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A Multicase Study Exploring Women's Narratives of Infertility: Implications for Counselors

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Abstract

Infertility affects 6.7 million women in the United States (Chandra, Copen, & Stephen, 2013). Women's experiences with infertility are not only influenced by biological health factors, but also by social, cultural, and personal variables. Given the prevalence and complexity of infertility, additional research is needed to further examine the nuances of women's experiences. The purpose of this multicase study, as informed by four individual cases, was to explore how women construct their infertility narratives. Review of reflective journals found five common elements: (1) Emotional Rollercoaster, (2) Mind-Body (Dis)Connection, (3) Secret Identity, (4) Supportive vs. Constrained Communication Patterns, and (5) Fatalistic- vs. Agency-Oriented Coping. Increasing our understanding of the whole experience of infertility, beyond the biological diagnosis, is essential to decreasing stigma and increasing the quality of healthcare services available for women.

Keywords

Infertility, Women's Health, Narrative, Counseling

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A Multicase Study Exploring Women's Narratives of Infertility: Implications for Counselors

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Infertility affects 6.7 million women in the United States (Chandra, Copen, & Stephen, 2013). Women's experiences with infertility are not only influenced by biological health factors, but also by social, cultural, and personal variables. Given the prevalence and complexity of infertility, additional research is needed to further examine the nuances of women's experiences. The purpose of this multicase study, as informed by four individual cases, was to explore how women construct their infertility narratives. Review of reflective journals found five common elements: (1) Emotional Rollercoaster, (2) Mind-Body (Dis)Connection, (3) Secret Identity, (4) Supportive vs. Constrained Communication Patterns, and (5) Fatalistic- vs. Agency-Oriented Coping. Increasing our understanding of the whole experience of infertility, beyond the biological diagnosis, is essential to decreasing stigma and increasing the quality of healthcare services available for women. Keywords: Infertility, Women's Health, Narrative, Counseling

Introduction

Infertility affects 6.7 million women in the United States (Chandra, Copen, & Stephen, 2013) and is defined as the inability to achieve pregnancy after one year of unprotected intercourse (Practice Committee of the American Society of Reproductive Medicine, 2013). There are two classifications of infertility: primary infertility and secondary infertility. Primary infertility refers to couples who meet the definition of infertility and have not carried a pregnancy to term (Medline, 2018). Secondary infertility is the inability to achieve pregnancy after having a child(ren) without difficulty (RESOLVE, 2018). For the purpose of this article, the term infertility will be used to describe any woman's desire to pursue parenthood that has been interrupted by physical or social barriers.

Experiencing infertility can affect women's perceptions and experiences of physical, spiritual, emotional, sexual, and psychological well-being (Hurd-Clarke, Martin-Matthews, & Matthews, 2006; Tufford, 2011; Watkins & Baldo, 2004). In many Western cultures, women are raised and socialized to believe they will eventually have children if and when they choose. When this expected milestone fails to occur, psychological distress can become overwhelming (Sexton, Byrd, O'Donohue, & Jacobs, 2010). Reflecting the degree of psychological stress concordant with fertility problems, women describe infertility as the most distressing experience of their lives (Freeman, Boxer, Rickels, Tureck, & Mastroiannai, 1985) and women experiencing infertility problems did not differ on measures of global distress from cancer, cardiac rehabilitation, and hypertension patients (Domar, Zuttermeister, & Friedman, 1993).

Culturally, pronatalist ideals can abound with many women expecting to have children but not necessarily considering if they will be *able* to have children (Spector, 2004). Infertility disrupts a woman's ability to obtain or maintain a valued life activity, even when attempts to manipulate or change the situation, result in infertility-related stress. It is well documented that the experience of infertility is stressful (Born & Preston, 2016; Greil, McQuillan, Lowry, & Shreffler, 2011; Johnson & Fledderjohann, 2012). Infertility-related stress is exacerbated by

elements of unpredictability, uncontrollability, and ambiguity (Gourounti, Anagnostopoulos, & Vaslamatzis, 2010; Hurd-Clarke et al., 2006). Additionally, infertility-related stress is worsened when women perceive a social pressure to have children (Miles, Keitel, Jackson, Harris, & Licciardi, 2009). Further, disruption in the achievement of a valued life activity can result in identity shock, where a woman encounters the painful realization that her “conceptualization of oneself has been irreparable fractured as a result of the failings of the body” (Hurd-Clarke et al., 2006, p. 97). Women have described feelings of alienation and hostility towards their bodies because their status of infertility perpetuates a feeling of defectiveness (Hurd-Clarke et al., 2006).

