Institute for Clinical Social Work

The Experience of Infertility among African American Couples

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By

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Abstract

This study examines the experience of infertility among African American couples. Six couples married for 10 or more years were interviewed. At least one member of each couple has been diagnosed with infertility. Three of the couples were able to conceive together following fertility treatment. Two couples were unable to conceive following treatment and decided to adopt. One couple did not seek treatment and have been unable to conceive. A phenomenological research approach was utilized to analyze the data and formulate the results. The personal stories provided by the couples illustrate the profound impact the experience of infertility has had on their lives. The findings demonstrate how infertility can be a traumatizing event that is experienced differently by men and women. The distress of the experience challenges one's sense of self. The findings also suggest how religion and spirituality played a central role in the lives of the couples, helping them to cope with infertility.

For the Walker Family

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Chapter I

Introduction

General Statement of Purpose

The purpose of this research project was to study the experience of infertility among African American, heterosexual, couples. The sociological research literature is for the most part, quantitative and speaks to African Americans being reluctant to seek infertility treatments as a result of religious beliefs, lack of awareness about infertility, shame, fear, lack of support, distrust of the medical community, economic barriers, lack of access to health care, and a preference for informal or formal adoption. Because of a lack of qualitative research on the experience of infertility among African American, heterosexual, couples, the researcher wants to narrow the gap with this research project.

Significance for Clinical Social Work

Infertility as it relates to African Americans is rarely examined and overshadowed by high pregnancy rates among teens and sexually transmitted diseases as well as other health related issues that plague this ethnicity group. In addition, infertility can be viewed as a taboo issue and direct threat to the virility of African American men and women. The reality is that this issue does exist and is more prevalent than it seems. Objectives were the following: a) Exploring what the experience of infertility is like for African American men; b) Exploring what the experience of infertility is like for African

American women; c) Exploring what the experience of infertility is like for the African American couple.

The study's findings contribute to the body of knowledge of clinical social work. Increased research evidence will lead mental health practitioners to assess the problems and treatment needs of African American couples. Furthermore, practitioners can possibly advocate for appropriate interventions and policies to improve services to this identified population.

The study utilized a phenomenological research methodology to study the impact infertility has had on the couples lives. This method explores in depth the meaning of parenthood for couples, the dynamics of relationships, and how the self is impacted by infertility.

History of the Problem

According to May (1995), prior to the nineteenth century, childlessness among women unable to conceive or carry to term was considered a misfortune. It was important for women to produce as many children as possible so that they could contribute to community production. The ability to give birth was viewed with awe and mystery. Women who were unable to procreate were viewed with suspicion and looked down-upon for their inability to contribute to the community. Barren women were resigned to prayer, acceptance of their fate or assisting others with child rearing.

During slavery, African American women who had the ability to procreate were considered prized possessions (May, 1995). "Slave breeding" (May, 1995) ensured more African American births and correspondingly more valuable slave labor. Women who

chose to bear children received some privileges and protection such as avoiding hard labor in the fields. Their owners did not want to risk any harm to an unborn fetus. The financial investment of the slave labor was too great to take a chance on compromising the health of a pregnant slave. As a form of resistance, it is believed that some women refused this practice of breeding (May, 1995). Although refusing to bear children came with many risks, it gave some women a sense of control over their lives in the face of slavery.

Following slavery, White people were no longer concerned with the fertility of African American children (May, 1995). As a result, the birth rate of African American children declined from 58.6% in 1850-1860 to 34.4% by 1910 (Farley, 1966). The birth rate for White children declined as well from 50% in the 1800's to 30% by 1900 (as cited in Elman, 2014). At the same time, the United States was becoming diverse as immigrants began to arrive from southern and Eastern Europe (May, 1995). In addition, because of advancements in health care, economics, and a shift from agriculture toward manufacturing, the quality of children was preferred over quantity.

The low birth rate among the White population and growing diversity of the United States was so great a concern that President Theodore Roosevelt made reproduction reform part of his national agenda (May, 1995). Advertising ads, magazine articles, contests and even the establishment of Mother's Day as a holiday in 1914 to promote and glamorize motherhood, did nothing to increase reproduction.

In 1909, performed by physician Addison Davis Hard, the first recorded artificial insemination by donor (AID) occurred in the United States (May, 1995). The successful experiment was the result of his work with a White, childless, married couple, in which

an examination revealed that the husband had no sperm in his semen. There were other accounts of artificial insemination prior to and following Dr. Hard's experiment. Some of the experiments were successful, other were not. The medical world viewed artificial insemination as a controversy because it challenged traditional beliefs about marriage, family, sex and reproduction (May, 1995). The medical world was less concerned with ethical issues regarding lack of patient informed consent and full understanding of the experiment process (May, 1995).

The concern with the low birth rate of white children shed a light on infertility. Researchers in the early 1900's began examining causes of infertility in White women. Their findings attributed the cause of infertility to education, careers, and the contraction of venereal disease from men (May, 1995). Women were to blame for their own childlessness.

There were also many White women who were involuntarily childless. Those leading the reform of involuntary childlessness and reproductive technology were mostly White, middle class individuals concerned with the sagging reproduction of their race (Roberts, 1997). Infertility among the poor and non-White was not of concern to researchers. They were concerned with improving the reproductive rates of their race.

By the mid-1940s the childlessness or infertility rate was twice as high among African American women than for White women (May, 1995). This alarming rate was the result of poverty, disease, poor health care and access to medical services (May, 1995). In addition, complications of childbirth and abortion, and environmental and workplace hazards have also contributed to the high incidence of infertility among African American women (Roberts, 1997).

African American women and men were subjected to forced birth control via contraceptive vaccines and sterilization procedures (Roberts, 1997), many of them unknowingly undergoing these procedures without their consent. Fannie Lou Hamer, the leader of the Mississippi Freedom Democratic Party, went to the hospital in 1961 to have a small uterine tumor removed and the doctor performed a total hysterectomy without her knowledge or consent (Roberts, 1997). Sterilization abuse via deceit or manipulation of uniformed or uneducated African Americans occurred often in an effort to exact population control. There was the fear and assumption that African Americans produced too many children, presumably resulting in an increase in welfare recipients (May, 1995).

Although the infertility rate is higher among African Americans than compared with other races, this issue is overshadowed by teenage pregnancy, violence, crime and sexually transmitted diseases as well as other health related issues that plague this ethnicity group. In addition, infertility often is viewed as a taboo issue and direct threat to the virility of African American men and women.

Chapter II

Literature Review

Overview of Infertility

Infertility is defined as the inability to become pregnant after 12 months of unprotected sex (intercourse) because of a male factor, female factor, a combination of factors in both partners, or there is no explanation (Vorvick, 2012). Diamond et al. (1999), Stoppard (2000), and Burnett (2003) have identified three categories of infertility: primary infertility, secondary infertility, and subfertility (as cited in Burnett, 2009, p. 167). Primary fertility is the experience of never having had a child. Secondary infertility is the inability to conceive or achieve a live birth after previously bearing one or more children. When both members of a couple have had children in prior relationships, but are unable to conceive together, subfertility defines their condition. For the purpose of this study, infertility is defined as the inability of a couple (man and woman) to achieve pregnancy after one year of regular sexual intercourse without the use of birth control as well as the inability to carry a pregnancy to live birth.

According to the National Survey of Family Growth conducted from 2006-2010 (Chandra et al.) the number of women between the ages of 15 – 44 with an impaired ability to have children is 6.7 million or 12.3%. The number of married women ages 15 – 44 who are infertile is 1.53 million or 6.1%. Causes of female infertility may be a result

of problems with egg production or fertilization, autoimmune disorders, defects of the cervix and uterus, ovarian cysts, clotting disorders, excessive exercising, eating disorders, or poor nutrition, and tumors (Vorvick, 2012). Some form of male infertility such as structural abnormalities, sperm production disorders, ejaculatory disturbances and immunologic disorders was found in 9.4% of men aged 15–44 and 12% of men aged 25–44 (Chandra et al., 2013).

There are a number of factors that can affect the fertility of both men and women. For men, these factors include the following: heavy use of alcohol, substance abuse, long-term chronic disease (for example, diabetes), obesity, infection, sexually transmitted disease, older age, exposure to high heat for prolonged periods, impotence, previous chemotherapy, radiation exposure, retrograde ejaculation, smoking, surgery or trauma, exposure to certain medications or toxins, hormone deficiency or imbalance (Vorvick, 2012). For women, these factors include the following: heavy use of alcohol, substance abuse, long-term chronic disease (for example, diabetes), obesity, infection, sexually transmitted disease, older age, scarring as a result of infection, previous chemotherapy, radiation exposure, smoking, surgery or trauma, exposure to certain medications or toxins, hormone deficiency or imbalance (Vorvick, 2012).

Infertility affects 7.2% of married African American women between the ages of 15 and 44 (Chandra et al., 2013). This percentage is higher than White women (5.5%), Hispanic or Latina women (6.1%), and Asian women (5.6%) who are in the same demographic (age, education, socioeconomic status). In addition, African American men between the ages of 25 and 44 have an infertility percentage of 1.6%. This percentage is

higher than White men (0.8%), Hispanic or Latino men (1.3%), and Asian men (1.4%) in the same demographic (age, education, socioeconomic status).

The physical symptom of infertility is the inability to become pregnant. Griel et al. contend that "the process of "becoming infertile" is a dialectical one in which husbands and wives interpret, respond to, and give meaning to physical symptoms and physiological conditions" (1988, p. 174). Society, physicians, and infertile couples tend to view infertility as the woman's problem despite the husband or wife or both having a diagnosed medical condition. As a result, Griel et al. (1988) and Jordan and Ferguson (2006) found in a review of literature that women are more likely to seek out information and initiate treatment for infertility (as cited in Sherrod & DeCoster, 2011, p. 30).

There is a standard protocol for infertility treatment. Before administering treatment, a complete medical history and physical examination of the husband and wife must be completed by a physician. Tests in women include the following: blood hormone levels, check of ovarian reserve, pelvic ultrasound, laparoscopy, ovulation predictor kit, pelvic exam, progestin challenge if periods are infrequent, serum progesterone, body temperature charting to check for ovulation, and testing of thyroid function (Vorvick, 2012). Testing in men includes: semen analysis and testicular biopsy.

Treatment of infertility depends on the cause and can involve education and counseling, medical procedures, and medicines to treat infections and clotting disorders, or promote ovulation (Vorvick, 2012). Eighty-five to ninety percent of infertility cases are treated via drug therapy or surgical procedures ("The costs of infertility treatment," 2011). In addition, less than 3% of cases need assisted reproductive technologies (ART - surgically removing eggs from a woman's ovaries, combining them with sperm in the

laboratory, and returning them to the woman's body or donating them to another woman) like in vitro fertilization (IVF - eggs are removed from a woman's ovary, fertilized with sperm in a laboratory procedure, and then returned to the woman's uterus) (“IVF/ART,” 2015).

The cost of infertility treatment is expensive and poses a financial hurdle to those who cannot afford to pay for it. Many health care plans do not provide coverage for ART treatments such as IVF (Jain, 2006). Treatment is expensive and the average cost for ART in the United States is $12,500 (“The costs of infertility treatment”, 2011). Treatment is primarily a fee for service model so clients have to pay out of pocket. According to the United States Census Bureau, the median household income in 2013 was $51,939 (DeNavas-Walt & Proctor, 2014). To date, the following fifteen states now require insurance companies to provide some level of coverage for infertility treatment: Arkansas, California, Connecticut, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, Texas and West Virginia (“The costs of infertility treatment”, 2011). Most ART facilities require full payment before providing services (Jain, 2006).

Cultural Considerations

Infertility affects couples from all cultural backgrounds, though most infertility related research tends to focus on the White middle class. Gerrity (as cited in Burnett, 2009) indicates that most research regarding infertility tends to focus on the White middle class. This can be attributed to the fact that White couples seek treatment for infertility earlier and in greater numbers than other racial/ethnic groups and that there

may be barriers to treatment for non-White people. Race and ethnicity based discrimination (intentional and unintentional), low socioeconomic status, and related limited access to health care can impact effective and culturally sensitive infertility interventions (Caesar and Williams, 2002). Generally speaking, individuals who encounter culturally insensitive healthcare providers are less likely to move forward with services. In addition, lack of appropriate education/information and cultural bias against infertility treatment can also be attributed to the underutilization of infertility services among minority groups.

There are many reasons why some Black people often fail to get diagnosed and treated for infertility early (Jain, 2006). Aside from discrimination, socioeconomic status, and limited access to health care, African Americans have a lack of comfort and trust with medical interventions (Burnett, 2009). This is because of past medical abuses, including the Tuskegee Experiment, in which African American men were denied medical care for syphilis. As a result, there is a shared belief among many African Americans that symptoms of disease are a part of life and must be endured (Sherrod & DeCoster, 2011).

Another factor that supports failure to get diagnosed and treated for infertility is the negative attitude toward infertility among African American men. African American men equate fertility with potency and struggle with how they may be contributing to the couple's infertility (Burnett, 2011). Regarding infertility as a threat to his maleness, thus evoking feelings of vulnerability, the African American man may disconnect by indicating his wife as the responsible party for fertility (Burnett, 2009; Sherrod & DeCoster, 2011). In addition, as the result of the stigma often associated with infertility

among the African American culture, findings from previous studies (Sherrod, 2006) indicate an unwillingness of men to disclose information related to infertility (as cited in Sherrod & DeCoster, 2011, p. 34).

In a study of minority groups, Inhorn et al. (2008) generated many fey findings regarding African American women and infertility. Most salient to this study are the following:

- African American women experienced infertility as a "highly stressful, devastating event" that "tore at the very foundations of their sense of self and womanhood" (p. 186).
- They often relied on religion and spirituality to cope with the emotional pain.
- African American women expressed taking their fertility for granted because of the assumption that it was not an issue.
- The inability of an African American woman to conceive is in stark contrast to historical public images of her as a highly sexualized object who is quite fertile, bearing way too many children to the detriment of society.
- African American women experienced a lack of willingness to participate in treatment seeking options on the parts of their husbands.
- Financial barriers greatly affected the ability of African American couples to seek treatment. They either gave up or attempted to negotiate a payment plan with their healthcare providers.
- Many of the African American women in the study struggled through the experience of infertility in isolation because of shame or embarrassment.

- The experience of infertility strained relationships with partners, family and friends.
- African American women in the study coped with infertility through religion and spirituality.

The African American women in this study experienced the effects of "stratified reproduction, including poverty, lack of access to affordable, high-quality reproductive health care, and marginalization within the United States" (p. 194). Embedded in this experience for the African American women in this study is a societally supported belief about self as less than and unworthy of becoming a parent.

Psychoanalysis and Infertility

There has been some debate about whether or not infertility can be caused by psychological conditions. Apfel and Keylor (2002) report that between 1951 and 1997, case reports and papers about psychogenic infertility, a condition in which psychological factors interfere with the body's ability to make pregnancy possible, have been written. Inquiry into psychogenic infertility began in the 1950's when researchers began to look at unconscious conflicts that could be preventing pregnancy in women with unexplained infertility (Wischmann, 2003). It is reported that the prevalence of psychogenic infertility lies at 10-15 percent (Wischmann, 2003).

In addition, psychological factors can be contributed to couples that are able to conceive naturally as well as those experiencing infertility (Zalusky, 2000). Stress, psychiatric issues, psychosomatic and maladaptive behaviors can be the resulting

behaviors of couples experiencing infertility. Apfel and Keylor (2002) indicate that in their clinical experience,

> …common are feelings of grief, anxiety, despair, depression, rage, envy of others babies, futility and magical thinking, all of which follow from being deprived of parenthood while enduring painful and humiliating medical procedures. The loss of parenthood is multifaceted and involved more than the loss of fertility; there is loss of spontaneous sexuality; of the pregnancy experience itself, of children and genetic continuity. There is stigma and isolation. (Our Clinical Experience, para. 1).

Therese Benedek in her psychoanalytic work and research with infertile married women in the 1950's theorized that infertility in women was the result of the unconscious repudiation of femininity and motherhood and fears of sexuality. Infertility was viewed by Benedek as a somatic defense that protected the self and child. In addition, it allowed the woman to be consciously ambivalent about her wishes for motherhood. Psychically fragile women would experience a spontaneous abortion or hyperemesis. In Benedek's study with six married women whose husbands had low sperm counts, it was inferred that the female subjects unconsciously chose infertile men to marry as a defense against pregnancy.

In response to Benedek's work and theories, some infertility clinics made psychiatric evaluations part of their protocol and procedure in order to determine if a patient was experiencing a biological issue or psychogenic infertility (as cited in Benedek et al., 1953, History of the Concept of Psychogenic Infertility, para. 2). In addition, self-

report tests were administered at infertility clinics that clearly mirrored the culture of feminine role compliance and infertility (Apfel & Keylor, 2002).

Wischmann (2003) on the other hand, indicates that there is not enough scientific data to support psychogenic infertility. The author points out that documented studies of psychogenic infertility utilized observations from small numbers of participants to make very broad statements about this issue. In addition, the author strongly feels that unexplained fertility is equated or used interchangeably with psychogenic infertility. Unexplained infertility is the result of an inadequately diagnosed organic disorder, whereas psychogenic infertility has to do with infertility attributed solely be psychological factors. The author also points out that many studies focus exclusively on women. More research needs to continue to be conducted regarding the psychological factor of male infertility (Palti, 1969). Overall, the author calls for more controlled studies on the effects of psychological stress on fertility in men and women.

Regardless of the cause of infertility, there are psychological effects that infertility has on an individual. These effects remain long after medical treatment has ended. Leon (1996) and his colleagues found that many women who experienced infertility were unwilling to seek psychotherapy. The narcissistic wounds of loss, body failure, helplessness and a ruptured sense of self create an impasse to psychodynamic treatment. Women experiencing infertility are less receptive to traditional psychotherapy in which "they are analyzing conflictual parts of themselves, then seeking and needing to feel whole again" (p. 345). The author calls for a more flexible approach to treating women who experience infertility. In particular, Leon (1996) finds that the use of self-psychology is beneficial in understanding and treating narcissistic injuries to self, marital, sexual and

social life as the result of infertility. Treatment using the self-psychological approach should be open-ended, with an emphasis on resonating with the woman's affective states, loss, restoration of self, and peace with one's decision or outcome. Leon views this form of treatment as more empathic and supportive of women struggling with the upheaval infertility has caused to their life.

In regard to psychodynamic work with couples, Pines (1990) and Leon (2010) acknowledge the importance re-establishing narcissistic equilibrium, satisfaction with self and the marriage. Like in individual therapy with infertility patients, there needs to be a focus on flexibility, utilizing a self-psychological approach. Leon (2010) indicates work may be segmented, with grief and loss occurring before exploring the narcissistic injury of infertility. The therapist must be open to fluctuations in frequency and meeting, as well as balancing individual and couple's work. Utilizing empathy, the therapist can synthesize and articulate the client's inner world of thoughts and feelings, enabling her and/or him to feel deeply understood and accepted.

Feminist Theory

Notwithstanding the complexity of feminism, a theory that seems to defy a consensus definition (Chodorow, 1978), it is critical in thinking about the topic of fertility, which historically has been rooted in the binary construction of gender. In exploring the experiences of heterosexual, African American couples, coping with infertility, feminist theory grapples with gender in its breadth and its multicultural dimensions (Hooks, 2000).

Gender is a broad, multicultural issue (Hooks, 2000). The term has traditionally been used to understand the differences between men and women. Scharf (1995) indicated that gender should also be used to identify individual differences among men and women (as cited in Stewart and McDermott, 2004, p. 436). Benjamin (1995) however, feels that there is too much emphasis on difference, which then dilutes the commonalities that exist among men and women. What occurs instead is an idealization of masculine traits and values and a devaluation of feminine traits and values. Benjamin (1988) argues that gender polarity "creates a painful division within the self and between self and other; it constantly frustrates our efforts to recognize ourselves in the world and in each other" (p. 172).

