may not. The inability to decide about treatment choices adds to the couples' frustration, as does the fact that there are so

many choices in treatment (Sherrod, 2004). This was the case with Participant 7 and her husband. She even thought about leaving her husband due to the stress they were under. Participant 6 and her husband also fought over how to proceed with treatment due to the financial concerns of the couple. Her husband was concerned because they were using up all of their saving while Participant 6 did not care, she simply "wanted a baby no matter what." Participant 6 also reported feeling "fed up" with the infertility doctors who were routinely suggesting she undergo more treatment.

Roller Coaster Ride of Emotions

Research shows that the emotional experience of infertility is similar to a roller coaster ride, due to its ubiquitous uncertainty each month and because it is composed of a series of crises and never-ending stress (Salzer, 1991). All 13 participants consistently used similar words to describe the constant fluctuation of their marriage quality during treatment. Many women actually used the word "roller coaster ride" to describe their feelings and the state of their marital quality. Many also used the words "up and down" to describe their feelings and their marital quality as well.

Secrets

Maill (1996) found that couples cut off social engagements with their family and friends to avoid the topic of babies or pregnancy. Throughout the 15 months of treatment, Participant 7 did not share her struggle with any friends, nor did Participant 4 or Participant 5. All three reported thoughts of "just not wanting to talk about it or having people feel sorry for me" type attitude.

Valentine (1986) studied the psychological impact of infertility and found that married couples experiencing infertility reported emotional reactions such as sadness, depression, anger, confusion, desperation, hurt, embarrassment, and humiliation. Behavioral reactions to infertility included disorganization, distractibility, exhaustion, moodiness and obsessive thoughts and behaviors. The findings of this study are consistent with the reported experiences of some of the women who took Clomid during treatment. Six of them reported feeling "sad, depressed, and moody."

Limitations

Although this study gathered important information about infertility and its effect on marital quality, there were limitations to the study. The sample consisted of 13 Caucasian women who are located in Texas. Participants were not randomly selected and were gathered through snowball sampling. The education levels and annual household incomes were also a limitation. A final limitation from this study, and perhaps the most important, is that the women were all discussing their infertility experiences retrospectively. None of them were undergoing treatment at the time of the interviews. Twelve out of the 13 women had a child or were pregnant during the interview. Because these women had a positive outcome (baby or pregnancy) their perceptions of the infertility experience may have been skewed due to their recent glee from motherhood or pregnancy.

Implications for Family Therapists

Mental health professionals who work with infertile couples have a unique opportunity to help these couples reframe their infertility stories, understand the emotional roots attached to the issue, and arm them with specific skills and tools that can be used during the difficult treatment process and on a day-to-day basis.

In terms of therapy models, the cognitive behavioral approach has received much study, and has been linked to great success with couples and individuals who are experiencing infertility (Myers & Wark, 1996; Newton, 1999; Smith & Smith, 2004; Tuschen-Caffier, 1999). The cognitive behavioral approach refers to the approaches inspired by Albert Ellis (1962) and Aaron Beck (1976) that emphasize the need for attitudinal change to promote and maintain behavioral modification (Nichols, 2006). This research study does not support the idea of a need for attitudinal change to promote modified behavior. The women in this study were hopeful end excited to be in treatment for infertility. Although it was a rocky road, their attitudes and their marriages remained strong.

Perhaps a better therapeutic model would be that of solution-focused therapy, a model that highlights the strengths of a couple. It seems more appropriate to dwell on the positives in a time when a woman's body is having difficulty attempting to do what it was designed to do, and when a couple is having trouble fulfilling the dreams they held for their marriage. A family therapist working with a couple who is receiving infertility treatment would help a couple far more by highlighting their strengths rather than focusing on the difficulties at hand. There are enough monthly reminders of those

troubles. A therapist should see this opportunity as a good time to work on the marriage and secure the positives that are keeping the couple connected during infertility treatment.

Recommendations for Future Research

Although this study has added to the body of literature regarding infertility and its effect on marital quality, more research would expand the field and better equip medical and mental health professionals who work with couples experiencing infertility. The following are suggestions for future research:

1. Repeat the study using a larger sample size.
2. Repeat the study and include husbands.
3. Repeat the study using a more diverse sample (varying socioeconomic levels, races, and education levels).
4. Interview women who are currently undergoing treatment and compare their responses to those of women who have completed treatment.
5. Compare the responses of those who had successful treatment ending in pregnancy and those who did not.
6. Research adoption and its effect on marriage separate from that of infertility.

Summary

This chapter included the conclusion, a discussion of the findings and implications of the study. Limitations of the study were presented, and recommendations for family therapists and future research were also included. The results of this study suggest that infertility treatment can be a time of emotional fluctuation or bonding in a

marriage. The monthly cycles of treatment bring on new challenges of hope and resiliency. Many couples from this study found their marriage was unbreakable during infertility treatment, some even externalized infertility and viewed it as something to conquer together. Some couples reported the years of treatment to be the most trying time in their marriage. Despite the differences found in this particular study, infertility remains an important topic on which to keep a dialogue going. In addition, medical and mental health professionals who work with these couples must be sensitive to the situation the couple is attempting to work through and find ways to support them during and after treatment.