Women who experience infertility also commonly navigate changes and new challenges in their intimate relationships with their partner. The trek to conceive can be laden with timed intercourse, semen samples, reviewing potential donor profiles, or complicated medical procedures, all of which are determined by the nature of the infertility diagnosis and financial resources available. Sex becoming a scheduled activity can increase relational tension in a couple’s relationship. Additionally, couples may experience varying degrees of interest in obtaining an infertility diagnosis or entering into treatment for infertility for fear that a partner may leave them if they are unable to become pregnant (Spector, 2004). Stress experienced during infertility can be exacerbated by the ambiguity infertility presents. Oftentimes, individuals undergoing infertility treatment do not know if they are permanently or temporarily infertile, nor do their medical providers (Hurd-Clarke et al., 2006).

Infertility has been found to not only bring about negative consequences but also can facilitate individual and partnership growth. Although much of the research designates infertility as a stressful experience (Born & Preston, 2016; Domar et al., 2011; Freeman et al., 1985; Johnson & Fledderjohann, 2012; Sexton et al., 2010; Shapiro, 2009), other research has highlighted experiences of growth (Born & Preston, 2016). Contrasting stress, Born and Preston (2016) found that women experiencing infertility also grew closer to their partner as they navigated, communicated, and problem-solved through their infertility journey.

Given the prevalence and complexity of infertility, additional research is needed to further examine the emotional, behavioral, and contextual nuances of women’s experiences. It is particularly important to increase understanding of infertility, not only as a biological challenge, but as a compounding influence on women’s social and emotional well-being because regardless of which partner has the infertility diagnosis (if one even exists), women’s bodies are the subject of, and primary locus, of infertility treatment (Hurd-Clarke et al., 2006). The purpose of this qualitative, multicase study is to explore how women construct a narrative around their experience with infertility.

A narrative, qualitative approach seeks to understand an experience through the evocation of story (Shkedi, 2005). “Essentially, the study of narrative is the study of the ways humans experience the world” (Grimmett & Mackinnon, 1992, p. 404). Narratives are subjective truths that assist an individual in making sense of their experiences. Further, narratives are a part of our identity and culture. Who we are, what has occurred in the past, and where we are heading are all construed through our self-narrative (Shedki, 2005). Infertility does not exist independently, but is influenced by social, cultural, and personal variables that women respond to cognitively, emotionally, and aesthetically. Therefore, exploring infertility through the narrative that women create is essential to understanding the multiple influences that women use to explain and justify their thoughts and actions (Shkedi, 2005).

About the Authors

An essential component of qualitative case study research is identification of the researchers’ impositions on their study. In this research, the first author acknowledges her own

bias as a woman who has been diagnosed with infertility and has experienced the impact of infertility on herself and her relationships. Conversely, the second author recognizes her bias as a woman who has not personally experienced infertility. The third author served as an external auditor of the data and has not personally experienced infertility but has provided social support to close friends who have experienced infertility.

Methods

We used a multicase study approach to explore how women construct their infertility narrative. The research and data collection processes were approved by the Institutional Review Board at South Dakota State University. Four women shared their stories of infertility through prompted journal entries. A constructivist epistemology guided this research by assuming that individuals “organize and manage their perception of the world through the stories they construct and tell” (Shkedi, 2005, p. 13). The constructed stories describe the past and influence the future. Using a multicase study approach, the research team aimed to preserve every single case’s context and identity, in order to provide in-depth insight into the stories women describe while encountering infertility (Shkedi, 2005).