As infants, males and females first identification is with their mother. This identification with mother is a continuous process for females, but not for males (Chodorow, 1978). As a result, a girl continues her Oedipal identification with the mother, whereas the boy must experience an Oedipal crisis, give up his identification with his mother and begin to identify with his father. In most homes, the mother is the more prominent caretaking figure. This causes girls to identify more directly with their mother and female oriented roles and behaviors. The girl learns how to be a female, a woman. This is a continuous, generational process. Throughout life, women are surrounded by a female constellation. This is not the same experience for boys who must learn to "develop a masculine gender identification and learn the masculine roles in the absence of a continuous and ongoing personal relationship to his father" (p. 176). Nonetheless, boys are taught in a very conscious and deliberate manner to be masculine.

Via the identification with the mother, females view motherhood as a natural instinct or necessary developmental stage (Ulrich & Weatherall, 200). Motherhood provides women with fulfillment and a sense of worth as well as a further identification with the female gender. The inability to achieve motherhood as a result of infertility causes disappointment and role failure. Feminism dictates that a broader definition of motherhood, and diversity in the cultural roles and expectations for women. There should be less emphasis on how the inability to become a mother is equated with disruption in the life plan or a flaw.

Gender and Infertility

The relationship between gender and infertility is important to understanding how individuals construct their meaning of this experience. A woman's wish for a child is based on her identity as a woman (Leon, 1996). Parry (2005) found in her research that women have conceptualized a traditional vision of the family. Family is viewed as a union of two married, usually heterosexual parents with children. Children are viewed as a key component to the social construction of family. Stoller (as cited in Pines, 1990, p.561) explains that this concept is because of the traditional view of gender identity that is established and reinforced by parental attitudes into a core gender identity.

Pines (1982) provides the following explanation for why reproduction is tied into self-image:

> For women alone, there is an additional maturational task, for although a woman's mature body concretely resembles her mother's, she is faced with the dual and conflicting tasks of identifying with her mother's female capacities, whilst at the same time emotionally separating from her and taking over

> responsibility for her own sexuality and her own body. Pregnancy the final stage of identification with her own mother, rooted in a bodily identification with her, contributes to the fulfillment of a girl child's ego ideal which contains her own maternal self in identification with her fertile mother. Thus we may see that, for the small girl, trust in her future capacity to bear a child as her mother did is critical in the confident development of her sense of femininity, sexual identity and self-esteem. These can come to fruition only when her body achieves physical maturity. Pregnancy fantasies and wishes may thus be seen as a normal part of the small girl's future identity, a goal to be achieved in her adult life. (p. 562)

Chodorow (1978) theorizes that the basis for parenting in both genders is developed through the development of the early relationship with the primary caretaker. In particular, women more than men, seek to be mothers in order to obtain gratification from the mothering relationship and to possess psychological and relational capacities for mothering. The experience of having been raised by a woman, leads to daughters growing up having an identification with their female figure and expectation that they, too will be able one day to inherit or possess this role through procreation. In addition, giving birth to a child allows the woman to experience a realignment called the motherhood constellation (Stern, 1995). The motherhood constellation begins in pregnancy and can last for months or years. The mother becomes organized around the wellbeing, connection with, and protection of her baby. Her identity shifts "from daughter to mother, from wife to parent, from careerist to matron, from one generation to the preceding one." (p. 180). During this period, her interests and concerns are more with her mother and less with her father. She develops a stronger bond and identification with

her mother-as-mother. She also seeks out other women who are mothers and available to offer support and shared experiences.

Knowledge that like her mother, she possesses the ability to have children, forms part of the woman's identification with her mother or other women (Notman, 2003). As a result, women learn early on that they have an internal clock that times the monthly cycling of their menstrual periods and provides a sense of bodily changes over time. The internal clock also counts down the limited time the women have for childbearing. In healthy women, fertility begins to decline by the late 30's. Menopause, the ending of fertility, typically occurs around the age of 50 for women. For women who experience infertility issues, there is a sense of urgency and disappointment.

Infertile women not only number their days in terms of fertility, but also their time on earth (Leon, 1996). For many women, having children is central to their identity. They begin to struggle with their self-definition and self-esteem. Feelings such as anxiety, anger, grief, guilt, shame, and competition begin to settle in. Women may begin to criticize themselves, feeling as if they are incomplete and don't fit in anywhere (Mahlstedt, 1985).

The woman's devaluation of her body derives from her own feelings about infertility as well as the negative messages she receives from family and friends regarding her failure to conceive (Notman, 2003). For example, her infertility is viewed as a sign of weakness or inadequacy by her spouse. In addition, her mother's disappointment with her inability to conceive can threaten their tie or bond. The woman worries about the possibility of never having a deeper identification and connection with her mother. Mourning the possible loss of the motherhood constellation experience, can

lead to a woman subsuming negative feelings of aggression, rage, and competition into self-criticism of her body in order to preserve relationships (Notman, 2003).

Wischmann (2003) indicates that the desire for a child is ambivalent. The author indicates that along with positive feelings and thoughts about parenthood, there is a degree of anxiety about the changes this life experience will bring about. Chodorow (2003) also supports this concept of ambivalence. The author describes how a constellation of fantasies and defenses that are unconscious, can delay childbearing. Women, who use feminism or career-based reasons for delaying motherhood, do so based upon their psychic realities and the behaviors these realities have generated. Anxiety around uncertainty of roles, career delays, and how the quality of significant relationships in their lives will be affected by the arrival of a child, can unconsciously lead to a delay in preparing for motherhood (Wischmann, 2003). Women feel that the struggles they are experiencing with becoming a mother and those who may be hurt in the process (spouse and/or other family members) is their fault.

Motherhood is a "conscious and unconscious fantasy first and foremost a gendered bodily, object-relational and cultural experience for women." (Chodorow, 2003, p. 1183). The preference for youthfulness over aging, longer life span, middle-age career changes, and fertility treatments for women in the late forties and fifties, sends the message there is time to spare. Kristeva (as cited in Chodorow, 2003, p. 1184), points out time is characteristic of women. Time is cyclical and eternal. Women experience the cyclical nature of menstruation and being a parented parent. As a result of the shift in culture, some women believe that motherhood is a choice and that time is not always of the essence. It can be a painful and sad experience when a woman experiences infertility

and realizes that it is too late. She blames herself for having delayed motherhood as a result of unconscious fears or the belief that she had time.

Greil, Suason-Blevins, and McQuillan (2009) found that research detailing the characteristics of infertility patients is growing. There is an increased recognition of the importance of looking at the experience of couples as well as that of men. It is important to understand how self-identity is impacted through the experience of infertility.

In a study by Greil et al. (1988) of 22 middle class, married couples with a range of medical, reproductive, and family growth histories were interviewed regarding their experiences of infertility. It was found that "men and women in American society interpret and react to infertility in radically different ways and that understanding the influence of gender on infertility is crucial to understanding how couples experience infertility" (p. 173). Women and men cope differently with the emotional impact of infertility. Wright et al. (1991) found in their research and similar studies that women are more distressed than their spouse. In addition to the disappointment and sadness, many women feel rage toward their bodies, themselves, and those who can reproduce (Tyler May, 1995).

Zayas (1987) indicates "the step from a man's wish to have children to the capacity to relate as father to his children is largely dependent on his early life history" (p. 444). Male and female children develop an attachment with the mother during the oral stage of development as a result of her nurturing behavior. The male child "goes on to identify with his father, who is often seen as protector and provider" (p. 444). The father replaces the mother as the nurturing figure. Ross (as cited in Zayas, 1987) indicates

that the father's presence and participation in his son's life aids in the son's "gradual identification with father 'as a father'" (p. 446).

Fatherhood causes men to enact earlier experiences with one or more parents. The male's Oedipal conflicts and symbiosis with his mother are revived. In addition, the male will "try to resurrect his own father's image as a source of identification, and foundation on which to construct his paternal identity (Zayas, 1987, p. 446). It should also be noted that in the process of becoming a father, the man begins to realize that his father is no longer an omnipotent figure, but a human being with limitations and vulnerabilities.

There is a lack of research on men's desire for children (Hadley & Hanley, 2011). This could be because of the various forms of fatherhood (divorced father, step-father, unmarried father or donor) (Mander, 2001). Nevertheless, many men have an emotional and physical desire to be a father. It is important to men to continue their genetic line by producing a child.

Men view infertility as a setback. Greil et al. (1988) found in their research that men found infertility to be "disconcerting" (p. 172). Men are able to put the disappointment into perspective and then either move forward or ignore the problem. Research shows that men tend to be more accepting of their reproductive fate as a couple because infertility is a problem for the wife (Greil et al., 1988). Men tend to "cope with their pain by keeping it to themselves and focusing on their wives" (Mahlstedt, 1985, p. 337). The concern is that a lack of congruence among the couple can affect the marital relationship (Peterson et al., 2003).

If the man has been diagnosed with infertility, this can further complicate things. In a study, Lloyd (1996) found that male infertility is perceived as more stigmatizing than female infertility. Men are reluctant to discuss male infertility, viewing it as a sign of their lack of virility and potency. As a result of these issues, Miall (1986) found that to alleviate this burden of feeling, of impotence, some wives have gone as far as utilizing courtesy stigma, where the woman identifies herself as being infertile in order to spare her husband the shame and guilt. Self-labeling infertility allows protects the husband from the stigmatizing effects of sexual dysfunction.

Unlike other peer researchers, Tyler May (1995) found that men possess very strong feelings about being infertile that they were willing to express. Male participants expressed feeling unworthy, bitter, and useless because they could not contribute to society via reproduction. One male participant expressed, " 'that one term (infertile) transformed this budding stud into a wimp.' And when he learned that the quality of his semen was "borderline," I was shattered. My voice went up two octaves." (p. 221).

There is very little research that examines infertility and its emotional impact on couples. Peterson et al. explores the impact of agreement between partner's perceived infertility related stress and its effects on depression and marital adjustment in infertile heterosexual couples (2003). The final sample consisted of 525 predominantly White couples that had been referred to a teaching hospital in Ontario, Canada between 1992 and 1998. Three months prior to infertility treatment, the participants were mailed four self-report measures and asked to complete them separately before mailing the questionnaires back to researchers. The findings yielded that couples that are in agreement regarding the stress they experience as a result of infertility, are better able to

manage the impact of stressful life events. The study also found a connection between women who are not in agreement with their husbands regarding issues in their relationships and female depression. In addition, couples that were in agreement about the need for becoming parents reported higher marital satisfaction than couples where the males reported a greater need for parenthood.

Infertility and African Americans

Several studies have been conducted in regards to infertility. The research reflects risk factor, education, psychological barriers, culture, and access to services, socioeconomic status and new technology. Very little of this literature reflects how race, culture, ethnicity and socioeconomic status influence how men and women deal with infertility and seek out services. In addition, Jenkins (2005) pointed out that research within underserved populations such as African Americans, Hispanics, Asians and Native Americans in the United States is limited and more should be conducted. The author discusses how race, culture, ethnicity and SES influence how men and women deal with cancer-related infertility and whether or not they seek out infertility services. Through an overview of Medline studies from 1980 to 2005, the author examined the influence of ethnicity and SES on the use of infertility services. All of the aforementioned factors were found to affect the access of infertility treatment services to the underserved populations. Jenkins postulates that African Americans may be reluctant to seek infertility treatment because of religious beliefs, distrust of the medical community, economic barriers, lack of access to health care and a preference for informal or formal adoption. According to Jenkins, research with underserved groups in the United States is

limited and more should be conducted. The researcher also suggests that qualitative research would be a useful tool in identifying differences in beliefs, culture religion and the influence of gender on infertility treatment seeking behavior.

Through qualitative and quantitative measures, Ceballo (1999) assessed the impact of infertility on 10 African American women. The author investigated the women's socio-emotional well-being and means for coping with infertility. It was found that the women often coped in silence and isolation. They experienced shame, frustration, desperation and anger. In addition, inability to access fertility treatment because of lack of insurance and/or financial resources, created yet another hurdle for the women. The women shared that doctors viewed them as medical anomalies, because the idea of an African American woman experiencing difficulty with conceiving was unheard of. Most of the women bought into this stereotype and it became internalized. This misperception further separated the women from their spouses, family and friends. They rarely sought support and were resigned to suffer in silence as a means of attempting to protect them from feeling different and the perceived insensitivity of others.

Bell (2009) further explores the issue of infertility and socioeconomic status. The author conducted a qualitative study with 20 poor and working class women, who identify as African American, to examine their experience of infertility. Specifically, the author wanted to capture the experience of women who are unable to afford medical treatment for infertility. The research yields that structural inequality contributes greatly to the shaping of the experience of infertility for low-income women. Without economic means to pursue costly treatment, the women were "forced to negotiate their infertility"

(p. 703). Many of the participants chose to become stepmothers, caretakers or pursue alternative medicines and lifestyle changes to increase fertility.

LaTaillade (2006) addresses African American women and men in her research on the treatment of this population in therapy. The author's article reviews research on the impact of cultural stressors and resources on African American couples and treatment approaches for addressing these issues in therapy. Cultural factors, such as religion, SES, gender differences, power and value biases are addressed. This article examines the difficulties that African American men and women encounter when trying to deal with cultural stressors and the impact on their willingness to seek psychoanalytic treatment as well as the barriers that may occur between them and the therapist.

Phipps (1998), via a phenomenological study, examines the experience of infertility among African American couples taking the factors of race and socioeconomic status into consideration. The researcher investigated the meaning of infertility to low income African American couples. The following nine categories were induced from the data:

1. Evaluation of the meaning of childlessness;
2. emotions experienced with infertility;
3. coping;
4. marital functioning;
5. relationships;
6. health care;
7. time;
8. expenditures;

9. self-perception.

Phipps (1998) found that the concept of family and traditional roles is fundamental to African American families. Divorce or conceiving outside the marriage was not an option and as a result, couples had to develop new coping skills and be on one accord in order to maintain their relationships. Managing affect and stress was done via informal support networks and the strong belief in God's provision and timing. In regard to family, couples tended to isolate themselves in an effort to protect their feelings from judgment and perceived insensitivity from others. In addition, pressure from family and the need for privacy were also reasons for isolation. In addition, couples tended not to rely on formal support networks as a result of concerns regarding lack of understanding of their unique experience and subsequent meaningful support.

Theoretical and Conceptual Framework

Heinz Kohut's theory of self-psychology provides the theoretical framework for analyzing and understanding the experiences of couples experiencing infertility in this study. The desire to become a parent is motivated by psychological factors such as the consolidating the couple relationship, the wish for a family and for women, developing an identification with their mother. The experience of infertility deprives a couple of the ability to fulfill these desires. Couples who endure the experience of infertility have gone through an upheaval in terms of their identity (Apfel & Keylor, 2002). It is a blow to the cohesion of the self. Infertility is experienced as a narcissistic injury creating disruption in the self-structure (Leon, 2010). Couples yearn to feel whole again and to repair the

narcissistic wound that has been caused by infertility. Self-psychology, as a theory, is well suited to describe and explain the type of narcissistic wound created by infertility.

Kohut proposed a developmental theory explaining how a person develops a healthy sense of self that enables engagement with others, the successful pursuit of ambitions, empathy, wisdom, and the an ability to sustain oneself in the face of disappointment and loss. The process begins with "the empathic milieu that parents create to sustain the child during development" (Palombo et al., 2009, p.263). Parents or caregivers provide what self-psychology refers to as self-object functions to the child by meeting his/her psychological needs.

Ideally, children are born into warm, nurturing and empathic environments that provide essential self-object functions. Others, such as the mother, provide essential self-object functions. These functions include mirroring, idealizing, and twinship needs. Fulfillment of these functions allows the child to develop a self-structure referred to by Kohut as the bipolar self (Siegel, 1996). The grandiose self is the pole of the self, which requires the self-objects' responses to mirroring needs. The grandiose self is "a perfect self, a developmental stage where everything good, pleasant and perfect is experienced as belonging to the inside and everything bad as belonging to the outside" (Siegel, 1996, p. 60).

Disruptions or empathic failures cause the grandiose self to be modified and the need for the idealized parent imago to restore the child's sense of grandiosity. The idealized parent imago is one pole of the bipolar self and contains the fantasy of a perfect other with whom union is sought (Siegel, 1996). Attachment to a caregiver who is powerful and perfect makes the infant feel whole and good. Eventually, normal empathic

failures lead to transmuting internalization, which strengthens the child's ability to regulate self-esteem and maintain a strong sense of self.

In order to feel intact, the child must eventually reclaim idealization or continue through life needing to attach to an idealized figure in order to feel whole (Siegel, 1996). Through re-internalization of the idealizing narcissism, permanent psychic structures are established. The child begins to view the caregiver as a "good enough parent" who is not perfect. Through transmuting internalization, the child is able to "internalize specific qualities of the parents' emotional attitudes and responses" (p. 71). He/she is then able to satisfy some of his/her own needs (Tolpin, 1971).

In addition to the idealized patent imago, the grandiose self must also change. Omnipotence, grandiosity and exhibitionistic narcissism, features of the grandiose self, transform with the help of caregivers who are sensitive to the needs of the child (Kohut and Wolf, 1978). The caregivers enjoy and are accepting of the child's grandiosity. This acceptance causes the child to relinquish the exhibitionistic narcissism and grandiose fantasies, realizing the limitations (Siegel, 1996). In place of the grandiose self is a self "replaced with pleasure in realistic functioning and realistic self-esteem" (p. 86).

Self-object needs "mature from needing a powerful all-protective parent to a parent who has admirable qualities that become the source for the formation of ideals" (p. 5). Kohut (as cited in Fosshage, 1998) later identified twinship, an experience of essential likeness, as a third self-object need. Individuals need to feel a part of family, culture, groups, community, etc. as these twinship experiences support a vital sense of self. When parents are able to connect with families and friends via a motherhood constellation or other shared understandings, these are twinship experiences. Kohut (as

cited in Fosshage, 1998) indicated, “these self-object needs and the availability of self-object responsiveness within relationships are crucially important throughout our lifetime for developing and regulating a positive cohesive sense of self” (p. 6). The sense that self (and other) has developed an internal, personal world knowledge and experience can be used to communicate and share a narrative.

When something interferes with the creation of a child, there is a significant blow to the self-structure and grandiose self (Leon, 2010). It is experienced as a trauma. Reproduction is the result of what one can do and who one is as a man or woman (Leon, 2010). Infertility can cause women to feel incomplete and men inadequate. As a result, the self-structure reacts to trauma by becoming more fragile and vulnerable.

There is a normal and healthy amount of narcissism in all of us (Siegel, 1996). This narcissism is experienced via self-worth, a positive self-image, confirmation and acknowledgement (mirroring), goals, and the ability to enjoy achievements and close, fulfilling relationships with others. According to Leone (2008), “we are particularly attracted to those who offer important self-object experiences and seem (consciously or unconsciously) similar to early figures in important ways” (p. 84). A healthy marital relationship is one in which each partner helps the other “consolidate and maintain a positive, cohesive sense of self” (p. 81). Furthermore, healthy marital relationships consist of partners who are,

> understanding, positive, and affirming; someone they can look up to, admire, and lean on in times of stress, who helps with the experience, modulation and integration of affect; and someone with whom they feel a sense of essential

> likeness and belonging – in other words, someone who functions as a reliable source of self object experience. (Leone, 2008, p. 81)

Couples with a healthy and cohesive sense of self are less reactive to disappointments and self object failures. They are able to emotionally regulate themselves without having to solely rely on one another to provide self-functions such as nurturance and affirmation. In addition, they are able to be empathic to the needs of each other.

Infertility can impact the healthy adult self and healthy relationship between couples. By being deprived of conception and parenting, couples have to endure feelings of role failure, inadequacy, guilt, anger, shame, and helplessness. Infertility creates an unstable image and sense of self. The threshold for narcissistic rage is lowered, establishing humiliation, helplessness and self-mortification (Leon, 2010). Rage is then directed at those who can conceive as well as family, friends, partners, and God.

Aside from narcissistic rage, couples are faced with having to disavow their desire and endure the disappointment that others express regarding their infertility. They have to mourn the loss of being idealized, as a parent, by their fantasied child (who they wish to serve as a narcissistic extension of them) as well as family and friends. There is loss of twinship function and anticipated mirroring of having a child. Parents are unable to have a shared experience with other parents. There is also a loss of being idealized and "viewed with awe and admiration" by another being (Siegel, 1996). How this is "experienced and ultimately channeled, repaired, or solidified may be as much a product of prior narcissistic vulnerabilities and defensive measure as of medical outcomes" (Leon, 2010, p. 51).