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APPENDIX A

Flier for Recruitment

Participants Needed

For a TWU Dissertation Research Study on

INFERTILITY

My name is Kelly Jameson and I am a doctoral candidate conducting a research study for my dissertation at Texas Woman's University in Denton, Texas. The purpose of this study is to explore the question, "Does Infertility Affect Marital Quality?"

The following requirements must be met for participation:

- Participants must be female.
- Participants must be legally married in the United States.
- Participants must be between the ages of 18-44 (on her last birthday).
- Participants must have a diagnosis of female infertility (type not specified).
- Participants must be part of a childless couple during treatment.
- Participants must have been undergoing treatment for a period longer than 12 months.

Participation in this study will include a 45 minute interview with me.
All interviews will remain confidential and names will not be used in the dissertation.

If you are interested in this study, please contact me at the information below. You may also contact my advisor, Linda Metcalf, PhD, at XXX-XXX-XXXX.

Please contact:

Kelly Jameson
(XXX) XXX-XXXX
XXXXX@hotmail.com

APPENDIX B

Participant Consent Form

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: Does Infertility Affect Marital Quality? A Qualitative Study

Investigator: Kelly H. Jameson, M.S. (XXX) XXX-XXXX.
Advisor: Linda Metcalf, Ph.D. (XXX) XXX-XXXX

Purpose:

This research study is being conducted by Kelly Jameson, M.S. as a part of the requirement for a Doctor of Philosophy degree in Family Therapy at Texas Woman's University in Denton, TX. The purpose of the study is to examine if marital quality is affected during infertility treatment as experienced by women based on face-to-face interviews that will last approximately 30-45 minutes each.

Confidentiality/Risks:

Confidentiality will be protected to the extent that is allowed by law. You will not be asked to provide identifiable information and no one will be contacting you following the completion of this interview. Names will be used in the final draft of the dissertation. Audiotapes, demographic sheets, consent forms, and transcripts of the interviews will be kept in a locked cabinet in the researcher's home office. Access to the cabinet will be limited to the researcher. All research data will be destroyed within five months upon completion of this research project. Consent forms will be on file in the Institutional Review Board office of Texas Woman's University.

Because the topic of this project can be difficult to discuss, the researcher will take precautions during the interviews to safeguard the emotional well-being of each participant. The referral list that will be given to participants will serve as therapeutic resources following the interviews. However, if during the interview, the participant or the interviewer requests a break, one will be taken. If the participant requests to end the interview, the interview will end immediately. The referral list will include area therapists who specialize in infertility, local counseling clinics, national infertility organization websites, and books relating to infertility. All participants will receive this referral list.

The researcher will try to prevent any problem that could happen because of this research. You should let the researcher know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Research Procedures:

Your interview will be transcribed and coded for themes. Themes will be identified in the coded data and the researcher will draw conclusion based on those themes. Therefore, analyses are based on anonymous coded transcriptions, rather than your individual responses from the interview.

Interview Data:

All transcriptions of the interviews will be shredded within five months upon completion of this project. The researcher will keep all information in a locked cabinet in the researcher's home office throughout the research process. Only the researcher will have access to the interviews.

Participant Initials

Benefits:

Your participation will add to the body of literature regarding infertility treatment and its possible affect on marital quality. This study may be read by mental health and medical professionals, as well as students and faculty members at Texas Woman's University.

Questions:

If you have any questions about the study following your interview, please feel free to contact the researcher (Kelly Jameson) at (XXX) XXX-XXXX. You may also contact the Texas Woman's University Office of Research and Sponsored Programs at IRB@twu.edu.

Participation:

You will need to set aside approximately 30-45 minutes for this interview process. Participation is completely voluntary. You may withdraw your participation at any point during the process of this study without consequences or explanation. If you choose to withdraw, any data you have provided will be destroyed.

Informed Consent:

The researcher will ask you to sign the Informed Consent document prior to the commencement of the interview. You will be given a copy of this signed and dated consent form to keep. If you have any questions about the research study you should ask the researchers; their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

If you would like to receive a summary of the results of this study, please provide an address to which the summary should be sent.

Participant Signature: _____ Date: _____

APPENDIX C

Referral Sheet

REFERRAL SHEET

Counselors in the Dallas area specializing in fertility issues:

Wendy Bauer
(214) 750-0000
12860 Hillcrest Rd
Dallas, TX 75230

Susan Leonard
(214) 346-3464
9027 Villa Park Circle
Dallas, TX 75225

Deann Ware
(214) 256-9273
5925 Forest Lane
Dallas, TX 75230

Local counseling services:

The Texas Woman's University Counseling Clinic
940.898.8600

National websites of interest:

RESOLVE: The National Infertility Association
http://www.resolve.org
8405 Greensboro Drive, Suite 800
McLean, VA 22102-5120
Phone: 703.556.7172
Fax: 703.506.3266

The InterNational Council on Infertility Information Dissemination
(INCIID – pronounced "inside")
http://www.inciid.org/

American Association for Marriage and Family Therapy
112 South Alfred Street
Alexandria, VA 22314-3061
703-838-9808
http://www.aamft.org