Participants

In multicase research, each case is understood as “a complex entity located in its own situation” (Stake, 2006, p. 12). To elicit rich narratives, we used purposeful sampling techniques to select participants who had the potential to inform additional research exploring women’s infertility narratives (Charmaz, 2006; Stake, 2006). Multicase research requires at least four, but not more than ten, cases to inform the quintain, or phenomenon that bound the cases in this study together (Stake, 2006). For the purpose of this study, four participants were recruited to complete bi-weekly, reflective journals over 28-days. Each participant and their journal served as a case to be studied and cross-analyzed. Participants were compensated with an Amazon gift card as a token of appreciation for their participation. Additionally, demographic information was collected from participants to add depth to the participants’ narratives.

The following are brief biographical sketches of each participant. Information regarding age, relationship status, duration of infertility and treatment, as well as strategies used to mitigate stress related to infertility, were requested in a demographic questionnaire from each participant. The purpose of providing participant biographical sketches is to assist the reader in understanding who contributed to the data collected. Participants’ names have been replaced with pseudonyms to protect their identity.

Anna is a 31-year-old Caucasian female with a graduate degree who has been married to her husband for three years. Anna has primary infertility. Her infertility history includes trying to become pregnant for two and a half years, seeking fertility treatments from medical professionals, experiencing one miscarriage, and receiving a diagnosis of female factor infertility. Anna has no insurance coverage for infertility treatment, has utilized drugs and hormone therapy to attempt to become pregnant, and has spent approximately \$3,500, in total, on fertility treatment. She has not received mental health counseling for an infertility-related concern but has used books, websites, and online message boards as sources of infertility support.

Lisa is a 37-year-old Caucasian female with an advanced degree who has been married to her husband for five years. Lisa has primary infertility. Her infertility history includes trying to become pregnant for three and a half years and experiencing one miscarriage without the use of fertility treatment. She, nor her partner have a medical infertility diagnosis, but meet the

criteria of experiencing infertility, as they have been trying to become pregnant but have been unsuccessful for more than twelve months. Lisa has not sought traditional medical treatments for infertility but uses acupuncture and other alternative treatments to assist with becoming pregnant. She has not received mental health counseling for an infertility-related concern but does use books, websites, and online message boards as sources of infertility support.

Shelby is a 39-year-old Caucasian female with a graduate degree who has been married to her husband for six years. Shelby has secondary infertility. Her infertility history includes trying to become pregnant for eighteen months and having a diagnosis of female factor infertility. Shelby has no insurance coverage for infertility treatment. She has utilized drugs and hormone therapy to attempt to become pregnant and has spent a total of approximately \$500 on fertility treatment. She has not received mental health counseling for an infertility-related concern but has used books as source of infertility support.

Natalie is a 29-year-old Caucasian female with an associate's degree who has been married to her husband for 10 years. Natalie indicated has secondary infertility. Her infertility history includes trying to become pregnant for 28 months, experiencing one pregnancy without fertility treatment and three pregnancies with the help of fertility treatments. However, all four pregnancies ended in miscarriage. She reported she was diagnosed with female factor infertility four years ago. Natalie's insurance coverage and use of specific fertility treatments is unknown. She has spent a total of \$5,800 on fertility treatment. She has not received mental health counseling for an infertility-related concern and uses websites and online message boards as sources of infertility support.

Data Analysis

The quintan, or phenomenon that bound the cases together in this study (Stake, 2006), was narratives of women experiencing infertility. In this multicase research, the quintan was informed by four individual cases. The research question organizing this study was: How do women construct their infertility narratives? The researchers utilized reflective journal prompts to elicit rich responses, targeted at deepening our understanding of how women experience infertility. Participants were asked to respond to journals prompts twice per week over four weeks. Prompts were generated by the first author in order to gain information about the quintan and included:

- 1) What feelings have arisen during infertility?
- 2) How do you experience your own mind-body connection?
- 3) How has your identity been impacted by infertility? How have you felt about your woman-ness and identity as a mother?
- 4) What relationships have been strengthened by your experience of infertility? What relationships have been stressed?
- 5) How have you coped with the feelings that have arisen during infertility? How have you felt about your past coping?