These ruptures in self can lead to a lack of cohesion in the couple as individuals and a unit. The inability to control fertility can lead to couples seeking narcissistic restitution via creating a child (Leon, 2010). There may be pressure internally, from family or a partner to create a child. Resolving infertility may repair psychological injuries created by the trauma associated with infertility as well as the earlier experiences of traumatic disappointment. In the face of infertility, the need for self-object functions becomes greater and more concrete.

In order to restore the self and reintegrate the trauma, narcissistic equilibrium must occur (Leon, 2010). Via transmuting internalization, there must be a mourning of the loss of fantasies of omnipotence and mirroring transference (Siegel, 1996). There must also be an acceptance of narcissistic limitations. Psychological growth may "enable the self to shift from the need to merge with idealized, mirroring and alter ego self-objects, in order to feel whole, to an ability to be sustained by the empathic resonance of the self-objects in adult life" (Siegel, 1996, p. 167). Couples experience a readjustment in relationships with friends, family and one another. By "deconstructing the internalized attributes of infertility stigma, one is less susceptible to narcissistic hurts when inevitably confronted with prejudiced attitudes about infertility" (Leon, 2010, p. 67). The individual and couple develops an empathic understanding of infertility that leads to a better appreciation and management of the experience.

Theoretical and Operational Definitions of Major Concepts

Infertility: The inability to become pregnant after 12 months of unprotected sex (intercourse) because of a male factor, female factor, and a combination of factors in both partners or, there is no explanation (Vorvick, 2012).

African American: A Black American of African Ancestry whose ancestors were originally brought to the United States of America as slaves between the 17th and 19th centuries and who self-define as an African American. It should also be noted that there are also Black immigrants from African, Central American, Caribbean and South American countries who self-identify as African Americans (Boyd-Franklin, 2003).

Couple: A couple would be defined as a heterosexual man and woman in a committed relationship of at least one year.

Phenomenology: A thick, rich description of the lived experiences of individuals about a concept of phenomenon (Creswell, 2007).

Statement of Assumptions

1. It is uncommon for African Americans to seek treatment for infertility.
2. The experience of infertility is unique for African Americans and influenced by more than culture.
3. Infertility is a “taboo” issue in African American culture. It is rarely discussed and treated with discomfort and shame.
4. Self-esteem and identity are impacted by the experience of infertility.
5. Couples will be able to articulate their experiences and give meaning to the experience of infertility.

6. Phenomenology as a research approach will allow this researcher to provide a thick, rich description of the lived experiences of infertile African American couples.

Chapter III

Methodology

Study Design

For the purpose of the proposed research question, the researcher carried out a qualitative research design to explore the meaning and experiences of infertility among African American couples. The researcher utilized a phenomenological qualitative process based on the methodology outlined by Moustakas (1994). The goal of phenomenological research is "to determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it. From the individual descriptions general or universal meanings are derived, in other words essences or structures of the experience." (Moustakas, 1994, p.13). The descriptions consist of what the individuals experienced and how they experienced it. The participant is trying to make sense of his/her internal and social world and the researcher is trying to make sense of the participant.

Phenomenology has philosophical underpinnings (Moustakas, 1994). Edmund Husserl, a German mathematician, founded it in the twentieth century. Husserl believed that there is a relationship between subjective experience and consciousness. He proposed that there is a contrast that exists "between facts and essences, between the real and non-real" (Moustakas, 1994, p.27).

In phenomenological research, Stewart and Mickunas (as cited in Creswell, 2007) indicate there are four philosophical perspectives: a return to the traditional tasks of philosophy; a philosophy without assumptions; the intentionality of consciousness; and the refusal of the subject-object dichotomy. By the end of the 19th century, philosophy was largely associated with science. Phenomenology is a return to the "Greek conception of philosophy as a search for wisdom" (p. 58).

There are two types of identified phenomenological research, hermeneutic phenomenology and transcendental phenomenology (Creswell, 2007). Hermeneutics involves "reading a text so that the intention and meaning behind appearances are fully understood" (Moutsakas, 1994, p.9). It is a process of the researcher reflecting on essential themes of a lived experience and writing a rich description of the phenomenon. Prejudice and pre-judgment are laid aside so that the researcher can fully understand and listen for the emerging themes. The researcher participates in a reflective interpretation of the text that "includes not only a description of the experience as it appears in consciousness but also an analysis and astute interpretation of the underlying conditions, historically and aesthetically, that account for the experience" (Moustakas, 1994, p.10).

Transcendental phenomenology, developed by Moustakas (1994), focuses less on interpretations made by the researcher and more on the descriptive experiences of the participants. The first step in this process is the epoche. The researcher sets aside all experiences, judgments and understandings in an effort to be open or have "fresh perspective toward the phenomenon under examination" (Creswell, 2007, pp. 59-60). The next step in this process is Transcendental –Phenomenological Reduction (Moustakas, 1994). In this process everything is perceived freshly and in an open way. Moustakas

(1994) indicates, “a complete description is given of its essential constituents, variations of perceptions, thoughts, feelings, sounds, colors, and shapes” (p. 34). From this process a combination of the textural description of what the participants experienced and a structural description, called Imaginative Variation (Moustakas, 1994), of how they experienced the phenomenon in terms of conditions, situations, or context are used to convey the overall experience (Creswell, 2007).

In phenomenological research, the researcher refrains from making assumptions and instead “focuses on a specific topic freshly and naively, constructs a question or problem to guide the study, and derives findings that will provide the basis for further research and reflection.” (Moustakas, 1994, p.47). The researcher must utilize the process of epoche and suspend what is real and exists until it is founded on a more certain basis (Creswell, 2007). By suspending judgment, the researcher can understand the subjective experience of participants and gain insight into their motivations and actions rather than relying on societal assumptions. The reality of an object is related to one’s consciousness of it. According to Husserl, reality “is not divided into subjects and objects, but into the dual Cartesian nature of both the subjects and objects as they appear in consciousness” (Creswell, 2007, p. 59). As a result, the “reality of an object is only perceived within the meaning of the experience of an individual” (Creswell, 2007, p. 59). For the purposes of this study, the researcher utilized transcendental phenomenology.

Data was obtained via interviews with participants. All participants were screened via phone for appropriateness. The researcher utilized an initial list of three to five questions to screen potential participants. The questions helped to discern whether or not the potential participants fit the identified population and were appropriate for the

study. In addition, the questions screened for the potential participants' level of comfort with discussing infertility and if they may possibly be in psychiatric crisis, and therefore unable to participate.

In qualitative research, there are not necessarily a definitive number of participants identified. For this study, the researcher interviewed six African American, heterosexual, couples (a total of 12 individuals). Six of the participants in this study were diagnosed with infertility.

Sample

For quality assurance, criterion sampling was used. Creswell (2007) indicates that for a phenomenological study, it is imperative that all participants have experience of the phenomenon being studied. The use of "criterion sampling works well all individuals studied represent people who have experienced the phenomenon" (p. 128). For the purposes of this study, all participants experienced infertility and self identified as African American.

To recruit participants for this study, the researcher sent a flyer to a fertility clinic in the Memphis, TN area. With the permission of the site administrators, the researcher sent her flyer to members of online fertility support groups. Lastly, the researcher created a Facebook page to advertise her study. The Facebook page contained a picture of the researcher, recruitment flyer, facts and information about African American infertility.

Twelve participants were selected through one of the online fertility support groups and the researcher's Facebook page. The participants do not live in the same state as the researcher. Participants in the study were from the following states: Illinois, Texas,

Pennsylvania, and North Carolina. As a result, interviews conducted in the study occurred via telephone.

The researcher screened the participants via phone in order to determine if they qualified for the study. A script was utilized to explain to the participants that their feedback is being sought about the experience and meaning of infertility for African Americans. Specifically, the researcher wanted to understand what it is like for the participant individually, and as a member of a committed relationship to live with the diagnosis of infertility. The researcher wanted to understand what experiences of infertility the participant encounters, and what he/she knows and does to overcome and/or deal with those experiences. The underlying assumption that this researcher was working with is that the experience of infertility is unique for African Americans and influenced by more than culture. Infertility is a "taboo" issue in African American culture. It is rarely discussed and treated with discomfort and shame.

Participants received consent forms via email and participated in a telephone information session. During the information session, the participants received additional information about the study and reviewed the consent form. The voluntary nature of the study was emphasized in a script used to review the consent form, and it was reiterated that participants could choose to move forward with participating or decline. In addition, participants were informed that they were free to cancel their consent and refuse to continue in this study at any time. The participants signed and returned the consent forms via email or fax.

The participants were informed that their confidentiality would be maintained via coded audiotapes and transcripts. Use of audiotape allowed for accuracy of the interview

content. The participants were interviewed individually and with their partner. The interviews with the wives lasted approximately 60 minutes. Interviews with the husbands as well as the couples' interviews lasted approximately 25 minutes. Each interview was scheduled for a different day.

Data Collection Methods and Instruments

Data were collected from interviews with the participants and later transcribed. The researcher used a transcription service, requiring the transcriptionist to sign a confidentiality form. The transcriptions provided the raw data for analysis. Upon receiving each completed transcript, the researcher checked the text against the audiotape for accuracy. This method offered validity and provided additional information.

At the beginning of each interview, participants were informed that they were free to cancel their consent and refuse to continue in this study at any time. Participants were also reminded of their confidentiality throughout the process.

The interviews were conducted with open-ended questions. Initially, the participants were asked two broad questions. The first question posed was, "How did the experience of infertility affect you? What changes do you associate with this experience?" Further questions followed from the information asking for elaboration on relationships, family life, self-image, role, and coping. Additional questions that were posed to the participants included the following:

1. Have you always thought about being a parent?
2. What feelings were generated by your diagnosis of infertility?
3. What thoughts stood out for you?

4. What bodily changes or states were you aware of at the time?
5. How did you feel about infertility before learning you were experiencing it? How if at all, have your feelings about infertility changed?
6. How do you envision the future of your relationship?
7. How did you envision yourself as a parent?
8. How does the experience of infertility affect how you feel about yourself and other children?
9. What is it like for you to not be able to have a baby?
10. What is it like for you as a couple to not be able to have a baby?
11. Tell me about how you came to discover that you and your spouse were experiencing infertility?
12. What, if you are aware contributed to your infertility?
13. What was going on in your life when you began to experience infertility?
14. How did the experience of infertility affect significant others in your life?

Data Analysis

Organizing and analyzing the data involved a modification of methods of analysis by Stevick-Colaizzi-Keen (Moustakas, 1994). The researcher began the analysis with a full description of the experience of the phenomenon. This step was done in an effort to set aside the personal experiences of the researcher so the participants can be the focus of the study.

The researcher then developed a list of significant statements as it relates to the significance of the experience. Via horizontalization of the data, statements, sentences or

quotes regarding how the participants are experiencing the phenomenon were developed into a list of non-repetitive, non-overlapping statements (Creswell, 2007). These significant statements were clustered into core themes of the experience. The themes were synthesized into descriptions of what the participants experienced with the phenomenon that includes verbatim examples. This is called a "textural description" (Creswell, 2007).

By reflecting on the setting and context in which the phenomenon was experienced, a "structural description" is developed by the researcher (Creswell, 2007). From the textural-structural descriptions of the phenomenon, the researcher constructs "a composite textural-structural description of the meanings and essences of the experience, integrating all individual textural-structural descriptions into a universal description of the experience representing the group as a whole" (Moustakas, 1994, p.122). This final step allowed the researcher to develop the common experiences of the participants.

After analyzing the results and constructing common experiences of the couples, the researcher employed the additional step of member checking, which involved having participants review the data. Via member checking, the descriptions that have been developed as the result of analysis were provided to the participants to "confirm or disconfirm the accuracy of the research observations and interpretations" (Rubin & Babbie, 2008, p.432). The researcher emailed the participants a draft of the write-up and asked for their feedback. This step allowed the participants to further elaborate and confirm the validity of the findings. To control for internal validity, the researcher kept a journal during data collection of personal thoughts and reactions. The researcher also

checked in with the chair of her dissertation committee throughout data collection for processing and feedback.

All participants in the study were voluntary. Although there were no physical risks associated with this study, the potential for emotional distress existed. Participants in this study were asked to revisit a time in their lives that could evoke emotional memories. They were asked to discuss past and present relationships as well as possible losses that they have experienced. As a result, the participants could experience some emotional distress. To minimize the potential for emotional distress, the researcher, a mental health clinician, utilized vulnerability screening. Participants with a reported history of extreme mental impairments and/or mental illness will be excluded from this study. If any participant had reacted with a severe emotional response while participating in this study, he/she would have been disqualified.

Participants were also given the option to pause or take a break if they experienced an emotional response during the interview process. All participants had the option to suspend, delay or end the interview process at any time. In addition, they had the option of opting out of discussing past and present experiences of their lives that they felt were too distressing. During the process, the researcher remained aware of signs of tearfulness, expressions of anger, frustration or irritability, loss of focus, withdrawal, prolonged silence, change in affect or tone. Upon observing any or all of these signs, the researcher would have assessed the participant's level of discomfort or emotional distress. The researcher also offered the participants clinical support in the form of an immediate debriefing and assessment of the level of distress. It should be noted that only one participant became tearful, briefly, during the interview. When the researcher

inquired if the participant would like to stop or take a moment, the participant declined. She indicated that she "had a moment" and would like to continue with the interview.

The researcher followed up via phone with the participant who became tearful during the interview. The participant reported that she did not feel distressed as a result of the interview. She indicated the she would utilize her employee assistance program benefits should she need it. The participant thanked the researcher for following up. The risk for severe emotional distress as a result of this study, were relatively low.

Statement on Protecting the Rights of Human Subjects

Participants were assigned a number as a way of safeguarding their identity. Interviews were conducted in an environment where each participant could feel assured of her/his privacy, in all cases, the participants' homes. The researcher will keep all data collection materials such as audio recordings, transcripts, and journal notes in a single file, locked cabinet to ensure confidentiality. Data will be retained for five years.

During the information session, the participants received additional information about the study, reviewed, and signed the consent form. Each participant was encouraged by the researcher to ask questions and express concerns in the information session as well as during any point in the process. The voluntary nature of the study was emphasized and it was reiterated that participants were free to cancel their consent and refuse to continue in this study at any time.

Chapter IV

Results

Introduction to Results

The recruiting phase of the study proved to be quite challenging. Initially the researcher recruited couples that were childless. As a result, there was reluctance in terms of participants coming forward to take part in the study. The first couple, who participated in the study consisted of a wife who wanted to share her story and a husband who supported her. After completing the individual interviews, the couple declined to participate in the joint interview. The couple struggled with being childless and although they found ways to compensate via careers, education and caretaking of others, the disappointment with being unable to parent was profound. The wife expressed such strong emotions and shared that discussing her infertility was a deep and powerful experience for her. Through this interview, the researcher began to understand the emotional intensity of this topic. It was an insightful and enriching interview experience.

Following the interview with the first couple, it would be three months before the researcher was able to successfully recruit another couple. During this time, there were couples that came forward expressing interest, but did not follow through with the interviews. The researcher connected with affiliate or active members of local and out of

state fertility support groups. Through this connection, the researcher learned that the couples often operate as a closed system. The couples struggle with discussing their experience when childless because it is too “painful and shaming.” Couples are more amenable to discussing their experience once they have children because they feel “less vulnerability and shame.” These sources have also shared that once they “are on the other side of it,” they want to be “more open and vocal about our experience”, finding that it will help them support others who have had the same difficulties. There are couples from these groups who are no longer childless, and willing to speak with the researcher if the criteria were to be amended. In response and with the approval of the Institutional Review Board, the researcher amended the criteria. As a result, recruitment improved and the researcher was able to obtain an additional five couples for the study.

After writing up the results of the initial interviews, the researcher reached out to the couples to conduct follow up interviews after they had a chance to go over the written results section, thinking about the results with them, and then using this as follow up member checking, as well as expanding on the data. Five of the six wives participated in the follow up interviews. Five of the six husbands had an opportunity to review the results and expressed satisfaction with the results. As a result of their satisfaction with the results, the husbands felt there was no need to conduct a follow-up interview. One of the six couples did not respond to several requests to review the results and participate in a follow up interview. The five wives expressed an overall satisfaction with the write-up.

The major concepts are not presented in any hierarchical order. They are the result of the experience of infertility among African American couples that is still reverberating in spite of having children. The concepts are grouped into three categories based on the

structure of the interviews – interviews with the wives, interviews with the husbands, and interviews with the couples. The concepts for the wives are as follows: Bodily Experience, Primary Emotions, Self-Image, Closed System, Female Constellation of Support, Trauma, Faith, Time, and Culture. The concepts for the husbands are as follows: Protector and Supporter, Experience Put Into Perspective Then Ignored, Faith, Self-Image, and Choosing Who to Tell. The concepts for the couples are as follows: Cohesion, Using Experience to Support Others, and Faith. A final concept that emerged during the follow-up interviews is It's Just Too Difficult to Talk About.

Description of Participants

At the time of the study, all six couples have been married an average of 10 years. Three of the women were aged between 34 and 39, and three were between 40 and 45. Two of the women are in the mental health field; two are in the medical field; two are in the business sector. Four of the women have master's degrees; one has a PhD; one has a bachelor's degree. Two of the men were aged between 35 and 40, and four were between 45 and 50. Two men are in the medical field; two are engineers; one is in information technology; and one is a business owner. Four of the men have bachelor's degrees; one has a master's degree; and one has some post-high school education and training.

Five of the women have been diagnosed with some form of fertility complications. One of the women has no specific diagnosis, but was diagnosed by a fertility specialist as being unable to conceive. One of the men was diagnosed with fertility complications and underwent corrective surgery. One man underwent testing for possible fertility complications and the results were negative. Five of the women sought

fertility treatment and one has not made a decision about whether or not she will seek treatment. Three couples conceived children together; two couples adopted children; and one couple contained a member who has children from a previous relationship.

Only one of the 12 participants interviewed had been in some form of psychotherapy.

Melissa (44 years old) and Mark (50 years old) have been married for 11 years and reside in Texas. This is their second marriage. They are both medical professionals and small business owners. Melissa and Mark are college graduates with some post baccalaureate education. After years of trying to conceive and being unsuccessful, Melissa sought out a fertility specialist and was diagnosed with endometriosis over five years ago. Melissa and Mark do not have any children together. Mark has three adult daughters from a previous relationship. Mark has a complicated relationship with his daughters (as a result of previous relational difficulties with their mother) and as a result, has limited contact with them. Melissa and Mark are caregivers to two adult males with intellectual disabilities. To date, Melissa and Mark have not made a decision about whether or not they will seek treatment or consider other options such as adoption.

Rachel (34 years old) and Ramone (37 years old) have been married for over 10 years and they reside in Pennsylvania. Rachel is a mental health professional with a doctoral degree and she maintains a private practice. Ramone has a bachelor's degree and he is a medical professional. After marrying and trying for over three years to conceive, Rachel was diagnosed with fibroids, endometriosis and a blocked Fallopian tube. Rachel and Ramone have two children, a 6-year-old son and three-year-old daughter. With each child, Rachel, underwent oral medication to stimulate development

of eggs and intrauterine insemination (artificial insemination of the woman with her husband's sperm) in order to become pregnant.

Patricia (35 years old) and Victor (39 years old) have been married for over 11 years and reside in Texas. Patricia has a master's degree and is a certified public accountant. Victor has a bachelor's degree and is an engineer. After marrying and trying for a year to conceive, Patricia and Victor went to see specialists to determine their fertility. Patricia was diagnosed with polycystic ovary syndrome (PCOS), a hormonal disorder causing enlarged ovaries and small cysts, at age 26. Victor's fertility testing was negative. Patricia and Victor have two children, a seven-year-old son and a two-year-old daughter. To conceive their children, Patricia took oral medication and underwent intrauterine insemination treatment. With their oldest child, Patricia became pregnant immediately following treatment. After a few years of unsuccessful treatment following the birth of their son, Patricia and Victor considered adoption before learning that they were pregnant with their daughter.