American Counseling Association
5999 Stevenson Avenue
Alexandria, VA 22304
800-347-6647
http://www.cousneling.org

www.asrm.org is the website for the American Society for Reproductive Medicine, a source of information, current advances, and educational materials for infertility patients and clinicians.

www.ivpcare.com is the website for ivpcare, a specialty pharmacy providing medications, supplies and information for infertility patients.

www.anjionline.com is the website for Anji Inc. There is some information about pregnancy, and a helpful section which addresses stress and infertility. They offer CDs for guided imagery, relaxation, etc.

www.inciid.org is the website for the International Council for Infertility Information Dissemination.

www.arcfertility.com is the website for Advanced Reproductive Care, Inc. which offers some financial options/resources for infertility related issues.

www.ivfconnections.com is the website for IVF Connections—an organization which provides couples going through IVF links to information, support, and others going through the same experiences. IVF Connections features IVF bulletin boards, IVF questions and answers, IVF stories, IVF links and an IVF in Canada section.

Books

Aronson, Diane and the staff of Resolve. (2001). *Resolving Infertility*. New York: Harper Resource.

Barbieri, Robert L, Domar, Alice, and Loughlin, Kevin R. (2000). *Six Steps to Increased Fertility: An Integrated Medical and Mind/Body Program to Promote Conception.* New York: Simon & Schuster.

Benson, Herbert, and Klipper, Miriam. (1975). *The Relaxation Response.* New York: Avon.

Benson, Herbert, Stuart, Eileen M., and the staff of the Mind/Body Medical Institute. (1992). *The Wellness Book: The Comprehensive Guide to Maintaining Health and Treating Stress-Related Illness.* New York: Simon & Schuster/Fireside.

Domar, Alice & Kelly, Alice L. (2002). *Conquering Infertility.* New York: Viking.

Domar, Alice & Dreher, Henry. (1996). *Healing Mind/Healthy Woman.* New York: Dell.

Northrup, Participant 1tiane. (2002). *Women's Bodies, Women's Wisdom.* New York: Bantam.

APPENDIX D

Demographic Questionnaire

Demographic Questionnaire

DIRECTIONS: Please fill out the following questions completely. If a question truly does not apply to you, please write N/A.

1.) Age of your last birthday: _____

2.) Ethnicity (Check all that apply):

□ Caucasian □ African American □ Latino/Latina
□ Asian American □ Native American □ Other

3.) Marital Status:

□ Married (first marriage)
□ Remarried (indicate 2nd, 3rd, ...marriage) _____
□ Widowed
□ Divorced

4.) Number of years married to the current spouse: _____

5.) Highest education level achieved (check one):

□ Less than high school
□ High school diploma/GED
□ Some college
□ Associate's degree
□ Bachelor's degree
□ Master's degree
□ Doctoral degree

5.) Employment status (check all that apply):

□ Full time
□ Part time
□ Unemployed
□ Full time parent
□ Full time student

6.) Socioeconomic status/annual household income (check one):

□ Below 20,000
□ $20,000- $39,999
□ $40,000 - $59,999
□ $60,000 – $89,999
□ $90,000-$109,999
□ $110,000 -$150,000
□ $150,000 and above

7.) Religious affiliation (check one):
□ Protestant (specify): _____
□ Catholic
□ Jewish
□ Muslim
□ None
□ Other (specify): _____

8.) Number of years you have been/were involved with infertility treatment:
_____

9.) If so, please list what kinds of treatment have you received?

- *Prescribed medications:*

- *Medical procedures (please list number of times procedure was done):*

9.) Have you experienced any of the following?
□ Eptopic pregnancy
□ Miscarriage
□ Stillbirth
□ None of the above

10.) Did you attend counseling during treatment? (check all that apply):
□ No, I did not attend counseling
□ Yes, I attended individual counseling

□ Yes, I attended couple's counseling with my spouse
□ Yes, I attended group counseling
□ Yes, I attended group counseling with my spouse

11.) Please list the number of children you have now: _____

12.) Please check the avenue in which you gained a child/children:
□ Natural
□ Adoption
□ In vitro
□ IUI
□ Surrogate
□ Other (please list): _____
□ I am child-free

THANK YOU FOR YOUR TIME AND CONSIDERATION!

APPENDIX E

Interview Guide

INTERVIEW GUIDE

Participant's Code: _____

Date of Interview: _____

Introduction:

6. Please tell me a little bit about yourself.
7. Can you tell me about your hopes and dreams you had when you got married?
8. How did you imagine your future with your husband?

Semi-structured Interview Questions

RESEARCH QUESTIONS	**INTERVIEW QUESTIONS**
RQ1.) Does infertility affect marital quality?	IQ1.) What was your personal reaction to your infertility diagnosis? IQ2.) Can you tell me about the quality of your marriage since your infertility diagnosis? IQ3.) Has infertility affected the quality of your marriage? If so, how? IQ4.) What have been your personal reactions to the changes in your marriage?
RQ2.) Does prescribed medication have side effects that affect marriage quality?	IQ5.) Has prescribed medication for infertility affected your marital quality? If so, how?