Multicase study research involves analysis of individual cases where patterns are identified within each case and then compared across cases to integrate into themes (Stake, 2006). Analysis entailed in-depth examination of each participant's responses to the reflective journal prompts. The first and second authors began by independently reviewing participants' journals, underlining or highlighting central elements within every entry, and recording individual and collective responses to each reflective prompt. To ensure consistency of interpretation, the first and second authors met bi-weekly for three months to discuss and establish consensus regarding key elements of each participant's journal entries and to identify similarities and

differences among responses. After establishing the central themes in each case, the cases were compared with each other to identify points of similarity and diversion. The cross-case analysis was then presented to the third author, who served as an external auditor, for feedback and this feedback was incorporated into the final report. Last, the results of the analyses were triangulated with existing literature.

Ensuring Trustworthiness and Credibility

We utilized specific strategies to increase reliability and validity in this multicase study research. Multiple types of information were collected about the cases to strengthen construct validity. Additionally, triangulation, redundancy, and an external auditor was used. Each finding included in this research was triangulated. Triangulation is the process of confirming findings through at least three confirmations, if not more (Stake, 2006). Triangulating the data increases the validity of the findings and is utilized to decrease researcher bias. To reduce the likelihood of misinterpretation, the first and second author reviewed the data multiple times to achieve redundancy of data gathering. This required these authors to read every journal entry at least five times and highlight central findings. These findings were shared with in the biweekly meetings, detailed further in the data analysis section. An external auditor, the third author, was used to build trustworthiness and credibility. This external auditor read the journal entries, reviewed the authors' findings, and provided feedback. Auditor feedback was incorporated into the final findings in this article.

Findings

Findings illuminated five common elements in women's narratives related to infertility: (1) Emotional Rollercoaster, (2) Mind-Body (Dis) Connection, (3) Secret Identity, (4) Supportive vs. Constrained Communication Patterns, and (5) Fatalistic- vs. Agency-Oriented Coping. The subsequent section provides rich descriptions supporting each narrative theme. The findings are presented in order to assist the reader in understanding the central elements that women shared in common, and in difference, when describing their infertility experience.

Emotional Rollercoaster

Women were asked to reflect on the feelings that have arisen during infertility. All participants described great swings in their emotions as they moved through their menstrual cycle. For example, as the first day of a woman's period appears, she is reminded of her previous failed attempt to become pregnant and must prepare herself for the tasks and emotions that arise in subsequent days and weeks. About midway through the cycle, she is preparing to conceive by closely monitoring symptoms of ovulation and ensuring that either intercourse or insemination occurs at the proper time. Then, in the latter half of her menstrual cycle she waits: searching for signs or symptoms of pregnancy or the arrival of her next menstrual cycle. The anticipation of a positive pregnancy test evokes nerves and excitement. The arrival of the menstrual cycle often yields disappointment, grief, and frustration. The first and second authors coded this as *Emotional Rollercoaster*. Shelby identified: "There's the constant hope that my period is late . . . and then the disappointment." Anna also described repetitive experiences of hope and letdown: "I feel disappointment every time I see a negative pregnancy test or ultrasound." Lisa went on to acknowledge, "I feel a cycle of these emotions every month." Participants articulated the dynamic shifts in emotions that occurred throughout the process of infertility, such as: The experience of high hopes for pregnancy, anticipation for conception, awaiting their pregnancy test results, and lastly the deep low of the negative pregnancy test.

Mind-Body (Dis) Connection

Participants were also asked to reflect on their awareness of a mind-body connection. For our study, mind-body connection was not defined for the participants, so women's interpretation of the construct was open. Within journal reflections, participants demonstrated varying levels of awareness regarding how their mental state is connected to their overall emotional and physical experiences. Women also described internal conflict and inconsistency in recognizing moments when their thoughts have steered their emotions and behaviors.

At times, women participants described experiences where they felt a strong awareness of the energy they were giving to their thoughts and how their thoughts impacted their affective and emotional experiences. The research team coded this as *Mind-Body Connection*. Several women recalled past efforts to focus energy on their own mind-body. For example, Natalie identified an awareness of her mind-body connection and emphasized, "It's how I had two babies with no drugs—I built and supported that connection." Anna also discussed increased awareness of her mind-body connection, stating: "... I can look back and see times when I had way too many negative thoughts about infertility and I see how that impacted my mood and attitude at work." She additionally recalled specific moments within her life where she consciously adjusted her thoughts and, as a result, experienced a different emotional reaction:

My husband recently bought some Vitex—a natural supplement intended to help ovulation. Previously I would get mad, and super sad about him wanting me to take these—but now I see he's trying to help—he's not being push—just trying to help and be supportive.