Adele (44 years old) and Jimmie (45 years old) have been married for over 12 years and reside in Illinois. Adele has a master's degree and Jimmie has a bachelor's degree. Both work in the business administration field. After marrying and trying unsuccessfully to conceive, Adele went to a specialist and learned that her diagnosis falls into the unexplained category, standard infertility testing has not found a cause for the failure to get pregnant. Adele underwent daily shots, oral medication, intrauterine insemination and in vitro fertilization (a woman's eggs are retrieved from her ovaries and fertilized by sperm in a lab). None of the treatments were successful and as a result, Adele and Jimmie adopted a newborn baby girl three years ago.

Tasha (42 years old) and Matthew (47 years old) have been married for over 10 years and reside in Illinois. Tasha and Matthew both have master's degrees. Tasha works in the social service field and Matthew works in the business administration field. Three years after marrying, Tasha and Matthew began trying to conceive, but were unsuccessful. As a result they sought out the help of a specialist. Tasha was diagnosed with fibroids and Matthew was diagnosed with a low sperm count (motility). Both underwent surgeries to correct the issues. Tasha was placed on oral medication to stimulate egg development. Matthew was placed on oral medication to improve sperm count. Tasha also had to give herself multiple daily shots to stimulate ovulation. Unfortunately, the fertility treatments were unsuccessful. After some consideration, Tasha and Matthew adopted a son four years ago.

Terri (37 years old) and Lamar (46 years old) have been married over nine years and reside in the Carolinas. Terri has a master's degree and works in the medical field. Lamar has a bachelor's degree and is a business owner. Terri has a previous diagnosis of pelvic inflammatory disease that she received in her early 20's. Although she was concerned about how this diagnosis could impact her ability to conceive, neither Terri nor her doctors raised this concern during regular check-ups. A year after marrying and trying to conceive, Terri went to see a specialist and was diagnosed with damage to her fallopian tubes as a result of pelvic inflammatory disease. In 2008, Terri underwent in vitro fertilization and gave birth to a son a year later. In 2015, Terri and Lamar decided to try for a second child. Within two months, she experienced two failed cycles of in vitro fertilization. As a result, Terri and Lamar are contemplating if they want to pursue treatment again.

Wives

Conception is traditionally viewed as a woman's responsibility. On a monthly basis, women are reminded of their fertility. Being unable to procreate fills a woman who wishes to be a mother with many thoughts and feelings about herself. In addition, culture reminds women of what their role is as a mother. It is a very personal experience that leads to a permanent change in a woman's self-concept. The wives expressed many thoughts about their feelings as it pertains to infertility and its impact.

- Bodily Experience describes the physical changes the wives experienced as a result of infertility.
- Primary Emotions is about the varying feelings the experience of infertility evoked from the wives.
- Self-Image describes how the wives conceptualized their internal identification as woman, wife, and mother during their experience of infertility.
- Closed System describes how the wives entered into a state of isolation from family, friends and their emotions as a means of coping.
- Female constellation of support describes the process in which the wives' sense of self becomes organized around the experience of infertility, desire for motherhood, and twinship experiences with other women. Through this experience the wives form an empathic support network with other women.
- Trauma describes how the wives view infertility as an experience that has a long-term, profound effect on their sense of self. They feel forever changed and impacted by the experience.

- Faith is a coping mechanism that has cultural significance. It is essential and embedded in the African American psyche.
- Time is presented as a factor that the wives felt they were up against and could not control.
- Culture explores the wives thoughts on disparity in the African American community as it pertains to seeking medical treatment.

Bodily experience.

The wives described bodily changes such as weight gain, soreness, discomfort, and "moodiness" while taking oral and/or injectable medication for fertility treatment. Melissa shared the following:

> Before going through infertility, I have always been lean and small, nice shape, small six pack, little booty, small breasts, but when I went through infertility, I saw that I have the typical big butt, big breasts, my stomach is not a six pack anymore. I gained weight. I went from always being underweight, 135 lbs., now I am 200 lbs.

Some of the wives became consumed with body image, mourning the loss of what their bodies once were.

On the other hand, there was the also the importance of maintaining good health for optimal treatment results. Patricia described being instructed by the doctor to lose weight in order to improve her endocrine system as she went through intrauterine insemination. "So, I wanted to get healthy and I was getting healthier and everyone thought I was getting healthier, to look nice which I was, but I was also trying to get

healthier so that I can prepare my body to perhaps conceive." The weight loss and its confirmation by others seemed to increase self-worth, motivating the wife to want to achieve pregnancy and motherhood.

Some of the wives shared that the side effects of their treatment mimicked some of the symptoms women experience during pregnancy. This gave them a sense of hope, that their treatment was a success and they were pregnant. In addition, it provided them with a twinship experience with other expectant mothers, fulfilling their need to be a part of a group in which they yearn to have membership. Rachel shared,

> Once the medications started, I'd say that some of the bodily changes were … a whole lot of moodiness and crying, happy one minute and sad the next minute, sore boobs and a lot of pregnancy stuff which were really annoying. So, you think, oh my God, it's working! Because I got sore boobs and I'm sleepy all the time this has to mean something.

In reality, the symptoms were simply an effect of the medication. By being deprived of conception (despite experiencing the symptoms), the wives endured feelings of disappointment and inadequacy. Patricia expressed, "I felt as if my body was failing me."

The wives in this study experienced several doctor's visits that included invasive treatments and/or surgeries. Some reported how fertility treatment became a daily part of their routine. They had to inject medication into their bodies several times a day and be aware of any bodily changes as it pertained to treatment. There was also a sense of alienation from their bodies as the functioning of their bodies was reduced to medical terminology. Rachel described needing to undergo surgery to treat blocked fallopian tubes. In the surgical paperwork, she had to agree to consent to a "full blown

hysterectomy" should the surgeons encounter any complications. She recalled this event sharing, "At 25 years old, my first surgery ever, basically, I have to sign away my uterus." Adele shared experiencing complications during an egg retrieval surgical process. As a result, the surgery was stopped and the surgeons were unable to continue, which affected the their ability to move forward with insemination. As Adele began to come out of the anesthesia, she was informed of the complications. She describes feeling despondent, begging with the nurses to resume the procedure so that she could become pregnant. "I said, 'Oh, no please put me back under and get more. Please put me back and get more.' And I can tell the nurse just wanted to cry because I was so upset." The risks were worth the benefits – becoming pregnant, successfully delivering a child and becoming a mother.

Primary emotions.

As they struggled with the need and desire to become a parent, because of the interference of infertility, the wives felt incomplete. This triggered a range of emotions during their experience of infertility such as anger, sadness, despair, resentment and jealousy. Adele shared the following:

> I would get very sad at times. I won't say I was sad all the time, but if I thought I was pregnant one month and it didn't happen, I would be very sad by getting a period and it would be devastating and then I think I was overly emotional and overly sensitive. If I heard about someone else that got pregnant, sometimes I would cry, things like that. I would definitely have sad days - days when I was just sad or just moments when I would be sad for no reason.

Tasha found herself questioning her faith when she would become angry with God because she could not conceive.

> But there were times when I was very angry. Why me? I'm looking at people like "Really, this couple got four kids and I can't get pregnant?" In this case, I'm not having any at all. So there was a lot of me that was angry at the same time, so it was crazy then because in the end, you're feeling guilty, like "Okay God, forgive me that I called you a butt hole because this lady got 4 kids and I can't have any." So that place was, you know, spiritually it was a tug-of-war.

Patricia expressed her anger over unsolicited advice and jealousy at yet another birth announcement from a friend.

> And then you get announcements from friends that are expecting or hear certain comments once you open up to friends regarding your journey and they tell you, "Oh well, such and such did this and they got pregnant again so maybe you should try that." Not knowing whether you tried it or not. They meant well, my friends, but it made me angry. I started to get angry. I started to get jealous and I'm just not normally that type of person.

She wanted advice only if she asked for it. She valued unconditional positive regard and support during her experience. In addition, she desired for those around her to take into consideration how she feels and demonstrate that in their actions. To know and understand that it is difficult to be happy when there are “growing bellies around.”

Some of the wives recalled feeling resentment when they witnessed women not taking good care of themselves while pregnant or their children post pregnancy. This filled them with rage and resentment because it was distressing to see someone who was

"blessed with the gift of motherhood" behave so carelessly with it. Adele shared the following:

> I remember one time seeing a pregnant woman, just a stranger on the street - a pregnant woman on the back of a motorcycle, smoking a cigarette and just being so mad because you ought not to smoke. She is pregnant and smoking, and if I could be pregnant, I wouldn't be riding a motorcycle and I definitely wouldn't smoke. She's exposing her baby to all whatever dangers of smoking when you're pregnant.

In hindsight, the wives found that it was a challenge to manage their emotions and they did not feel that their behavior as a result, was indicative of who they are at their core. Rachel expressed, "You're happy. It's just very hard to break away from the other emotions that you have." Tasha realized that she became so narcissistically consumed with her feelings that she began to devalue others as a means of defending against her fragility.

> I found that I was angry a lot of times and I took it out on a lot of people. Looking back in hindsight, there were a lot of events I had no business attending, friends that I really did not treat well because I couldn't deal with it. My view at that time was, "Woe is me, look at what I'm going through," and so, you know, "excuse me for snapping off on you, but I can't have a baby."

She needed to direct her rage and resentment at family and friends as a result of her humiliation and helplessness as a result of infertility.

Self-image.

Melissa disclosed that, “Ever since I was little I have always wanted to be a parent.” For the wives in this study, family is important. They grew up with various models within their immediate and extended family or community of strong, self-reliant women who bore and raised children. These women managed the household and did their best to maintain the wellbeing of everyone in and outside of the family. Having grown up with women in the prominent role as caretaker, the wives, identified early on with the many women around them who served as mothers (biological and non-biological). Observing their mothers and other prominent women, they learned to identify with female oriented roles. “Like all little girls I played with dolls. I had my baby dolls, I just always assumed I would get married and have kids like the family I grew up in.” Motherhood is a very important part of the self-image of these wives.

Infertility creates an unhealthy image of self. For most of the wives, they questioned their womanhood. Adele expressed, “It was definitely moments where I'm like, I'm less than a woman, like when can we have the kid? Like how am I going to not have a kid?” They experienced what they describe as role failure. Patricia expressed, “I felt like I failed”, after experiencing two failed treatments. A couple of the wives expressed questioned why they could not get pregnant, asking, “What is wrong with me?” Rachel shared how the experience affected her integration into her husband’s family. “I felt like I wasn't a full-fledged member of the family until I had some kids that's connected to them in some way.” In order to feel like a “full-fledged” woman and family member, it is necessary to bear children. The inability to do this, made their bodies as well as their sense of self, feel incomplete.

Closed system.

The wives felt the need to distance themselves from others. Some of the wives found themselves becoming more reserved and distanced from friends, family and significant others as a result of failed treatments and attempts to procreate. Tasha expressed, “I did feel closed off from people. I remember one day my pastor pulling me into the office and telling me, ‘…you need to get out of the cave.’ I was like, ‘What are you talking about?’ He was like, ‘It’s like you’re in a dungeon by yourself and you won’t come out, nor will you allow anybody in.’” Isolation was used as a defense to help with coping.

The wives also shared how they avoided social gatherings such as family get-togethers, baby showers, birthday parties, and other events where children may be present because it reminded them of their infertility. Patricia shared the following:

> I didn't want to be a party pooper, I didn't want to look depressed, I didn't want to, because you can smile and be happy and then someone can look at you and be like ‘You're not really happy’, you know? I didn't want that, I wanted them to enjoy their time, the special time that they had without here comes this grey cloud of doom coming over and she really doesn't want to be here but she's family.

Social gatherings were yet another opportunity for the wives to be reminded that they were incomplete. Adele expressed, “I did shy away from things because I didn't want to be around it. I didn't want to sit and talk to somebody about kids because I wanted that. I wanted to be the one that had the kids that people were talking to me about.”

Although they loved their extended family, some of the wives found it too difficult to share their innermost feelings about the experience of infertility. Having to explain personal details about reproduction to others felt invasive and evoked feelings of vulnerability. In addition, it could be a challenge to help family and friends understand the complex medical process of fertility treatment. Rachel shared, "…my family, they don't understand that. They don't understand that it's expensive. They don't understand that I have to go to the doctor several times during the course of it. They don't understand that it's hurtful when I've been trying to conceive a child and I feel like I've done everything right in life, as far as being married."

In addition, Rachel went on to disclose that well-intentioned loved ones could sometimes say hurtful things. "My mother was a bit more old school like, 'what's wrong with you? Why can't you have kids? What happened to you?' She's very much like that. So, I didn't like to share with people who I knew would not be from the same mindset as me." Comments like these have the potential to make a woman feel as if no one understood their pain of this difficult journey. These comments also evoked shame, inadequacy and guilt, triggering unconscious thoughts about whether or not fertility was their fault or what more could they be doing to become pregnant.

Female constellation of support.

In the midst of their experience of infertility, the wives began to search for sources of support outside of their family. They needed to connect with others, to feel an alikeness, a twinship experience. The wives sought out support from friends who were undergoing fertility treatment, very close friends who were empathic despite not

experiencing infertility, the church and support groups and boards. Patricia shared, “I joined a board for infertile women that had the same condition that I had and it was just nice reading about their experiences and what they've tried or what worked, what didn't work.” The wives found these outlets to be comforting and normalizing. Adele explained,

> The more I opened up, I think others saw that I was able to open up and then they started talking to me about it a little more and I realized that “Hey, I'm not alone. I'm not alone in my circle of friends." Everybody was going through it, but it was a handful of us enough that we were able chat about it.

Interestingly enough, prior to learning they about their issues with infertility, five of the six wives found one another through a wedding planning website. They became familiar with one another as they planned their weddings, sharing tips and ideas. The wives continued to stay in touch via the website after their weddings, keeping one another updated on personal events and milestones. While some shared birthing announcements, others began to open up and share their struggles with conceiving. As a result, a sub-group formed, where wives experiencing issues with conceiving began to share their stories and offer support to one another. This online female constellation of support served as a sounding board for the wives and where they turned for comfort and empathy. Adele went on to share,

> We have a special bond. There are others of us have kids around the same age and we have a special bond or like the black girls I've been talking with since 2002, we all have a special bond.

Via this group, the wives were able to share their feelings and thoughts with one another. Through this shared experience, they formed a bond that exists to this day. The wives

arrange get-togethers and play dates with their children. Tasha expressed, “Some of my closest friends that I have now are from the journey that we went through together - their journey, my journey, and the support that we gave each other.”

Trauma.

Adele feels that the experience of infertility is a trauma saying, “You're never the same. You just look at life through a different lens.” Likewise, Rachel shared, “Infertility remains with us as a couple; it is a distressing experience.” The wives in the study share these thoughts, describing infertility as a trauma that impacts the self emotionally and physically. As a result of the experience, they experienced loss, strained relationships, and their sense of self and belonging in the world. They feel permanently impacted by the experience. Rachel jokingly shared that she felt as if she had post-traumatic stress disorder as a result of the experience of infertility.

> You're just a little different. You just more ... you're eyes are open and it's not like a happy opening. It's kind of a sad opening. But you're eye, you just don't have that naivety of just, everything's going to be perfect, I'm going to have an easy pregnancy, nothing can go wrong. I'm going to get pregnant when I want to. I'm not going to get pregnant when I don't want to. You lose that false sense of “I have control” and that there's a guarantee. That's just gone, it's just, you know. I'm just more ... you could say bitter or negative, or you could just say realistic. I just have no more naivety about any of that stuff.

Tasha felt that once she and her husband adopted a child, she would feel better and struggle less with disappointment, sadness and anger. She ignored advice from friends

who cautioned that she would continue to be affected by the experience of infertility after becoming a mother. She shared, “I'm shooting out this baby, I'm going to be okay, I'm going to be okay. And so now when it happened, as sad as it was I was like, ‘Oh my God, this is what people were talking about’.” Not only does Tasha have to deal with the lasting effects of the experience of infertility, as an adoptive parent, she has to deal with reoccurring experiences in which she has to explain that she did not conceive her son.

> I think one of the other things for me, I'd say in terms of the trauma that's a trigger for me, is the introduction of how your child came to you to new people. So for instance, people don't know that MJ is adopted unless I tell them, right, like strangers. So when all the moms are sitting around and they're having their conversations about "Oh girl, when I was pregnant, do you remember this happening?" I don't share that experience with them. So that's kind of an issue for me because it's like, "Okay, do I just blurt it out, but then it's like why do I have to tell everybody that he's adopted? Do I just sit here quietly, what do I do?" Like one night, an acquaintance and I went out for a drink one night. So she's talking about her kids and stuff, and I said "Yes, because when MJ came" -- and it's like most people don't say that, most people say when MJ was born -- and so I'm not comfortable saying that, I wasn't with him when he was born. But then when I say "when MJ came" I get the dead stare like what the hell kind of comment is that? And then I got to explain it further. So for me, that's a constant thing. A constant thing, you kind of feel like having to relive like, "okay, how do" -- and I'm still struggling like there has to be another way I should be wording this that, I don't

> have to reveal all my business to some perfect stranger, but with a line that I feel comfortable with. And I don't feel comfortable with like "oh, when MJ was born."

The wives struggled with managing emotions, some choosing to repress their emotions in order to terminate the unbearable feeling created by the trauma of the experience. Melissa shared that she told herself, “I can’t grieve”, despite feeling empty and disappointed with her failure to conceive. She chose to suppress the experience to avoid against the painful emotions of the experience. On the other hand, for some wives, being around children, attending family events, or innocent questions from others about pregnancy plans could trigger a flood of repressed emotions. As a result, they are more cognizant of what they say to other women. Rachel shared that trauma of the experience of infertility has made her more empathic because she does not want other women to experience the discomfort and disappointment of fielding questions from others about pregnancy.

> …Unless I see a foot coming out and the umbilical cord, I'll never ask a woman if she's pregnant because you just don't know, they could just have gained weight or they could just be a little, have a little tummy or whatever.

Faith.

“I prayed a lot,” a sentiment expressed by all of the wives in this study. Faith is described as a long-standing and central tenet in the lives of the wives. As African Americans who grew up in church, the wives shared that they utilized faith to provide relief and fulfillment from the experience of infertility. Relying on their faith in “God’s will and provision”, allowed the wives to cope and draw strength from the experience. Accepting God’s will also helped the wives to acknowledge the possibility that they may

not be able to conceive. Melissa shared, "…if it doesn't happen naturally, it is not of God." If she could not have a child, then it was not God's will for her to do so and she had to accept that. Like many religious individuals, she was taught that you do not question God's will; you accept His sovereign plan for your life.

Some of the wives also shared their struggles with infertility with their church family; an instrument used by many African Americans to cope with the problems that impact their lives. The church family consists of the minister and members who are leaders and/or sources of support when one is in need. The act of sharing with the church family is called a testimony, a religious recounting of an experience. Rachel expressed, "I kind of wanted to share and for people that I knew to help me to be positive, so people could pray for me and believe with me." Sharing with the church family provided some of the wives with a sense of comfort and empowered them to believe that they could survive and deal with the experience of infertility. Their testimony also allowed some of the wives to help other church members who were secretly dealing with infertility.

Time.

"You're up against time and the quality of your eggs", Angela expressed when discussing the impact of time on infertility. The wives described knowing that their fertility is affected by their age. As a result, they felt pressure to become pregnant before they reached an age when their fertility rate began to decline. As self-described assertive, professional women, the wives were used to being in control and having most details in their lives planned out to the most finite detail. As Tasha explained, with each failed attempt at conceiving, the pressure began to mount.

> During the infertility process, everybody I know, you bank your holidays for when you're going to get pregnant or when your child is going to come. So, it would be like, oh God, maybe I'm going to be pregnant for Valentine's Day, what a lovely gift that would be. Oh, it didn't work? Okay, oh my goodness, my Mother's Day present would be that I'm going to be pregnant, and if this works, it means that by the Fourth of July, I'm going to have my baby celebration. Every holiday becomes the big significant one.

The wives learned that they had to relinquish time. Fertility was an area of their lives in which they had no control.