Shelby also highlighted a push-pull battle between her mind and body during her experience with infertility. During the "push," she was aware of the impact of her physical health and well-being on her ability to become pregnant. During the "pull," she became overwhelmed with the stress involved in becoming pregnant and engaged in unhelpful coping, "Trying to get pregnant stresses me out. To deal with the stress, I would eat. Eating means I gain weight, contributing further to my inability to get pregnant." However, the shame that followed her binge eating only exacerbated her already high level of stress. The latter part of this experience highlights the *Mind-Body Disconnection* that women may experience with infertility.

Secret Identity

While reflecting on how infertility has impacted their identity, each woman discussed ways in which their thinking about themselves has shifted. Participants specifically described a desire to protect themselves from the scrutiny of others, thus creating and harboring a secret and vulnerable identity, coded as *Secret Identity*. Anna described her altered identity as "like someone who is abnormal because of my infertility." Anna recounted social experiences that have impacted how she perceived herself: "People, especially extended family, are always wondering why we don't have kids." Lisa described "I'm keeping a front of some sort—I don't want to be overly vulnerable in this respect—I don't want people to feel sorry for me/us." The women participants shared the ideal of self-protection and hiding their struggle from others in order to maintain a particular social presence.

Supportive vs. Constrained Communication Patterns

Participants were asked to consider how their relationships have been strengthened or strained during their infertility experience. *Supportive communication patterns* were

alternatively tied to participants' increased sense of connection or communication with others and these interactions were described as an important source of support during the infertility experience. *Constrained communication patterns* were denoted by participants descriptions of unshared infertility struggles and interactions that seemed to contribute to overall stress or a sense of isolation. Unprompted, each participant discussed their spousal relationship and their connections with friends or other family members. Both supportive and constrained interactions were highlighted.

Spousal relationship. The infertility experience served to both strengthen and strain spousal relationships. Lisa explained, "My relationship with my husband has been both strengthened and stressed. It has strengthened us in that we have had to become more open and transparent. It has been stressed because this process has been stressful." Natalie expressed appreciation for her husband's support throughout the IVF process:

My husband has been awesome through all of this and didn't even question the choice to pursue IVF. I stress about money a lot and he has gone out of his way to reassure me that the money isn't a problem.

In their experience of infertility, these participants illuminate the fortification that can occur from persevering difficult experiences with a close other.

With support also came constrained communication with spouses. Anna reflected on her personal challenge with recognizing her spouse's support, referencing existing turmoil and a desire to continue to improve their relationship:

My relationship with my husband has been both strengthened and strained. Until I accepted the fact that [husband's name] is only trying to support me, I would stress our relationship. Now, I remember to put us first, if we're not healthy, and in a loving, strong relationship the environment won't be good for a child.

For these participants, infertility seemed to also be accompanied by strained communication with their partner. While infertility is a challenging experience, it has the potential to foster growth and challenge.

Extended family and friends. In addition to discussing their spousal relationships, women reflected on their relationships with friends and other family members. Participants again highlighted both *Supportive* and *Strained communication patterns* during their infertility experiences. For example, Natalie reflected on her relationship with her non-biological grandmother, sharing the story of how her grandmother's daughter struggled with infertility while her step-daughter (Natalie's biological mother), married multiple times, and conceived eight children. She explained, "I also feel like maybe my grandma understands more because of how she supported my aunt when she struggled to get pregnant."

Similarly, Shelby discussed her relationships with relatives and others who have struggled to get pregnant; noting that her compassion and understanding of their struggles has grown. Shelby also reflected on her relationship with her daughter, writing: "I don't take her for granted, especially knowing she may be the only one. If there is any silver lining to this struggle, that is it. I cherish her even more." For these participants, supportive communication patterns were denoted by relationship growth that seemed to stem from increased communication, shared experiences, and general support.

Constrained communication patterns, with friends or other family members, seemed alternatively derived from unshared infertility struggles, restricted communication, increased stress or a general sense of isolation. Shelby explained:

I feel awkward around my family and friends who don't know that we're struggling to get pregnant. They mean well when they suggest it is time to give [daughter's name] a sibling, but they have no idea what their suggestion does to me. It is difficult not to internalize it as criticism or failure.

Lisa additionally highlighted cumbersome communication patterns with her own parents and noted that these strained relationships compounded her overall infertility stress: "The stresses on relationships adds to the stress."

Fatalistic- vs. Agency-Orienting Coping

Women also reflected on the ways they have attempted to cope with the various emotions they have experienced during infertility. They commonly described beliefs they ascribed to that were either fatalistic- or agency-oriented. In *Agency-Oriented Coping*, some women attempted to regain a sense of control by anticipating disappointment and recognizing the trend of the emotional rollercoaster ride accompanied by infertility. Shelby and Lisa more readily identified and described strategies they employed for coping with challenging emotions. These women seemed to enact agency in the face of adversity. For example, Shelby was able to identify past coping efforts that were helpful. This included reaching out for support from others and simply allowing herself to cry when needed. Additionally, she acknowledged using food to cope with difficult feelings, which in her eyes, "further exacerbates the problem" by causing weight gain and confounding her fertility.

Other women seemed to give up control by casting anger toward a higher power or even themselves. Moreover, these women described a fatalistic view of themselves in which they are powerless in their circumstances, which the research team coded as *Fatalist-Oriented Coping*. For example, Natalie described how it had been easy to become pregnant once but very challenging for her at a later time in life, "I never expected to be in this situation. . . . It seems so unfair that it would come so easily before, but so difficult now." and as she compares herself to others: "Why was it so hard? Why did everyone else have it so easy? Why is everyone else getting what I want? Anger obviously turned into jealousy. . . . I don't understand why I have these issues." Here, Anna questions why she seems to have been individually persecuted or chosen to suffer while others have it easier than she. Of note, and supporting their fatalistic exclamations, these two women also forewent describing active strategies they might use to cope with their challenging emotions.

Discussion

Women's experiences of infertility are influenced by social, cultural, and personal variables that women respond to cognitively, emotionally, and aesthetically. Therefore, exploring infertility through the narrative that women create is essential to understanding the multiple influences that women use to explain and justify their thoughts and actions. Review of reflective journals maintained by each woman found five common elements in women's narratives related to infertility: (1) Emotional Rollercoaster, (2) Mind-Body (Dis) Connection, (3) Secret Identity, (4) Supportive vs. Constrained Communication Patterns, and (5) Fatalistic-vs. Agency-Oriented Coping. The impact of infertility is gendered and situated in gender roles and norms (Hurd-Clarke et al., 2006). Describing the elements of women's infertility narratives

is essential in order to increase counselor awareness of the implications of infertility. Without this knowledge, professionals lack empathy and understanding of the unique and varying experiences of women experiencing infertility. The following includes a discussion of findings as well as practical implications for counselors. While data from our small sample cannot be assumed global, information expanding awareness and practice with women experiencing infertility is essential to providing empathic mental health care.

In this narrative multicase study, women identified a range of negative emotions because of infertility. Women participants described previously reported experiences of the buildup of hope with each attempt to become pregnant, followed by great sadness and letdown when they received a negative pregnancy test (Born & Preston, 2016; Covington & Burns, 2006). Counselors working with women who have experienced infertility must be sensitive to the difficult emotions that arise. Preventatively assisting women, by increasing their awareness of the common emotions experienced in relation to infertility, would be ideal. Many women, however, may not seek counseling until after they have dealt with these challenging emotions for some time. Therefore, validating these challenging emotions when they occur is imperative. Beyond validation, it is essential for counselors to provide simple and effective coping mechanisms for managing challenging emotions, such as mindfulness, deep breathing, relaxation techniques, exercise, and social connectedness (Galhardo, Cunha, Pinto-Gouveia, & Matos, 2013). Instilling coping mechanisms allows women to proceed with engagement in the multiple roles of their lives and also prevents engagement in unhealthy coping.