Some of the wives also shared feeling pressure from their families. Mother in laws began to question when they would become pregnant, growing impatient at time moved on. Rachel wanted to meet her husband's goal of having a child by the time he was 30. "I met husband when I was 24 years old. When I was 24, he was older, but he always said he wanted to be a dad by 30. We were kind of ticking on that clock."

Culture.

The wives shared that issues such as shame, fear, lack of support, lack of education and awareness, lack of health care, cost and access to infertility services can impact the ability of African Americans to seek treatment. Melissa and Terri shared how they struggled with issues related to their reproductive health during adolescence, but did not seek adequate treatment because of lack of awareness, education and shame.

After a series of sexually transmitted infections, Terri developed pre-cancerous cells in her cervix. As a young, professional adult, she began to educate herself about her

health. When she was treated by a gynecologist, who told her that pre-cancerous cells were the least of her worries and because of her age, Terri did not have to worry about infertility because she was not married. She wanted to discuss her concerns, but was made to feel ashamed by her gynecologist. “I was already embarrassed, because this was a doctor who was treating me for pre-cancerous cells as a result of my promiscuous sexual activity.” As a result, Terri waited three years to seek additional treatment and to address issues of infertility.

Melissa struggled with a difficult menstrual cycle and eventually, developed endometriosis, a disease in which tissue that normally grows inside the uterus grows outside it. Although her mother was aware of her reproductive health issues, she never took her to a doctor as a child or encouraged her to seek help as an adult. Melissa felt that her family’s lack of education about reproductive health discouraged her from seeking help.

> In the black community, I wish that you know, that I would’ve known or my family would have been open to, ‘Lets go find out what’s happening’ ‘She’s losing eggs? Lets go freeze some eggs.’ That’s something we don’t … I can only say about my family, that my family was not open to.

Although five of the wives who sought fertility treatment were able to afford the costs, they acknowledged that cost and access to care can be a possible barrier to treatment for other African Americans who are unable to pay for services as a result of socioeconomic and insurance barriers. In addition, they shared that unless you live in or close to a major city, it can be a challenge to access a fertility clinic. Each of the five wives who sought treatment resides in areas that are close to a fertility clinic. Yet, some of them found the

experience isolating as there were often in the minority at the clinics. Terri shared, “I didn't see any black faces, like all I saw was Caucasians and Indians and Asians.” She views this as a hindrance to African Americans seeking fertility treatment.

> I didn't know ‘till I got brochures that there haven't been that many like black celebrities speaking out. Sherri Shepherd is one that has been pretty open about her background, her son and everything. But I think a lot of us suffer in silence and I wish that like more prominent black people would come forward and talk about it [infertility].

Some of the wives also shared that some African Americans have historically declined to seek out health services as a result of a cultural suspicion of health providers. Rachel expressed the following:

> …We generally like have less trust, you know, people still think of us and the Tuskegee Experiment, and all that stuff. ...Those events are long hailed with good reason. You know, like there's been studies that show black people going to the same doctor, get different treatment and bedside manner than the general population, so there's good reason for that.

The wives also acknowledged that there is a need in the African American community to overcome these cultural suspicions in order to develop preventative health care habits and become more informed about their bodies. Some of the wives even use their experiences with infertility as a cautionary tale, to empower others to be more proactive.

Husbands

The husbands in this study viewed infertility as a problem, but primarily for their wives. Although they expected to become parents at some point in their lives, they never imagined experiencing difficulty with conceiving. When the husbands discovered that childlessness may be part of their reality, they acknowledged the issue, but maintained a level of emotional detachment. The pain and disappointment was compartmentalized, a cultural response to society's expectation that men always present as strong in the face of adversity. Emotion and vulnerability are a weakness. Coping in less vulnerable ways is more socially acceptable. The husbands were very careful and limited in what they shared regarding their experience of infertility. As a result of this experience during the interviews, there is less to be said, but there are themes that emerged.

- Protector and Supporter explores the husbands need to protect and comfort their wives from harm, struggle, and emotional pain.
- Experience Put Into Perspective Then Ignored describes how the husbands rationalize, and present with composure and control despite the emotionally charged experience of infertility.
- Faith is a coping mechanism for the husbands. They use it as a tool for reframing their experience.
- Self-Image describes how the husbands conceptualized their internal identification as man, husband, and father during their experience of infertility.
- Choosing Who to Tell explains how the husbands carefully considered whom to share their experience with and who they reached out to for support.

Protector and supporter.

As males, the husbands in this study expressed the belief that their most important responsibilities in their family are being a protector and supporter. These beliefs are in accordance with their faith and what they have been taught by caregivers. There is an innate drive within them to serve as the protector and supporter of their families. As a result, the husbands protected and supported their wives through the experience of infertility by remaining optimistic. Any disappointment and hurt must be controlled in order to protect the feelings of their wives and be an encouraging partner. They felt that if they were okay, their wives would be fine. Lamar expressed the following:

> I handled it, making sure that she was okay. Making sure she understood I was fine with it and that God don't make any mistakes and that's kind of how I live my life. I would love to; you know make another attempt at it. But I understand that her body goes through a lot of changes and she made it clear that this would be the last time because of, the changes that she has to go through in order to make it happen. I wouldn't put any pressure on her, I love her, you know, and we gone ride, we gone ride or die together.

Lamar felt it important to show care, understanding, and place his wants aside, so that Terri could feel less emotional pain. Like Lamar, Victor wanted to do as much as he could to diminish the effects of infertility on his wife and marriage. "What helped me was helping her as much as I could. I don't like to see her sad. It was painful for me, but you just try to be as strong as possible."

As a show of love and support for his wife, Jimmie was willing to sacrifice his desires for fatherhood and remain childless. Before deciding to adopt, Jimmie recalled

telling Adele that he would be content with not having children if subsequent attempts proved unsuccessful. He felt that doing so would take the pressure off of Adele and demonstrate to her that he supported his wife regardless of the outcome.

> I always thought that I would be a good dad and that I would like to be a parent, but if it did not happen, I would not have like, jumped off a bridge. It's one of those things where I would have always wondered what it would have been like and that would have been a missing piece, but not a critical missing piece in my life. My life would have still gone on, you know, we probably would have been still taking trips and doing the crazy stuff we were doing like every year, we would take a honeymoon and other trips, so you know…It would have been a missing piece, but it would not have been a critical missing piece.

Experience put into perspective then ignored.

"If my wife can't conceive naturally then guess what? That'll be an experience that I won't have." This was Lamar's thought when discussing how he dealt with the possibility that Adele may not be able to conceive. He, like the other husbands intellectualized the experience of infertility as a means of coping. They internalized the experience as just that, an event occurring over the course of their lives. Lamar went on to say the following:

> You know I think I done been through enough in life you know where I just have a, it's almost like I got a, I got a calculator that all I got to do is just input the information and press the equal sign and then it gets filed away or it gets processed through that application and then it's done.

Some of the husbands expressed feeling less of a burden because they did not have to undergo any testing or treatment. This further enabled them to have some emotional detachment from the experience. Victor shared, “Well it was more of a burden on her than it was for me. I guess I may be easy going in that respect. It didn’t bother me as much as it did her.” Jimmie shared how communication plays a part expressing, “Well, we don’t communicate as well as ladies do in general. We don’t, usually when we are talking amongst the guys, it is more lighter stuff, you know, it doesn’t really get all that deep unless, you know, we’re really hurting or something like that.” In the face of adversity, the husbands had to be strong. Emotional vulnerability is a sign of weakness, unproductive, and does not solve the problem.

Faith.

Like their wives, the husbands utilized faith as a means for reframing the experience of infertility. They found faith to be a strength for them and key to their functioning. Ramone discussed the importance of prayer while he and Rachel went through treatment.

> Religion does help, keeping your faith in God. Pray. A higher power is behind you and doesn’t want any ill will toward you, only wants you to be happy and prosper. Prayer helped us so much, you know? It’s so much easier when you have a God to pray to that, you know that is there and will cover you, rather than you going through it by yourself. It’s so much harder and it’s all on you then. Of course you’re going to think about it because it's you and you’re going through it,

> but prayer does help. When you pray, 'Lord it's on you take it away from me', that type of thing – it does help.

Some of the husbands also turned to the pastors of their church for support. Viewing their pastor as a leader and the surrogate paternal figure in their lives, the husbands found solace in their words and prayer. Matthew shared, "…Me and my pastor are close, so we would, we would have discussions about it." For some, the pastor was one of the few people they confided in about their thoughts and feelings.

Self-image.

Some of the husbands equated infertility with a defect in their masculinity. The inability to procreate with their wives left some questioning their sexual identity and manhood. Probing questions from family and friends about the failure to conceive were experienced as an attack on self and the husbands' ability to "take care of business in the bedroom." Jimmie shared how challenging it was for him as a man to speak to others about infertility because of concerns of being ridiculed. He expressed the following:

> …As a guy, the first thing is everyone is like, "Oh you got a low sperm count? You can't get your soldiers to march?" Just the cracks, "You ain't feeling like a man today?" It's always an attack on your manhood, when you need to talk about fertility. It's a big joke, you know what I mean? It's like people don't think that other things could be a cause or a factor.

Comments like these further fueled the husbands' disappointment and feelings of inadequacy as a man and husband.

The experience of infertility created a feeling of incompleteness in the husbands. They never considered the reality that they could not become parents, it was always assumed this would naturally happen at some point in their lives. The fact that it did not, felt like a defeat. As Lamar expressed, “I'm a man that does not like to lose.”

The impact of the societal stereotype and misperception of African American men as virile individuals who can easily and frequently impregnate women, also weighed on the husbands. Although this perception is viewed as negative and hurtful, the husbands found themselves wishing it to be true during their struggles with infertility. Matthew shared, “…then also you have to deal with stereotypes. You know you have that stereotype out there, the black fertile male, the black fertile female and they get together and they have babies and they keep on having babies. You look at us and we were just unable to uphold that stereotype.”

Choosing who to tell.

Infertility is a very personal experience and as a result, the husbands were very careful about who they reached out to for support. A former coach, church leaders, and a close relative were the identified sources of support for the husbands. These sources of support are individuals who possess leadership qualities and are admired by the husbands.

Ramone disclosed, “…Did I need to talk to someone about it? I guess, but it wasn’t like, it was more like I needed to talk to someone. It wasn’t like I got a comforting feeling from talking to them about it. I just needed to talk to someone about what I was going through.” The husbands seemed to understand the importance of confiding in

someone, but struggled to find the importance in utilizing supportive outlets for their feelings and thoughts. They disclosed that admitting failure and asking for support proved to be very challenging. As a result, they chose to repress overt emotional responses.

Acknowledging how difficult it is for men to talk about feelings and frustrations, Lamar shared he feels men would benefit from a therapeutic support. He envisions a central headquarters for African American men in particular. This headquarters would offer seminars on issues related to African American men, including infertility. Lamar expressed that only in a forum such as this could men come together and discuss issues. "…Watch the auditorium fill up. You know I think that that with all of the issues that we as African American men face on a day to day basis, we need a venue like that."

Couples

The stress of infertility has the ability to impact a marriage. The couples talk about the negative and positive impact of the experience on their relationships. Open communication or lack thereof has the potential to strengthen or impact how the couples experience infertility alone and together.

- Cohesion describes the couples need to stick together, be supportive and maintain an open line of communication in order to preserve the relationship during the experience of infertility.
- Using Experience to Support Others explores how the couples utilize empathy for other couples, who are experiencing infertility, as a coping mechanism. They feel a need to take care of their own.

- Faith is central in the lives of the couples. Their religious and church involvement sustained them through the experience of infertility. It continues to sustain them to this day

Cohesion.

"I believe it (infertility) increases Believer's faith. And can either drive a marriage closer or tear it apart." The couples acknowledged that the experience infertility is a tremendous stressor that has the power to negatively impact a marriage. However, for four of the couples in this study, the experience brought them closer together. Adele and Jimmie shared how the experience of infertility made them more of a cohesive couple. Adele explained, "I personally think it brought us closer together, and there were times we would just talk and say, 'you know what? Maybe it'll just be us, and we would be ok with that.'" Infertility was viewed as a problem that they could overcome together as a team. Patricia and Victor shared the following thoughts on working together as a team:

> We began to be supportive of each other. Acknowledging each other's feelings and frustrations. Now, when we talked about it, we talked about why it was so hard. Then we just, tried to make our way through it. Sometimes you just have to grind and push your way through it and so, we did.

Keeping the lines of communication open were key for these couples. They found that the more they discussed their feelings and thoughts with one another, the more cohesive they felt as a unit in trying to work through this experience. In addition, they found that they developed skills that they continue to rely on now that they are on the other side of this experience. Tasha and Matthew shared the following:

> I'd agree …that the things that brought us closer during the infertility process are the things that keep us close. The skills that you would use, like, how are we going to make this appointment? How are we going to pay for this? Ok, we're going to rah-rah and cheerlead and for each other and when you're down, I'm going to be up for you. Those things that we were doing during that process are the things that we use during parenthood now.

Two couples of the couples, Terri and Lamar, and Rachel and Ramone, shared how the stress of the experience of infertility impacted the lines of communication in their marriage. The couples described how they would retreat into their own lives, choosing to deal with their thoughts and feelings separately. Rachel expressed, "I would say we didn't do a good job of that. I felt like it was always kind of like, separate. I did my own thing and he did his own thing to get through it." When asked how they coped as a couple, Ramone disclosed that Rachel was the "worrier" in the relationship. He felt that conception would happen with time. Terri shared that she would push Lamar away, preferring to "delve into work" rather than work through how the experience of infertility is impacting her and her marriage. In response, Lamar expressed that Terri's actions made him feel as is he had done something wrong. Rather than addressing his feelings with Terri, he gave her space, waiting until she would "come around" and want to talk.

Using the experience to support others.

As a means of coping, some of the couples offered their support and guidance to other couples and/or individuals who are experiencing infertility. The sharing of similar experiences has been affirming. The couples shared that other couples have drawn

strength from their empathy and support. Tasha shared that it felt good her and Matthew to be a "blessing to others." She recalled a moment when Matthew's college alum revealed that he and his wife decided to foster after seeking support from them.

> I heard the guy come up to Matthew and say, "I'm so glad that you guys talked to us about the baby." [Talking to his foster son] "This is Uncle Matthew and the reason that MJ is your cousin is because this is who I called and he prayed with us." So I thought that was like a cute little moment.

Through an adoption agency in their town, Adele and Jimmie regularly facilitate talks with pre-adoptive parents, who are also experiencing infertility. The couple finds their talks to be quite helpful to the prospective parents. In addition, they find the talks to be just as affirming for them as it for the other parents.

> …We met other couples that adopted after us, you know, chit chatting with them, they'll tell their story. Most of the couples we've met did experience infertility so you talk to them and you say, "Oh yes, we went through the same thing" and it's a bonding experience.

Interestingly, the husbands expressed that sharing their experiences with other husbands helps to normalize what they are going through. Some men find comfort in knowing that there are other males having similar experiences. Jimmie, explained, "So I've had other guys, people who know that my daughter's adopted, asking about the experience and I feel more open and willing to talk to people now about these situations." The husbands find that by helping other men, they are also helping themselves. Matthew shared, "A person, I work with, him and his wife are presently going through invitro. We've had long discussions on lunchtime about things that matter and it is therapeutic to be able to

help somebody else going through the same situation." He also went on to share that now that he is on the other side of the experience, he feels more open to discussing what he went through. It is important for Matthew and Tasha to help other couples. In a sense, they feel as if they are taking care of their own.

> I'm more open with information now. There are a lot of people going through the exact same thing, but no one's talking about it. Everybody's sitting in a corner and no one wants to talk about it because they're scared to hurt, or to hurt people's feelings, or to make people feel like they are inadequate.

Faith.

"And we prayed. A lot of prayer…" The couples shared that their faith and belief that something or somebody greater than themselves is watching over them has been a sustaining force. It is an essential part of who they are and a historical, familial practice. Utilizing faith to cope in the face of disappointment, loss, and grief has helped the couples to persevere and work to overcome these obstacles. Rachel shared the following,

> Infertility helped us to draw to our faith. I don't think I prayed as much in my life as when I was praying for a baby. I just wanted a baby. I didn't care if the baby was perfect or flawed; we just wanted a baby to call our own.

In addition, praying together and having faith as a couple helped to strengthen the couples, provide relief, and fulfillment. Matthew and Tasha shared, "… Our faith and our reliance on each other, we became extremely close during the years that we were going through our infertility phase. I think, that it helped us have an extremely strong marriage, based on those years." Patricia and Victor expressed that their faith made them grateful

and cognizant of what they had to endure in order to work through the experience of infertility.

> … It helped us ultimately to get stronger and to grow more in our faith because we had to depend on leaving things up to God and His will and plan for us because it's out of your control what your body does. …I felt like it strengthened our faith in God. I felt like it did enhance, you know, our relationship when we did have a kid, I think we were really, really joyful because we know what that cost us.

It's just too difficult to talk about.

When asked by this researcher during the follow up interviews to share any additional thoughts about infertility as a trauma, the four of the five wives expressed that infertility is a distressing experience that can be very difficult to deal with emotionally. Patricia feels that the experience of infertility is no longer a distressing experience for her, she expressed, "It's not challenging anymore because it's something I have overcome. Had I not conceived, or if I was still trying to conceive, I imagine it would be challenging."

Although, four of the wives are now on the other side of the experience as the result of having become mothers, the experience still resonates with them. As a result, it can be difficult to deeply discuss. Melissa, who has not yet conceived or decided to adopt, shared, "It is such a private matter that some people do not wish to discuss with anyone." She went on to say, "It is hard to open up. Having a deep discussion about infertility can trigger emotions that people may not be ready to deal with." Patricia shared

the same feelings, “From what I gather speaking with those who have gone through infertility, it’s a very private matter that many do not wish to discuss.”

Infertility is such a difficult experience and as a result it has been a challenge to get the participants of this study to deeply discuss how they have been impacted by it. In trying to get participants to talk openly about this experience and provide more insight into this closed system, the researcher encountered distance and discretion. The disappointment, shame, grief, and inadequacy serve as a barrier against the participants discussing the experience more deeply.

Summary of Results

This study analyzed data from six couples (12 total participants), who have experienced infertility. The couples were interviewed separately and together. Their personal accounts illustrate the profound impact the experience of infertility has had on their lives. Infertility is a traumatizing event that was experienced differently by wives and husbands in this study. The distress of the experience challenged their sense of self.

As previously mentioned, recruiting and obtaining information was a challenge. Some of the participants acknowledged infertility as a traumatic experience, but struggled to provide deeper insight into their descriptions. Furthermore, the researcher found that most of the participants preferred to focus on how infertility drew them to their faith. The couples relied on religion and spirituality, which play a central role in their lives, to provide strength and to help them cope with infertility.

Although it was thought that couples would be more willing to discuss the experience of infertility because they are “on the other side it,” the researcher found that

this was not necessarily the case. The participants in this study struggled to delve deep into their experience. To do so would possibly evoke past painful experiences that have been repressed.

Chapter V

Findings

Introduction to Findings

This study analyzed data from six couples (12 total participants), who have experienced infertility. Twelve participants were selected through one of the online fertility support groups and the researcher's Facebook page. The couples were interviewed separately and together.

The personal accounts provided by the couples illustrate the profound impact the experience of infertility has had on their lives. The findings demonstrate how infertility can be a traumatizing event that is experienced differently by men and women. The distress of the experience challenges one's sense of self. The findings also suggest how the religion and spirituality play a central role in the lives of the couples, helping them to cope with infertility. This chapter will take each of the findings and discuss them using the results. The findings will also be discussed in light of pertinent literature.

Discussion of Findings

Experience of infertility created narcissistic injury to self.

Infertility can disorganize one's sense of identity (Leon, 2010). Infertility can 'wash away' all the other identifying marks of a person (Letherby, 2012).

The experience of being deprived of conception and parenting, caused the couples to have to endure feelings of role failure, inadequacy, guilt, anger, shame, and helplessness. S/he becomes known as the "other," a person who is infertile. This identity is viewed as lesser and different than that of one who is a parent (Letherby, 2012).