Next, participants described a *Mind-Body (Dis)Connection* as they expressed varying levels of awareness regarding how their mental state is connected to their overall emotional and physical experiences. Some women acknowledged their autonomy and their ability to influence their emotional and physical well-being while others seemed to dismiss, deny, or experience frustration with their physical and emotional health. Partaking in targeted activities to increase mind-body connection is found to reduce stress for women experiencing infertility (Domar et al., 2011). Our Western social perpetuation of the mind and body disconnect can leave women lacking the resources needed to cope with infertility related stressors and to confidently manage their own physical and mental health. Counselors may assist women experiencing infertility by identifying common behaviors they may engage in when they become overwhelmed by stress; such as overeating, irritability, social withdrawal, anxious thoughts or behaviors that interfere with work or relationships. Increasing awareness of these behaviors can help women to identify antecedents and to enact alternative responses that better promote overall well-being.

Women participants also described a desire to protect themselves from the scrutiny of others through the element of a *Secret Identity*. This is consistent with existing literature that has illuminated how women's thoughts about themselves may evolve throughout their experience with infertility (Born & Preston, 2016; Ceballo, Graham, & Hart, 2015; Johnson & Fledderjohann, 2012). When this failed milestone interrupted their lives, women experienced an existential crisis and began to question their worth, their spiritual roots, their value, and contribution to their community. Women also articulated feeling as though their body was defective. This is consistent with existing research which has found that when a woman is diagnosed as having infertility, it can make her feel broken or unhealthy, when they had previously believed they were well and healthy (Hurd-Clarke et al., 2006; Spector, 2004) which has been associated with greater infertility-related stress (Jacob, McQuillan, & Greil, 2007). Counselors can act as agents for reducing self-stigma surrounding infertility by having open, and gentle assumptive dialogue. Gentle assumption helps counselors reduce stigma and apprehension by asking questions in a way that assumes the difficult experience has already occurred (Williams, Edwards, Patterson, & Chamow, 2011). For example, a counselor may

ask: “Tell me about how your relationships have been challenged since experiencing infertility.”

Next, women identified both growth and tension in their relationships with their spouse and others during their infertility experience. *Supportive vs. constrained communication* patterns played a central role in participants’ infertility related stress. Women expressed both appreciation and a desire, for more open or supportive conversations about their infertility experience. Existing literature has highlighted how supportive family and partner relationships can significantly decrease a woman’s infertility-related stress (Gibson & Myers, 2002). Additionally, relationship satisfaction, cohesion and positive expression of affect have been shown to be contributors to decreased infertility-related stress (Galhardo et al., 2013; Peterson, Newton & Rosen, 2003). These findings emphasize the importance of counselors addressing and promoting additional social supports for women experiencing infertility. Validating and normalizing discomfort with social events and perceptions reduces pressure and stigma. Further, assisting women in building safe and supportive networks is essential to promoting overall wellbeing (Martins, Peterson, Almeida, & Costa, 2011).

Finally, women identified a variety of strategies to cope with challenging emotions during infertility, noted as *Fatalistic- vs. Agency-Oriented* approaches to coping. Embracing the diversity of responses to challenging emotions experienced with infertility allows a safe place for women to express themselves and also to feel understood. This binary of fatalism and agency have been described in the existing health beliefs literature. Bell and Hetterly (2014) summarized fatalism as a belief of powerlessness and passivity in reaction to health and agency as a belief of activism, capability, and control of health. This existential dilemma was also noted in Born and Preston’s (2016) study where women with infertility were found to question their personal worth if they were not able to achieve the key role of becoming a mother. Counselors are encouraged to explore locus-of-control with women experiencing infertility, as greater external locus of control has been found to have a strong positive relationship with greater infertility-related stress (Alizadeh, Faraahani, Shahrarai, & Alizadegan, 2005).

Limitations of Current Research

While this study presents important qualitative findings on the cognitive, affective, and social narratives women create surrounding infertility, a larger sample size may provide additional insight into women’s infertility narratives. It is important to note, however, that the purpose of this study was not to generalize across all women, but rather to gain a more in-depth understanding of women’s lived experiences. Further, our sample remained consistent with the demographic of existing research in infertility, exploring Caucasian, middle-income, educated, heterosexual women’s experiences. Further research is needed to explore the narratives that diverse women and their partners construct around their infertility experiences.

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