As Adele expressed, "Something you want is not in your reach." This experience impacted the wives sense of self as a person. Rachel shared how infertility impacted how she viewed herself as a woman. "I would say it was definitely moments where I'm like I'm less than a woman. Like when can we have a kid? How am I going to not have a kid and my husband comes from a very big family?" The narcissistic injury of being unable to conceive with her husband, made Patricia feel like a failure. Her healthy narcissism and sense of identity as a full functioning woman was impacted.

Visions and plans for motherhood, marital life, and vitality as a woman were derailed.

For the wives in this study, prior to experiencing infertility, they entered into their marriages full of hopes and dreams. Early on in life, they identified with the many maternal role models around them who provided them with the template for female oriented roles. This is evident in the thought expressed by Melissa, "…I just always assumed I would get married and have kids like the family I grew up in."

The wives idealized fantasies of omnipotence and femininity, were also characterized by their membership to a website for wedding planning. They exchanged wedding tips and ideas, basking in the euphoria of becoming a wife and eventually, identifying as a mother. After marrying, they began to desire the shared experience of connecting with family and friends via motherhood. When producing offspring became a

challenge, the wives began to feel disappointed and ostracized. They began to question, "What is wrong with me?" Their sense of self as a woman with reproductive capabilities was disrupted by this experience (Jaffe, Diamond & Diamond, 2005). This led to them forming a subgroup within the wedding planning website they initially joined to plan their nuptials, where they could develop a female constellation of support for women who are experiencing infertility.

Infertility is a traumatizing event that psychologically impacted the couples.

Infertility is a traumatizing event that also psychologically impacted the couples. This means that damage or injury occurred to the psyches of the couples as a result of the distressing experience of infertility (Jaffe, Diamond & Diamond, 2005). As a result of this experience, they have encountered challenges in functioning or coping normally.

When the healthy adult self experiences trauma, one is able to soothe and calm him/herself when distressed (McCann & Pearlman, 2015). S/he is able to manage difficult feelings via regulation. A healthy adult self is resilient and able to persevere in the face of difficulty. S/he is able to utilize the support of a partner or others to problem solve and work through challenges. In addition, he/she is able to be empathic toward others in their time of need. Even when faced with failure, a healthy self is resolute and willing to try again. He/she is also willing to acknowledge limitations without becoming self–loathing or self-sabotaging (McCann & Pearlman, 2015).

When the vulnerable adult self experiences trauma, the experience is quite the opposite of the healthy self. According to Kohut (1972), the vulnerable self often becomes quite dysregulated and self-destructive when distressed or faced with difficult feelings, tending to rely on anger, negative self-statements and/or thoughts. S/he may

become closed-off, avoiding situations, people, and topics of discussion, or go to great lengths to avoid being alone in an effort to protect oneself against strong affect (McCann & Pearlman, 2015). Melissa expressed the following:

> I did shy away from things because I didn't want to be around it. I didn't want want to sit and talk to somebody about kids because I wanted that. I wanted to be the one that had the kids that people were talking to me about.

In addition, he/she lacks empathy, and may feel a sense of entitlement and resentment toward others. Tasha expressed the following:

> I found that I was angry a lot of times and I took it out on a lot of people. Looking back in hindsight, there a lot of events I had no business attending, friends that I really did not treat well because I couldn't deal with it. My view at that time was, 'Woe is me, look at what I'm going through', and so, you know, 'Excuse me for snapping off on you, but I can't have a baby.'

The vulnerable self struggles to communicate needs, selfishly hoping others will figure it out (McCann & Pearlman, 2015). When faced with failure and adversity, the vulnerable self tends to retreat, becoming hopeless and discouraged at the thought of persevering and trying again.

Melissa shared, "I do want to leave something behind. That has been my biggest thing. I want to leave me behind and I feel like people leave themselves in their children. They leave a part of them behind to be good to the world." The couples in this study craved and longed to have babies. They had fantasies about creating children who would be an extension of them. These children became idealized thoughts in their minds. The accomplishments of these fantasied children would reflect the hard work and

achievements of their parents. As a result, becoming a parent was one of the many tasks these couples identified in order to fulfill their goals of adulthood. When faced with difficulty procreating and then receiving a diagnosis of infertility, their dreams and hopes came crashing down.

In addition, to becoming preoccupied with medical procedures, ovulation, and finances, the couples found themselves on an emotional roller coaster. The wives in particular shared feelings of euphoria one moment and then complete devastation if a treatment were unsuccessful. As Patricia expressed after a failed treatment, "I found myself grieving something I would never have." The husbands also struggled with disappointment, but as Victor explained, "…there is no blue print", so they did the best they could, continuing to support their wives and put the experience into perspective.

Infertility is a trauma that attacks both the physical and emotional sense of self, it presents one with multiple, complicated losses, it affects the most important relationships, and it shifts one's sense of belonging in the world (Jaffe, et.al, 2005). With each failed treatment and/or attempt to procreate, the couples in this study have had to consistently re-experience loss. "The trauma of infertility is such that what you had taken for granted and expected is lost" (p. 29-30). For five of the couples in this study who were able to have children, that trauma of the experience remains with you.

For the wives who adopted, the traumatizing experience of infertility is triggered during doctor's visits when their medical history is taken, or while engaging in casual conversation with other mothers when the topic of pregnancy comes up. Tasha shared a difficult exchange with a nurse in the doctor's office that happens all too often for adopted mothers:

> ‘If you have one child, Mrs. W., then you have been pregnant once.’ I was like, ‘No. I have never been pregnant.’ She was, ‘Okay, let’s go back. You have one child, correct?’ I was like, ‘Yes, I have one child.’ ‘Okay, that means that you’ve been pregnant at least once unless or other times.’ I was like, ‘Why are you talking to me like I’m slow? You should give a little bit more thought. I have a son whom I adopted, that’s why I’ve never been pregnant.’ She was like, ‘Oh my God! I’m so sorry!’

Adele also shared how the trauma of the experience impacted how she views procreation and women who appear to be naïve about the experience.

> You're never the same. You just look through life through a different lens. Like I said you know, on the inside you have a little bit of eye roll or just, to be so naïve. The young people at work are just like, ‘Oh you know, yes, I'm going to have two kids, and they're going to be two years apart, that's going to be a boy and a girl. And we want to get pregnant on our honeymoon.’ They just have an innocence, or they never even think that something could go wrong. Or like people that pee on a stick and then immediately tell people they're pregnant, whereas I was like ‘I'm not going to tell people’, cause I know all the bad things that can happen, you know?

For Melissa and Mark, who have been unable to conceive together, the traumatic effect of the experience has taken its toll on them both. Mark expressed feeling disappointment, “I finally have the love of my life and not being able to create a seed together is upsetting.” Melissa expressed that being unable to have a child has affected her more deeply than she realized. Family events and spending time with her stepchildren can trigger strong

emotions and thoughts about her experience. It was during a phone conversation with a friend that she realized how the experience has impacted her. “I never realized how deep, my infertility ran until we had a conversation and were talking and I started to cry. I never really realized how much this had affected me.”

Failure to produce a child caused narcissistic injury to the husbands’ self esteem and ability to fulfill their societal role as producer and man.

The role of father and man are typically associated with power, provider, virility, authority, and status. The biological aspect of fatherhood and the patriarchal status are important experiences for men and masculine identity (Letherby, 2012). Infertility alters this experience for men.

The husbands possessed idealized fantasies of omnipotence and masculinity. It was important for them to produce a child who could carry on the family name and/or bear their likeness. Ramone expressed, “I always wanted kids. …there’s six of us and I’m the last of the six. My brothers and sisters all have three-plus kids, some of my brothers have six.” Failure to produce a child caused narcissistic injury to the husbands’ self-esteem and ability to fulfill their societal role as procreator and man. Like their wives, this led to diminished self-worth and feelings of role failure. Their sense of being as man is called into question.

Even if there is no male factor involved, infertility impacts a man’s ability to feel masculine. He may feel helpless, vulnerable and ashamed that he is unable to remedy this problem. The reliance on medical help makes this feeling worse.

Like the other husbands, Jimmie shared how challenging it is for him to deal with feelings of inadequacy as a result of infertility. Jimmie always envisioned himself as a

father. With his father and other positive male role models around him, he identifies with them as men and as a father. “I always thought I would be a good dad and that I would like to be a parent.” He wanted to be able to share experiences with his child that he had when he was younger. Failure to produce a child impacted his sense of self as a whole person. Questioning and jokes from others were perceived as an attack on the self.

> …As a guy, the first thing is everyone is like, “Oh you got a low sperm count? You can’t get your soldiers to march?” Just the cracks, ‘You ain’t feeling like a man today?’ It’s always an attack on your manhood, when you need to talk about fertility.”

Comments such as the one above further contribute to the husbands’ sense of shame, guilt and failure as men. This finding is similar to what Tyler may (1995) found in her research on the experience of infertility among men. The author found that men possess very strong feelings about being infertile. Male participants expressed feeling unworthy, bitter, and useless because they could not contribute to society via reproduction.

The husbands in the study did not express the same range of emotions that their wives struggled with.

Although the husbands in this study were just as vulnerable to the experience of infertility as their wives, they were restricted in how they expressed their feelings. They identified feeling some disappointment and helplessness because they could not fix or control infertility. Some of the husbands also admitted some shame when questioned by others about why they could not get their wives pregnant, even though infertility was not the result of a male factor.

The vulnerability of this experience and sharing it with a female interviewer may have impacted how willing the husbands were to disclose a full range of emotions as their wives did. Rather than fully opening up and expressing their thoughts about the experience of infertility and parenthood, they preferred to put things into perspective and focus on supporting their wives. As Lamar expressed when asked about how he feels the experience of infertility has affected him,

> You know I think I done been through enough in life you know where I just have a, it's almost like I got a, I got a calculator that all I got to do is just input the information and press the equal sign and then it gets filed away or it gets processed through that application and then it's done.

Like the other husbands shared, rather than dwelling on infertility and the feelings surrounding it, Lamar felt it was more important to move on and possibly accept fate.

> You know I don't I don't get too up, I don't get too down, what's for me I get. You know and if I don't get it, it wasn't for me. You know and I just look at it as you know that may not be for us, that may not be in the cards for us.

They tried to organize around the pain by holding emotion and being stoic. The husbands opted to remain optimistic and supportive of their wives. This is similar to what Greil et al. (1998) found tin their research. Men are able to put the disappointment into perspective and then either move forward or ignore the problem.

In terms of support systems, the husbands were very careful in deciding whom to confide in. They often sought out support and guidance from a father figure in the community, close friend, or church leader. These individuals served as admired, respected, and idealized self-objects for the husbands. Matthew confided in his pastor,

"…Me and my pastor are close, so we would have discussions about it." Like a therapist, these individuals provided a mirroring function for the husbands of validation and unconditional positive regard that strengthened them (Leon, 2010). As a result, the husbands were more optimistic and solution-oriented in regards to dealing with infertility.

The experience of infertility can impact a couple's cohesion.

The experience of infertility takes a toll on the cohesiveness of a couple. Treatment, medication schedules, and failed attempts can create stress and a disconnect between the couples because their coping styles may differ. The need to seek narcissistic restitution via procreation created a significant amount of pressure. As a result, the couples struggled to experience self-object functions from one another. They began to communicate less, and became a closed system, retreating into a world of self-loathing, resentment, and anger.

For two couples in the study, Rachel and Ramone, and Terri and Lamar, the stress of the experience caused them to cope with infertility differently and in ways that impacted them as a unit. Rachel and Ramone both retreated into themselves, choosing to cope alone with their thoughts and feelings rather than turning to one another. Rachel expressed, "I would say we didn't do a good job of that. I felt like it was always kind of like, separate. I did my own thing and he did his own thing to get through it."

Terri tended to push Lamar away rather than reach out to him for support. Terri expressed feeling disappointment and "like a failure" with each failed IVF attempt. In response to her feelings, she would push Lamar away, preferring to delve into her work rather than deal with the shame and guilt of a failed procedure. Feeling rejected and disappointed as if he had done something wrong, Lamar would withdraw from Terri.

When couples experience challenges like trauma, they struggle with reliably providing self-object experiences for one another. This is especially the case if one or both partners lack a cohesive sense of self, emotional regulation, and an ability to articulate needs. In the face of trauma, these couples may be too overwhelmed by their own affective experience or affectively deadened to empathically respond to the experience and needs of others (Leone, 2008).

In response to feeling overwhelmed with the experience of infertility, these two vulnerable couples chose to retreat rather than come together. Failure to communicate about their thoughts and feelings, as well as recognizing each other's defense mechanisms, affected their closeness during the experience of infertility. As a result the couples were unable to be supportive and empathic to one another.

These findings are in line with research conducted by Peterson et al. (2003). Couples that are not in agreement about the stress they experience as a result of infertility tend to experience marital discord. Discord among couples leads to higher reports of marital dissatisfaction.

The experience of infertility brought some couples closer.

For four of the couples in this study (Patrice and Victor; Adele and Jimmie; Tasha and Matthew; Melissa and Mark), the experience of infertility brought them closer together. Empathy, open lines of communication, and, an awareness of their partner's style of coping helped these couples to remain intact during stressful periods. Patricia and Victor shared the following thoughts on working together as a team:

> We began to be supportive of each other. Acknowledging each other's feelings and frustrations. Now, when we talked about it, we talked about why it was so

> hard. Then we just, tried to make our way through it. Sometimes you just have to grind and push your way through it and so, we did.

These couples also recognized that any problems they experienced were the result of the stress of the experience and not problems in their relationship. They could not take differences in coping personally. By keeping the line of communication open and being honest with their feelings, the more cohesive they felt in trying to work through the experience of infertility. Tasha felt these skills were key in maintaining her marriage. She also expressed that not maintaining these skills had the potential to negatively impact relationships.

> I've seen a lot of people have their marriages end around fertility. So like by the time I met them, they were either in another relationship or they decided I'm just going to go through the donor process. You know my husband or myself wasn't on board with it. So I think I can see that a lot, that if you don't find the things that bond the two of you through that process, then it's the thing that tears you apart, especially if you don't communicate about it

The couples discussed their fears and acknowledged the pressure they felt to create a child. By sharing their internalized feelings about infertility with one another and grieving the loss of fantasies about conception, they felt better about their self-worth individually and as a couple. The couples were drawn closer by the experience and found that it made them more empathic toward others.

These findings are similar to what was found by Peterson et al. (2003) and Phipps (1998) in their studies on infertility and couples. Couples that are in agreement regarding the stress they experience as a result of infertility are better able to manage the impact of

stressful life events. In the face of infertility, couples had to develop new coping skills and be on one accord in order to maintain their relationships.

The couples in this study utilized faith as a coping mechanism for stressors.

A study of religious coping conducted by Chatters et al. (2008) suggests that faith is an essential part of the daily experience of married couples. African Americans in particular are more likely to identify religious resources and behaviors, such as prayer and pastoral support, as being important for coping with difficult life situations, possibly due the pain and shame of acknowledging a mental health problem (Chatters et al., 2008; Ellison & Taylor, 1996; Ward et al., 2009).

Each of the couples in this study recalled growing up in church, learning, and believing that there is a force greater than them that watches over them and provides relief from distress and fulfillment. They view God as loving and non-judgmental. As Ramone expressed, “A higher power is behind you and doesn’t want any ill will toward you, only wants you to be happy and prosper.” God never puts more on a person than he/she can bear. A strong belief in God’s provision and timing helped to manage affect and stress (Boyd-Franklin, 2003; Phipps, 1998).

For the couples in this study, faith was an important daily coping mechanism that provided comfort and solace during the most difficult times. It also served a self-object function in that praying together and having faith as a couple helped to strengthen the couples, provide relief from the trauma of the experience, and restore a healthier sense of self. Matthew and Tasha shared, “… Our faith and our reliance on each other, we became extremely close during the years that we were going through our infertility phase. I think, that it helped us have an extremely strong marriage, based on those years.”

Religious African Americans are more likely to seek help from the church in times of need (Ward et al., 2009). Individually and as a couple, the participants in this story also shared their testimony with the church as a way of obtaining support in a time of need. Rachel expressed, "I kind of wanted to share and for people that I knew to help me to be positive, so people could pray for me and believe with me." Viewing their pastor as a leader and a surrogate paternal figure in their lives, the husbands found solace in their words and prayer. Matthew shared, "…Me and my pastor are close, so we would, we would have discussions about it." These discussions helped Matthew feel confident and encouraged that he and his wife could persevere.

The couples in this study utilize their faith as a coping mechanism for stressors. Their faith helped them to grieve the disappointment of infertility, strengthen their commitment and fidelity, which also increased stability and satisfaction in their relationship. Via active participation in church services, psychological and emotional support from church leaders and members, the couples began to experience increased self-esteem and acceptance of their limitations. Religion plays a central role for African American couples and families, and is related to couple and familial wellbeing (Boyd-Franklin, 2003; LaTaillade, 2006).

Faith was also utilized by the couples as a defense against the unbearable feelings and vulnerability of the experience of infertility. Via the act of sublimation, the couples placed their emotions into the culturally and socially acceptable practice of faith and religion. Faith served as a defense against the anguish, pain, and emotional trauma of the experience. It is possible that it may have been more sustaining for the self if the couples remain in a grateful place for all that they have endured than to fully revisit the pain.

Faith also created a barrier for the researcher in getting the couples to speak more deeply about the results of this study. In trying to get the participants to elaborate on the results, the researcher experienced the same closed-system the couples utilized as a defense against the painful affect of the experience of infertility. In follow-up interviews, when asked to comment more about the results and in particular, infertility as a trauma, the participants were unable to fully open up to the researcher about their thoughts on the results. There was no openness to the experience of infertility as a trauma. Participants chose to reiterate the importance of their faith and the effective use of religious coping strategies in dealing with infertility. Being on the other side of the experience, or for one couple who has not yet conceived, "in a better place" than where they began, the couples feel a tremendous amount of gratitude to God for helping them "get through this experience." This barrier speaks to the intensity of this study and it painful effects upon the couples. In addition, it speaks to the importance of religious coping as a central resource in handling life problems (Chatters et al., 2008).

Couples bought into the myth that African Americans are very fertile and this belief created shame within them regarding their struggles with conceiving.

History and stereotypes have created the perception that it is quite easy for African Americans to procreate. The reality is, it is not. The couples disclosed that they too bought into this misperception. Adele shared, "…the stereotype of black women is, you know, we're the welfare mama. We have five kids by the time we're 22, and at least two or three different daddies. So we are not fertility challenged as people, right?" The myth that African Americans are very fertile made the couples in this study feel shameful

about their struggles with conceiving. Terri expressed that she felt uncomfortable discussing her concerns about the impact of her previous sexual history on her fertility with doctors who were dismissive. "…out of all the times I've been diagnosed with any STD, not once did any doctor ever say, 'you know what? You may never ever be able to have kids, as a result of your lifestyle," Like other African Americans who may be distrustful of or embarrassed by medical intervention, she wore a "shame cloak," declining to push for answers. It was not until she was referred to an African American specialist in the field that she felt comfortable enough to express her concerns.

This finding is in line with what Ceballo (1999) found in a mixed methods study of the impact of infertility on 10 African American women. It was found that the women in Ceballo's study often coped with infertility in silence and isolation. They experienced shame, frustration, desperation and anger. The women shared that doctors viewed them as medical anomalies, because the idea of an African American woman experiencing difficulty with conceiving was unheard of. Most of the women bought into this stereotype and it became internalized.

Victor and Matthew both had to undergo medical intervention to determine whether or not they were infertile, and expressed feeling "less than a man" during the process. They too felt that they did not live up to the stereotype of the African American man as a potent male. Infertility was an attack on their manhood and identity as an African American male. Matthews shared, "…you have that stereotype out there, the black fertile male, the black fertile female, and they get together and they have babies and they keep on having babies and they, and you look at us and we were just unable to

uphold that stereotype." Infertility is stigmatizing to males (Lloyd, 1996). As a result, they view it as a sign of their lack of virility and potency.

Summary of the Findings

For the wives in this study, prior to experiencing infertility, they entered into their marriages full of hopes and dreams. They had idealized fantasies of omnipotence and femininity, as characterized by five of the wives' membership to a website for wedding planning. They exchanged wedding tips and ideas, basking in the euphoria of becoming a wife and eventually, identifying as a mother. After marrying, they began to desire the shared experience of connecting with family and friends via motherhood. When producing offspring became a challenge, the wives began to feel disappointed and ostracized. Developmentally, their sense of self was disrupted by this experience. This led to them forming a subgroup within the website where they could develop a female constellation of support for women who are experiencing infertility.

For all of the wives (one who is unable to conceive, three who were able to conceive, and two who chose to adopt) the experience of infertility has had a marked influence on their functioning. Seeing pregnant women or meeting couples who are experiencing infertility can trigger a flood of emotions and create shared experiences that may or may not be welcomed. For the wives who adopted, they are reminded of their infertility during doctor's visits when their medical history is taken, or while engaging in casual conversation with other mothers when the topic of pregnancy comes up. For the wives who were able to conceive, their children are a daily reminder of the struggles of

infertility. For the one wife who is unable to conceive, family events and spending time with her stepchildren can trigger strong emotions and thoughts about her experience.

The husbands are also psychologically impacted by the experience of infertility. They expressed the wish to continue their genetic line by producing a child with their wives. The husbands possessed idealized fantasies of omnipotence and masculinity. To protect their identity as man and husband, it was important for them to produce a child who could carry on the family name and/or bear their likeness. Failure to produce a child caused narcissistic injury to the husbands' self-esteem and ability to fulfill their societal role as procreator and man. Like their wives, this led to diminished self-worth and feelings of role failure.

Although acknowledging that infertility is a struggle and disappointment, the husbands in this study did not express the same range of emotions that their wives struggled with. The husbands utilized fewer coping strategies, opting to remain optimistic and supportive of their wives. In terms of support systems, the husbands were very careful in deciding whom to confide in. They often sought out support and guidance from a father figure in the community, close friend, or church leader. These individuals served as admired, respected, and idealized self-objects for the husbands. Like a therapist, these individuals provided a mirroring function for the husbands of validation and unconditional positive regard that strengthened them (Leon, 2010). As a result, the husbands were more optimistic and solution-oriented in regards to dealing with infertility. Similar to research conducted by Cousineau and Domar (2007), the husbands in this study were more accepting of remaining childless if treatment failed and/or were no longer an option.

As the research presented in the literature review suggests, the stress of medication schedules, doctor's visits, surgical procedures, and disappointment with unsuccessful treatment, can impact a couple's ability to experience self-object functions from one another. For the two of the couples in this study, the impact of treatment on their lifestyle and subsequent ruptures in self and identification led to a lack of cohesion. The need to seek narcissistic restitution via procreation created a significant amount of pressure. As a result, the couples began to communicate less, and became a closed system, retreating into a world of self-loathing, resentment, and anger toward self and one another.

For the remaining couples, the experience of infertility brought them closer to their spouse. The couples discussed their fears and acknowledged the pressure they felt to create a child. By sharing their internalized feelings about infertility with one another and grieving the loss of fantasies about conception, they felt better about their self-worth individually and as a couple. The couples were drawn closer by the experience and found that it made them more empathic toward others.

As previously mentioned in the literature review, in order to restore the self and reintegrate the trauma, narcissistic equilibrium must occur (Leon, 2010). Narcissistic equilibrium must be established and internalized stigmas diminished. Historically and still to this day, religious African Americans look to their faith and the church for emotional support. Religion plays a central role for African American couples and families, and relates couple and familial wellbeing (LaTaillade, 2006). The couples in this study utilize their faith as a coping mechanism for stressors. Their faith helped them to grieve the disappointment of infertility, strengthen their commitment and fidelity,

which also increased stability and satisfaction in their relationship. Via active participation in church services, psychological and emotional support from church leaders and members, the couples began to experience increased self-esteem and acceptance of their limitations. Faith also served as a defense against the emotional trauma of the experience. Lastly, faith served as a barrier for the participants in that they were unable to further discuss the trauma of the experience of infertility and any emotional affects. Instead, participants preferred to talk about the importance of faith and being in a grateful place.

History and stereotypes have created the perception that it is quite easy for African Americans to procreate. The reality is, it is not. The couples shared that they also bought into this misperception. They myth that African Americans are very fertile made the couples in this study feel shameful about their struggles with conceiving.

Chapter VI

Theoretical Discussion

> Whether or not we have a child, whether or not we want a child, we still have a reproductive story. You might think that your reproductive story begins when you choose to get pregnant. But this is not the case. Even if we don't have children, we once were children, learning from and identifying with our parents. And our parents' role modeling and various cultural influences also play a role. When all this material gets pieced together, it comprises our reproductive story, which is an underpinning of our adult identity. (Jaffe et al., 2005, p. 51)

When something interferes with the creation of a child, there is a significant blow to the self-structure and grandiose self. It is experienced as a trauma. Reproduction is the result of what one can do and who one is as a man or woman. Infertility is a narcissistic blow to masculinity and femininity. It prevents a man and woman from identifying with his/her caregiver and actualizing the capabilities of his/her gender.

Although none of the participants in this study disclosed prior trauma, it should be noted that infertility can revive old conflicts around earlier losses unrelated to fertility, past traumas, and other experiences that may have ruptured development (Apfel & Keylor, 2002). Traumatic memories can threaten the maintenance of the sense of

continuity over time (Ornstein, 1994). These unresolved traumas contain a lot of emotional power around the need for compulsive control that can further impact one's experience of infertility if not worked through in some manner. The dilemma of this psychological experience can be overwhelming to the individual and couple.

The desire to parent for men and women is developed through the early nurturing and empathic relationship with the primary caretaker (Chodorow 1978; Jaffe et al., 2005; Leon, 1996; Zayas,1987). The participants in this study recalled early memories of being parented and wanting to repeat this experience with their own children. Parents or caregivers provide the empathic self-object functions to the child by meeting his/her psychological needs. As human beings, we all need affirmation, belonging and protection to make us feel cohesive. These feelings sustain us during our development and become our own through transmuting internalization (Elson, 1986).

Adele shared," …like all little girls I played with dolls. I had my baby dolls, I just always assumed I would get married and have kids." Melissa expressed, "Ever since I was little I have always wanted to be a parent." Adele and Melissa, like the other wives in this study, wanted to repeat what they observed their mothers doing, taking care of children. These observations were imitated via play as children and identified as a desired goal for adulthood. The experience of having been raised by a woman, leads to daughters developing an identification with their female figure and expectation that they, too will be able one day to inherit or possess this role through procreation (Leon, 1996).

Jimmie shared, "I always thought that I would be a good dad, and that I would like to be a parent," Like women, men develop an attachment with the mother during the oral stage of development because of her nurturing behavior. However, the male child

begins to develop an identification with his father, whom he views as a protector and provider (Zayas, 1987). The father then replaces the mother as the nurturing figure. Based on their relationships and early experiences with male caregivers or father figures, the husbands in this study also desired to replicate this experience by becoming parents one day.

Caregivers provide essential self-object functions for children. Self-objects are valued for the internal functions and emotional stability they provide. These functions include mirroring, idealizing, and twinship needs. Essentially, an individual's thoughts and feelings about parenthood begin as a mirroring of what he/she experiences as a child, and this mirroring continues to develop into stories, fantasies, wishes, and plans that are carried into adulthood (Jaffe et al., 2005). An identification is developed around what the caregiver did and did not do that influences parenting, lifestyle, and relationships.

Absent or turbulent relationships with caregivers, loss, violence, abuse, neglect, etc. in childhood are painful experiences that can shape who an individual becomes. Disruptions or repeated empathic failures on the part of the caregiver can impact development. In order to feel intact, the child must eventually reclaim idealization or continue through life needing to attach to an idealized figure in order to feel whole (Siegel, 1996). Through re-internalization of the idealizing narcissism, permanent psychic structures are established. The child begins to view the caregiver as a "good enough parent" who is not perfect. Through transmuting internalization, the child is able to "internalize specific qualities of the parents' emotional attitudes and responses" (p. 71). He/she is then able to satisfy some of his/her own needs (Tolpin, 1971).

The process of adult development involves consolidating one's sense of self (Jaffe et al., 2005). Becoming independent, developing a career, owning a home, and establishing a committed relationship are some of the ways in which one develops as an adult and strengthens sense of self. Parenthood is a major developmental milestone that also brings about a new identity. When the decision is made to have a baby, "identity shifts from being a child to being a parent, from being a couple to being a threesome, from being a husband and wife to being a father and mother" (p. 104). As a result, in adulthood, an individual will decide to do things differently, hoping to heal old wounds by providing his/her children with all the things that he/she lacked growing up. Becoming a parent allows an individual to reconnect with family and friends in a different way. When the circumstance of infertility interferes with an individual's plan and hopes for parenting, it is difficult to recognize any other way to "fix" the past hurts and disappointments (Jaffe, et al., 2005).

There is also a loss of belonging among family, friends and society. There is loss of twinship function and anticipated mirroring of having a child. Couples impacted by infertility are unable to have a shared experience with other parents. There is also a loss of being idealized and "viewed with awe and admiration" by another being (Siegel, 1996). As a result, couples begin to wonder where they belong among those around them if they cannot participate in shared experiences. This sense of inadequacy contributes to a poor sense of self. The threshold for narcissistic rage is lowered, establishing humiliation, helplessness and self-mortification (Leon, 2010). Rage is then directed at those who can conceive as well as family and friends. Couples find themselves avoiding social engagements and in particular, baby showers. As Adele expressed, "I did shy away from

things because I didn't want to be around it. I didn't want to sit and talk to somebody about kids because I wanted that. I wanted to be the one that had the kids that people were talking to me about."

Infertility is a narcissistic injury to the self, making an individual feel as if he/she is to blame for his/her infertility. Individuals blame themselves for not taking care of themselves well enough, for sexual encounters they may have had, or for birth control they may have used (Jaffe et al., 2005). Terri blames herself for a having contracted sexually transmitted infections that led to pre-cancerous cells in her cervix. She feels that her lack of awareness, education, feelings of shame has contributed to her infertility. It is more comforting for Terri to blame herself than to have no answers at all about her infertility. Blaming oneself provides a false sense of security and control over a situation in which one is powerless (Chodorow, 2003). Feeling in control, even if it makes one feel guilty, is better than having nothing to blame.

The couples in this study are professionals who work in settings where they must maintain a certain level of control in order to be successful. This level of control also contributes to their sense of who they are. Once couples agree to utilize reproductive technology, they are in essence giving up control of their bodies to specialists. Relinquishing this control and having to identify as an infertility patient can impact self-esteem, leading to feelings of failure as a professional and a person.

The experience of treatment creates a disconnection between the self and the body. The functioning and management of one's body is no longer his/her own. The most intimate acts are now controlled by doctors in order to promote ovulation. Although viewed as a means to become pregnant, reproductive technology creates feelings of role

failure, inadequacy, shame, guilt, anger, and helplessness. As Patricia expressed, “I felt as if my body was failing me.” Infertility impacts idealized fantasies of omnipotence, femininity, masculinity, and defiance of mortality (Jaffe et al., 2005).

The loss of control and narcissistic injury as a result of the experience of infertility, leads to a redefining of self (Jaffe et al., 2005). In order to feel whole, in control, and recognizable, couples become consumed with having a child. Having a baby becomes a desperate need to provide narcissistic restitution (Leon, 2010). It is a way to regain all that has been lost internally as a result of infertility.

As a result of becoming consumed with having a child, infertile couples experience the narcissistic wounds of loss and body failure when they are unable to successfully procreate. They tell themselves (as well as hear from others) that they need to be strong and weather this life trial. As the couples in this study shared, they tend to retreat and become a closed system as a way of dealing with the pain and disappointment. Tasha expressed, “I did feel closed off from people. I remember one day my pastor pulling me into the office and telling me, ‘…you need to get out of the cave.’” Shame, that is a result of the narcissistic injury of infertility, causes individuals to isolate themselves and operate in secrecy. The pain of the experience causes them to become closed off from others. They alienate themselves as a defense and protective measure. The irony is that this protective measure is harmful and fuels narcissistic vulnerabilities (Jaffe et al, 2005; Leon, 2010). Isolation from friends and family disrupts the need for self-regulating self-object functions.

In what was probably an unconscious effort to repair this rupture and experience self-object function, five of the six women in the study formed a sub-group from their

original membership to a wedding planning site where wives experiencing issues with conceiving began to share their stories and offer support to one another. This group membership provided mirroring and self-validating aspects that helped with replenishing some of their self-worth (Leon, 2010; Siegel, 1996). This online female constellation of support served as a sounding board for the wives and where they turned for comfort and empathy.

"And we prayed. A lot of prayer…" The couples shared that their faith and belief that something or somebody greater than themselves is watching over them has been a sustaining force. Faith is a powerful and unique force used by the couples as a self-object function to help support their sense of self during a trying time (Goldberg, 2013). Through faith, they established narcissistic equilibrium. Like a nurturing caregiver, prayer, testimony, and support from the church family provided the couples in this study with the nurturance, calmness, and emotional warmth needed to strengthen their internal world. Active participation in church provided the couples with mirroring, idealizing, and twinship functions that they may not have been able to obtain elsewhere. Faith helped the couples tolerate the frustrations and narcissistic injury of infertility by making meaning out of suffering. In addition, it deepened their ability to self- reflect and use their positive experiences of being loved unconditionally and understood, to help others in the church. In regard to the follow-up interviews, faith may have served as a defense against the anguish, pain and emotional trauma of the experience. It is possible that it may be more sustaining for the self if the participants remain in a grateful place for all that they have endured than to fully revisit the pain.

Melissa shared, “You have all these dreams and hopes and fantasies and things that you hope for and they don’t manifest they way you want them to. It is hard to handle all of that and the emotion around it.” Couples who are unable to have a baby together, like Melissa and Mark, must mourn for the longed for identity of parent that will never come to be. They are left incomplete and must begin the task of becoming whole again, developing a new sense of self that does not necessarily include parenting. They must also find a way to deal with the unbearable feelings and thoughts surrounding the trauma of infertility.

Via transmuting internalization, there must be a mourning of the loss of fantasies of omnipotence and mirroring transference (Siegel, 1996). There must also be an acceptance of narcissistic limitations. Melissa explained, “As time goes on, we don’t talk as much about it [experience of infertility]. I don’t bring that up as much because you can’t keep beating a dead horse. You can’t keep beating yourself up about something you don’t have control over.” Couples experience a readjustment in relationships with friends, family and one another. By “deconstructing the internalized attributes of infertility stigma, one is less susceptible to narcissistic hurts when inevitably confronted with prejudiced attitudes about infertility” (Leon, 2010, p. 67). The individual and couple develop an empathic understanding of infertility that leads to a better appreciation and management of the experience.

Couples who are able to procreate following infertility, are working to heal the emotional wounds of their experience while embracing parenthood (Jaffe et al., 2005). Although pleased to be on the other side of the experience, couples still deal with the trauma of narcissistic injury to their sense of self. Quite happy to be a mother but still

cognizant of what she went through, Adele expressed, “You're never the same. You just look at life through a different lens.” The wounds are still present and contain much grief and loss to be worked through.

Although the trauma of infertility is still present, couples are happy to join the ranks of other parents. They delight in the twinship experiences they get to have with peers and family (Leon, 2010). There is a sense of belonging that brings about some healing and restoration of the self. The reproductive story can begin to unfold, allowing the individual to finally shift from child to parent. In this process, the individual will begin to identify with his/her parent, coming to understand the caregiver as well as his/her own childhood better. She/he will also begin to view the baby as a narcissistic extension of his/herself, taking pride in the child’s mannerisms, traits, accomplishments that are a reflection of him/her (Jaffe, et. al, 2005). With nurturing support from a caregiver and/or partner, a new parental identity is built.

Summary

The study of infertility among African American couples provides a rich description of the experience for an ethnic group that has some of the highest rates but receives little attention. The societal perception of African Americans and fertility tends to focus on birth rates, contraception and the financial plight of procreation among this group. Fertility clinics and services tend to focus on the majority.

The participants in this study demonstrated that despite the traumatic experience of infertility, they were able to persevere and rely on their strengths to cope. For those couples, which were unable to conceive or adopt, they continue to rely on their strengths

every day. Unlike some of the literature that indicated that infertility strains and can permanently damage the marriage, these couples remain faithful and cohesive. They view themselves as a team that is supportive of each member and reliable in the face of adversity.

Although the couples expressed experiencing a range of emotions such grief, loss, anger, helplessness, etc. they prevailed, relying on their constellations of support to normalize the experience and display empathy. The understanding and support of those they trust and admire, allowed the couples to manage the physiological and psychological stress of the experience. The importance of faith as a historical guiding factor in the African American culture helped to strengthen the participants individually and as a couple. Through faith and the support of others, the couples are able to find comfort, establish narcissistic equilibrium through the reorganization of their sense of self, and help others who are going through the same destabilizing experience. The act of supporting other couples who are experiencing infertility also served to help the participants of this study in furthering their healing and experience of self-object functioning.

Chapter VII

Implications for Clinical Social Work Practice and Future Research

Limitations of the Study

In qualitative research, the researcher utilizes the process of validation, making sure that he/she has engaged in practices that will provide as accurate a reflection as possible of what the participants in the study have said (Creswell, 2007). The researcher began the analysis of data with a full description of the experience of the phenomenon. This step was done in an effort to set aside the personal experiences and/or assumptions of the researcher so the participants can be the focus of the study.

The researcher then developed a list of significant statements as it relates to the significance of the experience. Via horizontalization of the data, statements, sentences or quotes regarding how the participants are experiencing the phenomenon were developed into a list of non-repetitive, non-overlapping statements (Creswell, 2007). These significant statements were clustered into core themes of the experience. The themes were synthesized into descriptions of what the participants experienced with the phenomenon that includes verbatim examples.

After analyzing the results and constructing common experiences of the couples, the researcher conducted member checks via email with the six couples to confirm how accurately the researcher understood their experience. Participants were sent the results of the study and asked if the product reflected their experience of infertility as a couple.

Conducting the follow up interviews, the researcher found that although there was an overall expression of satisfaction with the write-up (one participant responded, “I believe you captured our story well!”), there was also avoidance on the part of the participants to more deeply expound upon the results. Although acknowledging that infertility is a distressing experience, the participants were unable to further discuss the trauma of this experience and any emotional effects. Instead, participants preferred to talk about the importance of faith and being in a grateful place. The couples did not recommend any changes to the results.

The participants consisted of heterosexual, African American couples in a committed relationship, who were either childless or parents. The participants were made up of middle to upper-middle class couples. The sample size was small, consisting of six couples. As a result, it is possibly only generalizable to those with similar characteristics of the participants and not reflective of a broader population. The researcher is a woman. While not necessarily a limitation, it could have influenced the willingness of the male participants to disclose information and respond fully to questions. The interviews with each of the husbands were an average of 25 minutes compared to those of the wives, which lasted about 60 minutes. A study in which a man conducted interviews on this topic might yield different results or additional data. Further research is needed to explore the experience of infertility among African American couples.

To summarize, the researcher utilized phenomenological theory to analyze the data and formulate the results of the experience of infertility among African American couples. After analyzing the results and constructing common experiences of the couples, the researcher employed the additional step of member checking, which involved having

participants review the data. Via member checking, the descriptions that have been developed as the result of analysis were provided to the participants to "confirm or disconfirm the accuracy of the research observations and interpretations" (Rubin & Babbie, 2008, p.432). The researcher emailed the participants a draft of the write-up and asked for their feedback. This step allowed the participants to further elaborate and confirm the validity of the findings. The researcher also checked in with the chair of her dissertation committee throughout data collection for processing and feedback.

Implications for Clinical Social Work Practice

As a result of the more recent psychoanalytic literature on infertility, there has been a shift from attributing infertility to psychogenic explanations of psychological factors such as fear of sexuality, and repudiation of motherhood and femininity (Apfel & Keylor, 2002). Therapists are now trying to understand infertility from a psychological and physiological point of view. There is more emphasis on the meaning of loss, negative coping, and identity.

In his study of 20 women presenting with psychological problems following pregnancy loss, Leon (1996) found that women avoided therapy, viewing it as a "mark of shame and inadequacy rather than a search for understanding and relief" (p. 345). African Americans tend to cope with mental health problems by using informal resources such as the church (Ward et al., 2009). Therapy is viewed as a sign of weakness, shame, and/or a threatening experience to a woman who is mourning a loss of self. The preoccupation with the experience can be so consuming that it impacts the woman's ability to be present in treatment and engage in transference.

Infertility can also revive old conflicts around earlier losses unrelated to fertility, past traumas, and other experiences that may have ruptured development (Apfel & Keylor, 2002). These issues coupled with invasive, costly, fertility treatment procedures that may or may not be successful, can compound a couple's pain. The dilemma of this psychological and physiological experience can be overwhelming to the couple. As a result, therapy may too overwhelming of an experience, resulting in a clinical impasse. Exploration and analysis of past and present disappointments may be too painful to bear and much easier to avoid.

Couples and individuals who seek therapy are looking and yearning to feel whole again (Leon, 1996; Chodorow, 2003). Infertility has ruptured their sense of self and esteem, and they wish to regain an earlier sense of identity and wellbeing. Therapy should be flexible, with the therapist following the client's lead and motivation for working through.

The therapist should serve as an empathic figure, who is able to resonate with the loss and affective state of the client (Leon, 1996). The client will mourn the loss of fantasies of omnipotence and mirroring transference (Siegel, 1996). Via the therapeutic relationship, the self is strengthened; narcissistic wounds and object loss can be healed. The client is at peace with decisions and outcomes, regardless of whether or not they result in motherhood. The client can choose healthier, sustaining self-object experiences such as personal and/or professional accomplishments that can substitute (although never fully replacing) for parental wishes.

Motherhood and fatherhood are taken for granted, considered an inevitable identity within an individual's life course (Letherby, 2012). When circumstances and

conditions that prevent this life course from occurring, distress can occur. This study found that infertility is a traumatizing event that derailed the couples' plans for accomplishment through parenthood and impacted their sense of self. The couples experienced the narcissistic wounds of loss and body failure when they were unable to successfully procreate. The stress of the experience of infertility brought four couples in the study closer, increasing empathy and strengthening communication. For two couples in the study, the experience of infertility affected their cohesion as a couple. Failure to communicate about their thoughts and feelings, as well as recognize each other's defense mechanisms, affected their closeness during the experience of infertility. As a result the couples were unable to be supportive and empathic to one another.

To cope with the stress of this experience, the couples utilized their faith. Faith is important to religious African Americans and was a daily coping mechanism that provided comfort and solace to the couples during the most difficult times. It should also be noted that only one participant in this study sought out therapy to cope with the experience of infertility. The remaining participants did not see it as a need, preferring to rely on faith and support systems.

Recommendations for Clinical Social Work Practice

In dealing with African American couples, who, present with a history of infertility, the clinician must be mindful of cultural considerations. A history of slavery, racism and discrimination has shaped how African Americans respond to therapy with avoidance and/or distrust of the process (Boyd-Franklin, 2003). Cultural beliefs can

impact how experiences are internalized and whether or not they choose to seek support. As a result, the following are recommendations for clinical practice

1. The therapist's use of self and values, perceptions, and cultural similarities and differences that can have an impact on work with clients. The therapist should be self-aware, empathic, and attuned to the client in order to create conditions for receiving thoughts and feelings from the client in order to effect healing of the narcissistic injury of the experience of infertility.
2. Establish credibility through a connection and therapeutic rapport that makes the client feel understood.
3. Awareness that because of gender socialization and discomfort with vulnerability, African American men may find it a challenge to disclose and share painful experiences with a therapist. There is a fear that this may be interpreted as a sign of weakness. Clinicians must understand this in order to resonate with the client and help alleviate the emotional suffering caused by the experience of infertility.
4. Understanding and acknowledging the importance of faith and religion in how African Americans may conceptualize their experiences. Clinicians should understand that the use of faith and religion to manage perception, occurrence and/or consequences of an undesirable or threatening event is a common practice among religious African Americans (Chatters et al., 2008). Religious coping may inhibit help-seeking behaviors and encourage treatment by religious leaders/advisors. As a result, African American clients may possibly avoid psychotherapy or struggle with fully committing to treatment.

5. Clinicians should provide psychoeducation to clients about trauma so that they know what to expect and what to do to manage it.
6. Ask questions in a non-imposing, respectful way.

Recommendations for Further Research

The findings suggest the following recommendations for further research:

1. Conducting this study with a larger sample size, utilizing a male and female co-researcher might yield additional data.
2. Consideration should be given to exploring the experience of infertility for African American men only. There is very little research that speaks to the male and in particular, African American male, experience. More information on how men organize this experience in light of gender socialization and societal expectations could be useful.
3. An area of research that arose from this study is the therapeutic experience of infertile African Americans. As previously mentioned, only one participant in this study sought psychotherapy. The remaining participants did not see it as a need, preferring to rely on faith and support systems.

Appendix A

Recruitment Flyer

VOLUNTEERS NEEDED FOR RESEARCH STUDY ON INFERTILITY

Are you African American?

Are you part of a heterosexual relationship?

Are you in a committed relationship of at least 1 year?

Are you and your partner currently childless?

Have you and/or your partner been diagnosed with infertility?

Are you over the age of 18?

If you answered **Yes** to these questions, you may be eligible to participate in a study about African American couples and their experiences with infertility.

The purpose of this study is to research and find out what the experience and meaning of infertility is for African American couples.

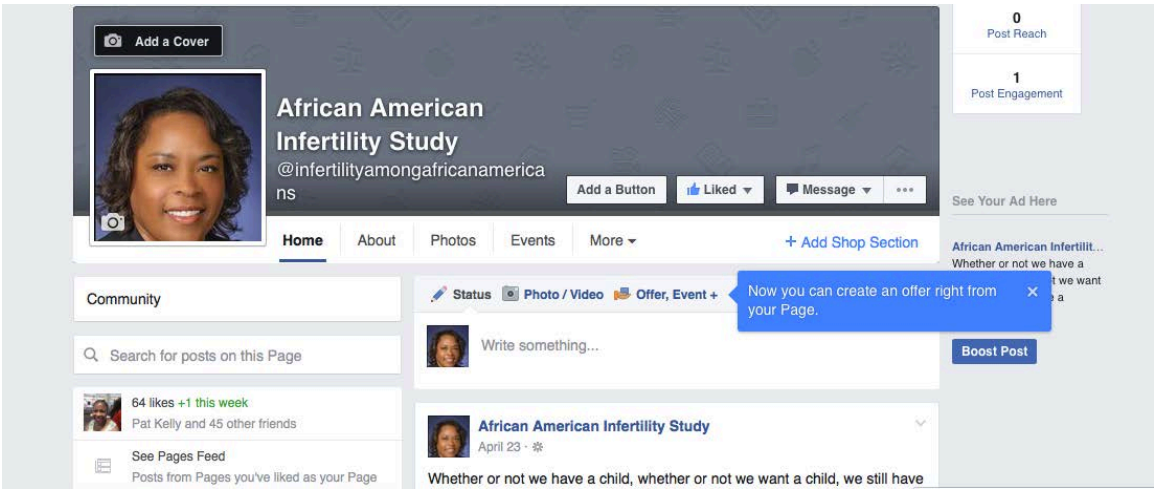
Confidentiality is assured.

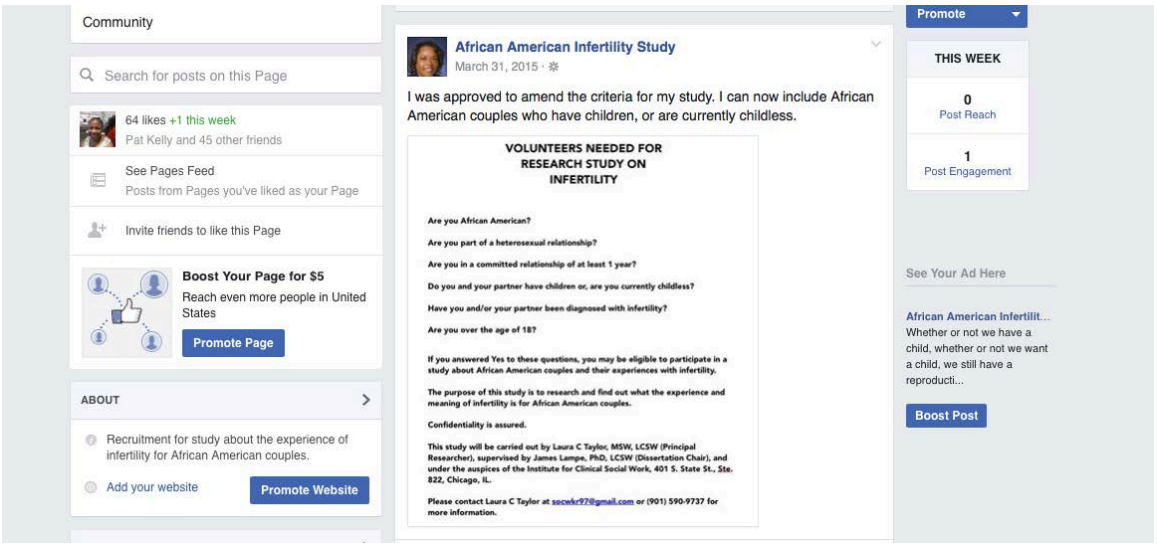
This study will be carried out by Laura C Taylor, MSW, LCSW (Principal Researcher), supervised by James Lampe, PhD, LCSW (Dissertation Chair), and under the auspices of the Institute for Clinical Social Work, 401 S. State St., Ste. 822, Chicago, IL.

Please contact Laura C Taylor at socwkr97@gmail.com or (901) 590-9737 for more information.

Appendix B

Facebook Page


Add a Cover
African American Infertility Study
@infertilityamongafricanamericans
Add a Button
Liked
Message
Home
About
Photos
Events
More
+ Add Shop Section
0
Post Reach
1
Post Engagement
See Your Ad Here
African American Infertilit...
Whether or not we have a
Boost Post
Community
Search for posts on this Page
64 likes +1 this week
Pat Kelly and 45 other friends
See Pages Feed
Posts from Pages you've liked as your Page
Status
Photo / Video
Offer, Event +
Now you can create an offer right from your Page.
Write something...
African American Infertility Study
April 23 ·
Whether or not we have a child, whether or not we want a child, we still have


Community
Search for posts on this Page
64 likes +1 this week
Pat Kelly and 45 other friends
See Pages Feed
Posts from Pages you've liked as your Page
Invite friends to like this Page
Boost Your Page for $5
Reach even more people in United States
Promote Page
ABOUT
Recruitment for study about the experience of infertility for African American couples.
Add your website
Promote Website
African American Infertility Study
March 31, 2015 ·
I was approved to amend the criteria for my study. I can now include African American couples who have children, or are currently childless.
VOLUNTEERS NEEDED FOR RESEARCH STUDY ON INFERTILITY
Are you African American?
Are you part of a heterosexual relationship?
Are you in a committed relationship of at least 1 year?
Do you and your partner have children or, are you currently childless?
Have you and/or your partner been diagnosed with infertility?
Are you over the age of 18?
If you answered Yes to these questions, you may be eligible to participate in a study about African American couples and their experiences with infertility.
The purpose of this study is to research and find out what the experience and meaning of infertility is for African American couples.
Confidentiality is assured.
This study will be carried out by Laura C Taylor, MSW, LCSW (Principal Researcher), supervised by James Lampe, PhD, LCSW (Dissertation Chair), and under the auspices of the Institute for Clinical Social Work, 401 S. State St., Ste. 822, Chicago, IL.
Please contact Laura C Taylor at socwkr97@gmail.com or (901) 590-9737 for more information.
Promote
THIS WEEK
0
Post Reach
1
Post Engagement
See Your Ad Here
African American Infertilit...
Whether or not we have a child, whether or not we want a child, we still have a reproducti...
Boost Post

Appendix C

Screening Questions

Screening Questions (to assess manner of verbally interacting and to assess vulnerability and anything that may adversely impact the study)

1. Are you African American?
2. Are you part of a heterosexual relationship?
3. Are you in a committed relationship of at least 1 year?
4. Are you and your partner currently childless?
5. Have you and/or your partner been diagnosed with infertility?
6. Are you over the age of 18?
7. Are you now or have you ever been diagnosed with a mental health issue? If so, specify which.
8. Are you currently taking any medications for mental health issues? If so, specify which.
9. Are you now or have you ever been in therapy?
10. Can you think of anything currently going on in your life that causes you to feel vulnerable or distressed?
11. What are some of the ways that you deal with issues that cause you to feel vulnerable or distressed?

Appendix D

Participant Informed Consent Form

Individual Consent for Participation in Research

INSTITUTE FOR CLINICAL SOCIAL WORK

I, _____, acting for myself, agree to take part in the research entitled: "The Experience of Infertility Among African American Couples."

This work will be carried out by Laura C Taylor, MSW, LCSW (Principal Researcher) under the supervision of James Lampe, MSW, PhD (Dissertation Chair).

This work is being conducted under the auspices of the Institute for Clinical Social Work ICSW); 401 S. State St., Suite 822; Chicago, IL 60605; (312) 935-4232.

Purpose

The purpose of this study is to research and find out what the meaning and experience of infertility is for African American couples.

PROCEDURES USED IN THE STUDY AND THE DURATION

The researcher will interview African American men and women individually and then together, as a couple. Each interview will be audiotaped and uploaded to a company via the Internet for transcription. There will also be an opportunity to review the transcript of the interview, in a separate meeting, for accuracy. Each interview will last approximately 60-90 minutes and will not occur in the same day. Each interview will be scheduled for a different day. Interviews will be conducted either in a quiet, private setting in the private office of the researcher or in your home. If you are unable to conduct interviews in-person, there is the option of utilizing videoconference program with the necessary technological precautions and protections taken.

Benefits

Research regarding infertility and the African American population is limited. The study's findings will contribute to the body of knowledge of clinical social work. Increased research evidence would lead mental health practitioners to assess the problems, treatment needs and barriers to the diagnosis and treatment of fertility related challenges faced by African American couples. Furthermore, practitioners could possibly advocate for appropriate interventions and policies to improve services to this identified population and potentially increase access to fertility related treatments and services.

Costs

There are no costs associated with participation in this study.

Possible Risks and/or Side Effects

Participation in the study is voluntary. Although there is no physical risk associated with this study, there exists the potential for emotional distress. During this study, you will be asked to revisit a time in your life that may evoke emotional memories. You will be asked to discuss past and present relationships as well as possible losses that you have experienced. As a result, you could experience some emotional distress. To minimize the potential for emotional distress, the researcher, a mental health clinician, will utilize vulnerability screening.

During the interview process, if the researcher detects any severe emotional response or signs of distress, you will be offered at least three courtesy follow-up sessions with a qualified mental health clinician for debriefing. Should further psychotherapeutic treatment be necessary, the researcher will make a referral to a network of skilled clinicians geographically convenient to where you are located and/or to a local community mental health clinic. You will be provided with the number of the researcher and encouraged to contact the researcher with any further emotional reactions to the study. The risk for severe emotional distress as a result of this study is relatively low.

You have the option to pause or take a break if you begin to experience an emotional response during the interview process. You have the option to suspend, delay or end the interview process at any time. In addition, you have the option of opting out of the study altogether, or opting out of discussing past and present experiences of your life that you feel are too distressing.

Privacy and Confidentiality

The researcher will take all necessary efforts to maintain your confidentiality and privacy. All data that will be explored in the study will come from the interviews. All initial interviews will be conducted face-to-face in a private setting such as my office or a setting suggested by you that provides privacy. Follow up interviews will be conducted in the same manner. Each interview will be audiotaped and later transcribed. Your name will not be used in order to maintain confidentiality. Each audiotape and transcripts will be coded with a unique identifier. Audiotapes will be kept in a locked file cabinet, in a private office and transcribed as soon as possible following the interviews.

All transcripts and notes will be kept in a locked file cabinet, in a private office, for a period of five years following this study and then destroyed. All analytical work will also be kept in a locked file cabinet, in a private office, for a period of five years and then destroyed. This data will be saved on a backup and protected by a security code known only to the researcher. At any time after the conclusion of this study and up to five years

during which study data will be maintained, you can review the results of the study by making a request. The results can be furnished as a verbal report or written summary of the study's results.

Subject Assurances

By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Laura C Taylor, MSW, LCSW (Principal Researcher) at 901-590-9737 or James Lampe, MSW, PhD (Dissertation Chair), at 773-665-1380.

If I have any questions about my rights as a research subject, I may contact John Ridings, Chair of Institutional Review Board Committee; ICSW; 400 S. State St., Suite 822; Chicago, IL 60605; (312) 935-4232.

Signatures

I have read this consent form and I agree to take part in this study as it is explained in this consent form.

_____ _____

Signature of Participant Date

I certify that I have explained the research to _____ (Name of subject) and believe that they understand and that they have agreed to participate freely. I agree to answer any additional questions when they arise during the research or afterward.

_____ _____

Signature of Researcher Date

Appendix E

Interview Script

INTERVIEW SCRIPT

Investigator will collect consent forms.

"Thank you for agreeing to speak with me today."

"The purpose of this interview is to get your feedback about the experience and meaning of infertility for African Americans. Specifically, I want to understand what it is like for you individually and as a member of a committed relationship to live with the diagnosis of infertility. I want to understand what experiences of infertility you encounter, and what you know and do to overcome and/or deal with those experiences. The underlying assumption that I am working with is that the experience of infertility is unique for African Americans and influenced by more than culture.

"You have a better understanding of what the experience is like. That is why I am talking with you. I want to hear from you what you believe to be common or unique experiences of infertility among African American couples. Your feedback may have the potential to increase awareness and understanding of the experience of infertility among African American couples."

"I would like to remind you that names of participants will not be used in order to maintain confidentiality. Each audiotape and transcripts will be coded with a unique identifier."

"You will be interviewed individually and with your partner. These interviews will not occur in the same day. Each interview will be scheduled for a different day. All interviews are confidential."

"The interviews will last approximately 60-90 minutes and I will audiotape the discussions to make sure that they are recorded accurately."

"To ensure that you fully understand this research study, I am going to ask you to explain to me what you understand about it."

"In addition, can you please explain to me what you understand the potential risks and benefits of this study to be?"

"Please allow me to reiterate that you are free to cancel your consent and refuse to continue in this study at any time without penalty or loss of benefits."

"Do you have any questions for me before we begin?"

Appendix F

Interview Questions

The interviews will be conducted with open-ended questions. Initially, the participants will be asked two broad questions. The first question posed will be, "How did the experience of infertility affect you? What changes do you associate with this experience?" Further questions will follow from the information asking for elaboration on relationships, family life, self-image, role, and coping. Additional questions that will be posed to the participants will include the following:

15. Have you always thought about being a parent?
16. What feelings were generated by your diagnosis of infertility?
17. What thoughts stood out for you?
18. What bodily changes or states were you aware of at the time?
19. How did you feel about infertility before learning you were experiencing it? How if at all, have your feelings about infertility changed?
20. How do you envision the future of your relationship?
21. How did you envision yourself as a parent?
22. How does the experience of infertility affect how you feel about yourself and other children?
23. What is it like for you to not be able to have a baby?
24. What is it like for you as a couple to not be able to have a baby?
25. Tell me about how you came to discover that you and your spouse were experiencing infertility?
26. Tell me how you understand what contributed to your infertility?
27. What was going on in your life when you began to experience infertility?
28. How did the experience of infertility affect significant others in your life?

Appendix G

Transcriptionist Confidentiality Form

Transcription Services Confidentiality Agreement

I, _____, transcriptionist (or representative on behalf of _____ company), agree to maintain full confidentiality in regard to any and all audiotapes, digital audio files, and documentation received from Laura C. Taylor related to her dissertation study titled "The Experience of Infertility Among African Americans."

Furthermore, I agree:

1. To hold in the strictest confidence all information contained in the interviews transcribed;

2. To not make copies of any audiotapes, digital audio, or computerized files of the transcribed interview texts, unless specifically requested to do so by Laura C. Taylor;

3. To store all study-related audiotapes, digital audio, and materials in a safe, secure location as long as they are in my possession;

4. To return all audiotapes and study-related documents to Laura C. Taylor in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices immediately after Laura C. Taylor has acknowledged receipt of the transcribed interviews.

Transcriber's/Representative's name (printed) _____

Transcriber's/Representative's signature_____

Date _____

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